

**HUSBANDS' RESPONSE TO ACCOMPANY THEIR PREGNANT WIVES
FOR HIV/AIDS TEST IN ANTENATAL CLINICS IN MOROGORO
MUNICIPALITY, TANZANIA**

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**A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE
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ABSTRACT

The concern for HIV/AIDS cannot be isolated from its devastating effects on socio-economic development of any nation. Tanzania is one of the countries with HIV prevalence rate of over 4% whence, like many other countries in Africa, Tanzania adapted the Prevention of Mother-to-Child Transmission (PMTCT) in 2003 to curb new HIV infections. Despite this assorted intervention, infant and child mortality rates by AIDS have remained a puzzle. This study therefore, aimed at conducting an assessment of husbands' response to accompany their pregnant wives for HIV/AIDS test in Antenatal Clinics (ANC) in Morogoro Municipality. Specifically the study looked at awareness of testing, challenges for testing, the importance of testing in ANC and factors influencing husbands' reluctance to get tested in ANC. Total of 120 respondents were involved in this study and data were analyzed by using Statistical Package for Social Sciences (SPSS) where both inferential and descriptive statistics were done. Women were found to be more aware of HIV testing in ANC compared to their counterpart. Among others, the study identified occupational demands, inadequacy of practitioners and lack of education as the major challenges for testing in ANC while, arranging to deliver in health facility, early administration of ARVs and enhance trust among couples were identified as the importance of testing in ANC. On the other hand, awareness on testing and frequency of conception were found to be the main predictors of husband's willingness to get tested for HIV in ANC. The study has concluded that, men's role in HIV prevention is pivotal to changing the course of the epidemic men participation in PMTCT programs increases their knowledge of HIV, develop supportive behavior and increases their

receptiveness to HIV testing. The study has acclaimed policy intervention to enhance men participation in PMTCT as well as eradication of HIV-related stigma to encourage HIV testing among couples in Antenatal Clinics.

DECLARATION

I, GODFREY R. JOACHIM do hereby declare to the Senate of Sokoine University of Agriculture that, this dissertation is my own original work done within a period of registration and that it has neither been submitted nor being concurrently submitted in any other institution for a higher degree award.

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Date

The above declaration is confirmed by:

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LIST OF ABBREVIATIONS AND SYMBOLS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinics
ARVs	Antiretrovirals
HIV	Human Immunodeficiency Virus
KII	Key Informants Interview
NACP	National AIDS Control Program
NBS	National Bureau of Statistics
NGOs	Non-Governmental Organizations
PLHAs	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
RCH	Reproductive and Child Health
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
UNAIDS	United Nations Program on HIV/AIDS
URT	United Republic of Tanzania
VCT	Voluntary Counseling and Testing

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Globally HIV and AIDS continue to sweep across the continents, the estimated number of people living with HIV has almost quadrupled since 1990s from 10 to 35.3 million up to the end of the year 2012 (UNICEF, 2014a). Of these 3.3 million were children under 15 years of age and about 17.7 million were women, each day in 2012 more than 6 000 people were newly infected and approximately 4 500 people died of AIDS, mostly because of inadequate access to HIV prevention, care and treatment services. However, on a positive note, new HIV infections among children are declining rapidly, largely due to scaled-up efforts to prevent mother-to-child transmission (UNICEF, 2014a).

About 90 percent of HIV infections in infants and children are vertically transmitted from mother to child during delivery or breastfeeding. Vertical transmission of HIV can be sharply reduced if antiretroviral drugs are administered to a woman during pregnancy and delivery and to her baby shortly after birth therefore, without any intervention between 15 and 45 percent of babies born to HIV-positive mothers will become infected and half of all infants infected with HIV will die before their second birthday if they do not receive treatment (UNICEF, 2014b).

Africa remained the most heavily affected region in the global HIV epidemic, an estimated 24.7 million people are living with HIV and AIDS in the region representing over 71 percentage of the global HIV burden. Additionally, 23.5 million

people living with HIV are residing in Sub-Saharan Africa (UNAIDS, 2013). Women remain disproportionately impacted by the HIV epidemic, accounting for 58 percent of all people living with HIV in the region and 92 percent of pregnant women living with HIV globally are residing in Sub-Saharan Africa (UNAIDS, 2012). However, on a positive note the number of people dying from AIDS-related causes in Sub-Saharan Africa declined by 32 percent from 1.8 million between 2005 and 2011 (UNAIDS, 2013).

Men who have sex with men have been reported to be at higher risk of transmission and acquisition of HIV and other Sexually Transmitted Infections (STI) and is a newly identified route for HIV transmission in Sub-Saharan Africa (McKirman, 1998). Studies on HIV prevalence rates among men who have sex with men conducted in various African countries particularly, Mombasa-Kenya, Dar es Salaam and Zanzibar-Tanzania and Cape Town-South Africa have revealed higher (2 to 3.2%) prevalence rates (Mmbaga *et al.*, 2012; Sanders and Okuku, 2007; Baral *et al.*, 2011). Yet, HIV-related programs in many parts of Africa including Tanzania have often failed to address anal sex in general and male-to-male penile anal sex in particular (Dahoma *et al.*, 2011).

Since its discovery in Tanzania the situation is still worse, the numbers of people living with HIV/AIDS have been tremendously increasing; the first three cases were reported in Kagera Region in 1983 and by 1986 all regions of Tanzania mainland had reported AIDS cases (URT, 2008). The HIV situation based on surveillance data from the National AIDS Control Program (NACP) suggest that 1 600 000 people were living with HIV/AIDS in the country by the end of 2011 out of these an

estimate of 960 000 were women and 640 000 men (URT, 2012). Only about 1 900 000 of AIDS cases have been reported officially since the first three cases were discovered in 1983, AIDS cases are highly underreported however, the Ministry of Health report that the average HIV prevalence rate among adult age 15-49 to be 5% in Tanzania; 6% for women and 4% for men. Furthermore, 6.9% of women who attend Reproductive and Child Health clinics (RCH) are HIV positive.

Pregnant women reached Antenatal Clinics (ANC) by Prevention of Mother to Child Transmission (PMTCT) services has increased over time from 958 103 in 2008 to 1 660 894 in 2010; the number of pregnant women attended ANC clinics for HIV testing have also increased from 919 377 to 1 414 051 in 2010 which in turns, raise the proportion of women reaching ANC clinics for HIV test versus the estimated number pregnant women in the population from 61% in 2008 to 99.7% in 2010 (URT, 2011). Despite the current tormenting situation, only 15% of people attended clinics for voluntary counseling and HIV testing (URT, 2008).

1.2 Problem Statement

The endeavor to combat HIV/AIDS crisis hit the highest point which calls the attention of both husbands and wives. However, men's engrossment in this battle does not depict any promising hope and thus, does not please the current alarming HIV prevalence. Despite almost a decade of efforts in sensitizing men to take part in pre and post-natal care still a good number of men are not adhering to the PMTCT recommendations that both parents should check their HIV status during prenatal care leaving them reluctant to accompany their pregnant wives to the ANC for

checkup. For instance, URT (2009) reported that there is relatively low turn-up of men who accompany their wives to ANC.

Therefore, it is against that background a strong substitute approach is prerequisite to enhance men participation in PMTCT services and other interventions of the like. Sensitizing and mobilizing men to attend antenatal clinics for HIV/AIDS test with their pregnant wives will be a milestone towards achieving the global goal of reducing infant and child mortality rate as well as reducing the pace of HIV new infections especially among children and infants by 90% by 2015 (UNAIDS, 2013). These were also highly recommended in National Policy on HIV/AIDS and National Multi-sectoral HIV Prevention Strategy 2009/012 which vows for an HIV test to parents (both, mother and father) during pregnancy for future of the unborn baby (URT, 2001; URT, 2009).

Previous studies on this topic such as Nyoni (2008); Boniface (2009); Alemayehu and Ali (2011); Kabote and Niboye (2012); have centered only on trends in HIV/AIDS voluntary testing in Tanzania, willingness and participation towards prevention of mother to child transmission among males of reproductive age, factors affecting the willingness to HIV counseling and testing among patients with controversial sexually transmitted infections, as well as social cultural factors and practices that impede upon behavioral change of women in era of HIV/AIDS respectively.

In reference to the above cited studies, there is no doubt that little attention has been given to HIV testing among couples, especially men's adherence to HIV/AIDS

testing with their pregnant wives in antenatal clinics. Therefore, this study attempted to fill that knowledge gap and get a clairvoyance of why men have remained unenthusiastic to get tested for HIV with their pregnant wives notwithstanding the assorted intervention.

1.3 Justification of the Study

The study on husbands' response to accompany their pregnant wives for HIV/AIDS test in antenatal clinics can assist the responsible authorities and the community at large to have a clear reflection of HIV/AIDS crisis among married couples and partners. It informs decision to planners, policy makers and relevant stakeholders by proposing ways to assess the existing problems and suggest strategies for improving the implementation of the PMTCT related interventions. Furthermore, the findings of this study can play a vital role towards reshaping the mindset of the people about testing and provide the community with a wide range of expertise in dealing with HIV and AIDS crisis among spouses. Additionally, this study adds a portion to the existing literature about HIV/AIDS among couples and can be used as a reference to other similar studies.

1.4 Research Objectives

1.4.1 General objective of the study

The main objective of the study is to assess husbands' response to accompany their pregnant wives for HIV/AIDS testing in antenatal clinics in Morogoro Municipality, Tanzania.

1.4.2 Specific objectives

- i. To assess awareness on HIV testing during antenatal care
- ii. To analyze challenges for HIV testing in antenatal clinics
- iii. To determine factors influencing husbands' reluctance to get tested for HIV/AIDS with their pregnant wives in antenatal clinics.
- iv. To analyze the importance of having husbands tested for HIV/AIDS with their pregnant wives in antenatal clinics

1.4.3 Research questions

- i. Are couples aware of the HIV testing in antenatal clinics?
- ii. What are the challenges associated with HIV testing in antenatal clinics?
- iii. What are the factors influencing husbands' reluctance to get tested with their pregnant wives in antenatal clinics?
- iv. What is the importance of having husband tested for HIV/AIDS in antenatal clinics with their pregnant wives?

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Definitions of the Key Concepts

- i) **Human Immunodeficiency Virus (HIV)** is the virus that attacks the immune system results in progressive illness that leaves people vulnerable to opportunistic infections. When the body's ability to fight these infections is mutilated to the maximum the disease is called AIDS (Acquired Immunodeficiency Syndrome). On average, one can take up to 10 years to progress from initial HIV infection to AIDS. This depends mainly on age, immune status and genetic makeup of an individual (TACAIDS, 2005).
- ii) **Antenatal Care** refers to a preventive care with the goal of providing regular checkups that allow doctors and midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefits both mother and the unborn child, is a medical and nursing care recommended for women during pregnancy sometimes known as Prenatal care

2.2 Empirical Literature Review

There are compelling arguments for HIV counseling and testing services for Sexually Transmitted Infections (STI) cases in Sub-Saharan Africa. First, individuals have the right to know their infection status and plan for the future to reduce further transmission of the virus. Second, early detection of HIV may improve medical and

psychosocial support for HIV-infected individuals. Third, HIV counseling and testing may enable people to cope with the anxiety associated with HIV sero-status. Finally, HIV counseling and testing promotes behavioral change (Yahaya *et al.*, 2010). However, HIV counseling and testing services and Antenatal Care Clinics (ANC) currently in place does not reach substantial number of people both, those who knows their HIV sero-status and those unaware (Parker *et al.*, 2000). Therefore, programs that wish to link up with HIV counseling and testing services in antenatal care clinics need to be aware of the most common obstacles to testing and do what they can to help reduce or eliminate them. According to Pietrzyk (2005) this helps to increase routine HIV screening of spouses in healthcare settings, including other sexually transmitted infection cases; to foster earlier detection of HIV infection, to identify and counsel spouses with unrecognized HIV infection and link them to clinical and prevention services and to reduce further transmission of HIV in the community.

The problem of HIV/AIDS remains a complicated and awesome one among Sub-Saharan Africa. Research suggests that power dynamics, gender roles and cultural practices have impacted negatively on women's quest to attain safe sexual behavior Nyoni (2008). For women in Africa HIV/AIDS problem begins with a total lack of control over sexual lives and behavior of their husbands, especially outside marriage, it is noted that the majority of women stay faithful to their husbands and partners according to cultural orders and roles while their husbands do not comply. Women noted that cultural prescriptions in their various ethnic settings condone male infidelity, but expect women to stay faithful to their partners. As a result, women sometimes contract HIV straight on their matrimonial beds (Pietrzyk, 2005). Despite

the alarming HIV prevalence among pregnant women, still a great deal of men in the worst hit Tanzania and Sub-Saharan Africa in general has reported not being interested in knowing their HIV-status which makes efforts to tame HIV/AIDS difficult.

2.2.1 Culture and HIV/AIDS

Culture has been shown to have positive and negative influences on health behaviors; indeed it is often shown to be a factor in the various ways that HIV/AIDS has impacted on the African population. These factors range from beliefs and values regarding sexuality including when to become sexually active and the number of sexual partners (Campbell, 1997). Culture plays also a vital role in determining the level of health of the individual, the family and the community which is particularly relevant in the context of Africa.

The values of the extended family and community significantly influence the behavior of the individual. Therefore, the behavior of an individual in relation to family and community is one major cultural factor that has implications for sexual behavior and HIV/AIDS prevention (Alemayehu and Ali, 2011). As the impact of HIV/AIDS remains undiminished, hitherto Africa still hold cultural values that exposes its population to the danger of new HIV infections. For example, it has been proved that, circumcision gives men the unlimited and unquestionable right to access sex rather than marking the point at which sexual responsibility and restraint is introduced into the lifestyle of young men (Vincent, 2008). The practice of female genital mutilation on the other hand, is very common in Africa, the reasons given for

this practice range from ensuring fidelity during marriage, enhancing sexual pleasure for men, upholding traditional values/rite of passage as well as observing religious custom (Tholoana, 2010). This practice has received widespread global concern which demands for its complete abolition however, the task has remained a conundrum in African countries.

2.2.2 Prevention of mother-to-child transmission of HIV

Since the mid 1990 the studies generated a general consensus on the facts that HIV can be prevented from mothers to infants. Thereafter, number of preventing strategies for mother to child transmission of HIV came into existence particularly in high income countries where the use of antiretroviral drugs, elective caesarean section and avoiding breastfeeding were the best preferred (Simba *et al.*, 2001). By 2001, UNICEF and other UN agencies were supporting 80 programmes to prevent mother-to-child transmission of HIV in 16 countries. Between 1999 and 2001 these programmes reached over 300 000 new clients in antenatal care centers, providing counseling to 220 000 women and HIV testing to 138 000 women (UNICEF, 2013).

In Tanzania mainland, prevention of mother-to-child transmission of HIV services are fully integrated in the Maternal and Child Health (MCH), labor and delivery services to support essential package of prenatal care which includes at a minimum the focused visits, birth preparedness, disease detection, prevention and treatment of diseases and counseling on nutrition (URT, 2008). The protocol for the national PMTCT program includes voluntary HIV counselling and testing during antenatal care, short course on preventive ARV regimes to prevent mother-to-child

transmission; single dose nevirapine for mother during labor and infants within 72 hours after delivery as well as counselling and support for safe infant feeding practices (URT, 2011).

Prevention of mother-to-child transmission (PMTCT) was shown to be effective in well-resourced settings through the administration of antiretroviral prophylaxis to the mother during pregnancy, labor and delivery and to the infant for the first six weeks of life. Further evidence demonstrated that combined antiretroviral therapy given to the mother together with elective Caesarean section and avoidance of breastfeeding reduced mother-to-child transmission to less than one percent. Consequently, guidelines were developed for high and in low-income countries (Katzet *al.*, 2012).

2.3 Barriers to voluntary HIV/AIDS Testing

2.3.1 Violence

An important component of HIV/AIDS Voluntary Counseling and Testing (VCT) programmes is encouraging clients to inform partners of their status however, many clients do not disclose result to their partners. Studies have found that among the major barriers to disclosure for women is fear of violent reaction from their male partners and those HIV infected women are at increased risk for partner violence (Gourlay *et al.*, 2013). Building on previous research, this study explored the links between HIV infection status disclosure and partner violence among women attending antenatal clinics in Dar es Salaam. According Maman *et al.*, (2002) voluntary HIV/AIDS testing especially among women has been hampered by violence and threats from their partners especially those who tested and found to be HIV positive.

2.3.2 Lack of well-trained counselors

Counselors have an important role to play in helping clients to develop safe disclosure plans, which include finding out about the role violence plays in their lives. Counselors need to be trained on how to ask sensitive questions about voluntary HIV/AIDS testing and to use this information to foster but not force disclosure among the clients, they must also be aware of existing services to help clients especially women living in violent relationships so that they can make appropriate referrals when necessary by maintaining confidentiality, partner involvement and self-efficacy regarding alternative feeding (Manongi, 1999).

2.3.3 HIV/AIDS related stigma

HIV-related stigma and discrimination leads to unwillingness to take an HIV test and disclose results to family, friends or sexual partner, stigma was discussed in general terms, describing how participants feared the reactions, feelings and expectations of others in relation to either being diagnosed with HIV or going for an HIV test (Fakoya *et al.*, 2010). HIV-related stigma are prominent in Africa and world at large, hence deserves a joint global concern to eradicate it. Burns *et al.*, (2008) explored how fear of high levels of HIV-related stigma specifically within African communities living in London, the study described how participants felt the disease was strongly associated with promiscuity and inappropriate sexual behavior however, Marks *et al.*, (2007) suggested that HIV was virtually invisible in England in comparison to some parts of Africa where media and educational campaigns increased awareness of HIV

therefore, low visibility and general lack of positive imagery about HIV meant that Africans in Europe may face stronger HIV-related stigma than in Africa.

In 2008 Tanzanian parliament passed the HIV and AIDS Act. The Act was passed for the sole purpose protecting the rights of people living with HIV and AIDS as it provides a legal framework for the national response towards people living with HIV and AIDS (Roura, 2009). The 2008 law makes it illegal to discriminate against someone because of their HIV status or the status of a family member and obliges the government and employers to advocate against stigma and discrimination (Mshana, 2008). However, sufficient training on the reform for those who implement the law and public awareness on the rights of people living with HIV and AIDS is needed for the law to be effective (Evans, 2008).

The law must be harmonized with other legislation in order to ensure that different laws do not contradict and work against each other. For example the criminalization of high-risk groups in Tanzania such as sex workers and men who have sex with men is at odds with the 2008 law as it makes it almost impossible for these groups, already marginalized and stigmatized, to access care and treatment (USAID, 2008). A study conducted by the USAID in Dar es Salaam found that, only half of HIV positive respondents had disclosed their status to intimate partners while the average time from receiving the results to disclosing them was 2.5 years for men and 4 years for women. Stigma, specifically fear of abandonment, job or property loss and violence were the reasons for this delays, such fear increases the chance that HIV will be

transmitted to a partner, that preventive behavior will be avoided and that uptake of treatment will be delayed (USAID, 2005).

2.4 Women and HIV

Preventing new HIV infections among women is critical not only for their own health but also to reduce the number of future HIV infections among infants, especially in Sub-Saharan Africa, where half of the female population is of child bearing age, this is even more important as few pregnant women are aware of their HIV status (Nkuoh *et al.*, 2013). In 2007, only 18 percent of pregnant women in low and middle-income countries received HIV test (UNAIDS, 2010). There are various factors making women more vulnerable to HIV/AIDS than males. These include, biological factors whereas, it has been scientifically proved that, the risk of HIV transmission during sex is greater for anal sex, followed by vaginal sex and least for oral sex. During vaginal sex which is commonly practiced in Africa, the chance of HIV transmission from a man to a woman is two to three times greater than transmission from woman to a man, this is due to biological make-up of the female biological tract. The female genital tract is made up of a larger exposed area (Tigalawana, 2010).

Semen has higher viral load than vaginal fluids and semens stay longer in the female genital tract after the act of sex which increases the chances of HIV transmission. It has also been proved that, the genital tract of young girls is immature and more prone to invasion by HIV (IWHC, 2006). The vulnerability of women and girls to HIV infections however, cannot be explained by biological factors alone but gender inequality that exist in African society, culture risk factors such as polygamy, early

marriages and vindicated violence as well as little knowledge and awareness among women about the existing prevention strategies such as mutual monogamy and male condom use. These have largely failed to address the sexual vulnerability due to fact that none of which are easily controlled by women and rather, plays a significant role in validating women's susceptibility to HIV infections (Byamugisha *et al.*, 2011).

2.5 Theoretical Literature Review

Marxist view health and health care problems as rooted in a capitalist system of economy, the poor get poor medical care because they get less of everything. Access to good medical care, preventive medical action, healthy knowledge, and limitation of delay in seeking treatment are privileged to the rich people in today's world, lower class people may well be disadvantaged. In fact, as the control of chronic health complications and infections like HIV/AIDS become more important the differences in health between the poor and rich are likely to increase because of people's relative lack of access to high quality health care (Kornblum and Julian, 1992).

In analysis of the relationship between social class and poor health, conflict theory suggests that, the mere fact of being poor promotes poor health, thus HIV/AIDS will continue to ravage and torture African countries and other poor communities around the globe for they cannot afford proper diet, hence more likely to be undernourished and therefore susceptible to AIDS, they often live in the densely populated areas so they are prone to respiratory diseases because they cannot afford proper housing (Stolley, 2005).

The theory further postulates that poor people seems to feel middle-aged earlier than non-poor as the result they are more likely to accept illness and diseases as natural

even, hence ignoring the sign and symptoms of AIDS until they become debilitating by which it may be too late to administer medications (Scott, 2006). Furthermore the profit motive has driven corporation to oversell many expensive technological advances even though they have benefited only a limited number of patients and have not significantly improved the society's health (Savage and Warde 1993).

The theory, however, does not suggest that modern clinical medicine and technologies do not alleviate pain or cure diseases, the point here is the medical institution fail to bring about significant improvement in the health of the population as whole. Why then, do societies continue to spend vast amount of resource on medical care and advanced technologies which do not benefit the entire if not majority of the society members. This, according to Dorrschmidt (2000) has much to do with the pursuit of private profit in our capitalist society, for example, in a Marxist analysis of coronary-care technology found that since its introduction in the 1960s, the expensive coronary care unit has become so popular that today they can be found almost in every country of the world, but the intensive care provided by that medical technology has not been proven more effective than simple resting at home.

Social interaction perspective argues that the spread of HIV and other sexually transmitted infections is due in part of our lifestyle, including occupation, prostitution, and alcoholism as proposed in Turner (1999) publication. Social Interaction explanation of HIV/AIDS draws upon the study of sociability (interaction between people within their groups) and the way people socialize in different society and communities. This perspective contends that certain features of social lifestyles

such as prostitution, smoking, dieting, and alcoholism are deeply embedded in social interactions. However, it goes beyond lifestyle and patterns of sociability it often applied to problems that stem from the doctor-patient relationship.

According to Sica and Sica (2010) it is assumed that patients tend to evaluate warm, friendly doctors favorably even when these doctors have not provided successful treatment by contrast, patients are more likely to sue for malpractice physicians who are highly trained and practice in sophisticated and high profiled hospitals even when these physicians are not intentionally negligent. It is a friendly doctor's effective style of communication that will augment patient satisfaction, and it is highly competent but bureaucratic doctor's **dominant style** that estranges the patient. Scott (2006) accentuates that affiliate style involves behavior that communicate honesty, compassion, humor, and nonjudgmental attitude, while dominant style involves the manifestation of power, authority, professional detachment, and status in physician's interaction with the patients. Why does the doctor's communication affect patient satisfaction?

Thio (1997) assumes that in interacting with patients, friendly doctors are more likely than dominant doctors to take into account the views, feelings and expectations held by the patients about themselves, their illness, and their doctors. To them, the illness is unusual as it does not happen to them every day, and their suffering is a highly intimate, emotional reality, thus they expect their doctors to show a great deal of concern for obviously they want a cure, but they also crave emotional support so if the doctor attune themselves to these expectations they can develop a warm

relationship with their patients, although this is not such an easy task because physicians have been trained to take an objective, dispassionate approach to diseases and they learned to view patients unemotionally especially when performing surgeries.

Such emotional detachment according to Sica and Sica (2009) often intrudes into the medical interview whereby doctors dominates with the questions based on their technical understanding of the cause and treatment of the illness when the patients tries to get the doctors to pay attention to their very personal sense of illness, the patient's effort to tell their stories were cut off by doctors within the first 18 seconds of the interview, in fact the patient never goes beyond the first question. In cases where they were allowed to talk, the physician will often respond only with "um... hum..." Such responses are noncommittal and indicate only minimal interest (Sica and Sica, 2009).

Detached professionalism tends to alienate the patients, making them feel that they are being treated as a mere disease rather than as people such patients are also likely to suffer other consequences and about 60 percent of these patients leave their doctor's offices confused about medication instructions and more than half prescriptions are taken improperly or not at all (Burry, 2003).

Structural Functionalism argues that, both physicians and patients play roles that contribute to social order. The patient must play the **sick role**, a set of social expectations regarding how an ill person should behave. Roles are associated with status, which in turns presents the person with a set of rights and obligation (Parsons,

1957). In his classical definition of the sick role he essentially laid out what rights the sick can claim and what obligation the sick should discharge. He gave out the rights of the sick as firstly, the sick has the right to be taken care of by others because, they did not choose to be sick and thus, they should not be blamed for their illness. Secondly, they have right to be exempted from certain social roles and duties, they should not be forced to go to work in the case of students they should be allowed to miss examinations and take it later when they will be better.

Parsons (1957) went further and identify two obligations of the sick as first, they should not expect to remain ill and use their illness to take advantage of others love, concern, and care or to shirk their work and other responsibilities and secondly, they should seek technically competent help, in seeing a doctor they must cooperate to help ensure their own rights and recovery (Gabe *et al.*, 2003).

On the other hand, doctors have their own rights and obligation in playing their **healing role**, a set of social expectations regarding how a doctor should behave. Basically doctors are expected to help the sick get well as required by the Hippocratic Oath, which they take when embarking on their medical career at the same time they have the right to receive appropriate compensation for their work because their work is widely regarded as highly important they may expect to make a great deal of money and enjoy considerable prestige (Tanner, 2003). Therefore, both the sick and healing role serves a social control function, they help to prevent illness, infections and diseases from disrupting economic production, family relations, and social activities.

This theory however, is highly criticized for justifying the existence of illness and diseases by claiming that they serve a social control function for doctors, physicians, and drug manufacturers are making a living out of them (Stolley, 2005). A question here is do people really need diseases in societies only because they serve a social control function? What about diseases which are already eradicated like Smallpox, Diphtheria and Whooping cough were they not serving a social control function, does the society need them now.

2.6 Conceptual Framework

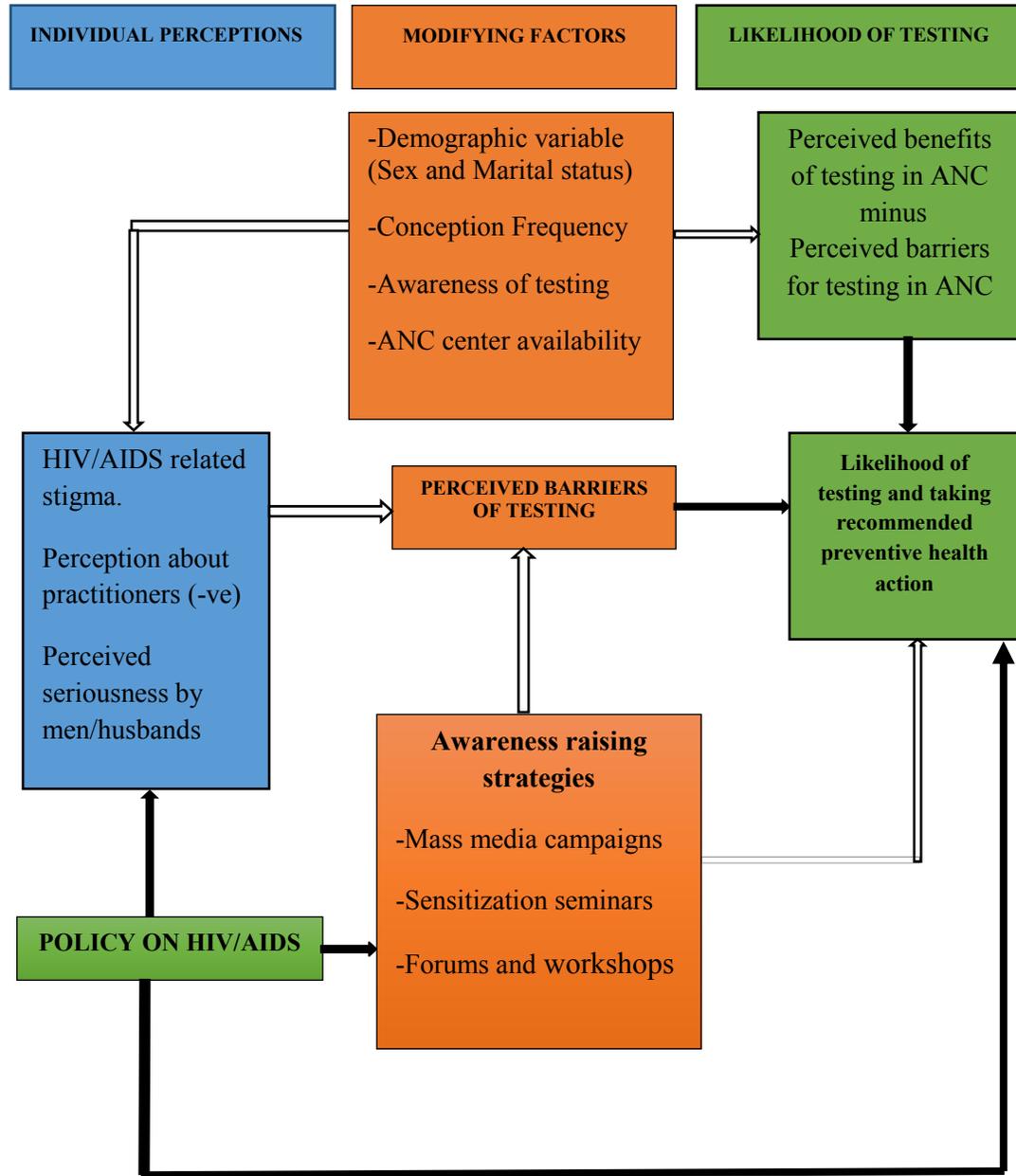
The conceptual framework designed for this study comprises of three major categories, the individual perceptions, modifying factors/intermediate variables and the likelihood to an action (deciding whether to test or not).

The modifying variables such as sex, marital status, frequency of conception, awareness of testing and antenatal clinics availability, all influence the individual perception as well as the likelihood of testing in ANC among partners. It was conceptualize that a good number of ANC stations influence awareness to testing and people who are aware of testing in antenatal clinics are more likely not to stigmatize others or consider stigma as the major barrier for them to get tested, these people will always develop a positive perception about the practitioners (Doctors, Nurses and Midwives) compared to where there is scarcity of ANC and where awareness is low.

Frequency of conception, on the other hand, has an influence to the perceived seriousness by men as well as the likelihood of testing in ANC, it is conceptualized that the higher the frequency of conception the highly men become serious and thus,

translate their seriousness into voluntary testing in ANC. The combination of individual perception and modifying factors leads to the perceived barriers for testing in ANC, which strongly impede the likelihood of testing among couples and partners and taking recommended health action while, the combination of the modifying factors and the likelihood of testing on the other hand, strongly enhance the likelihood of testing. The Tanzania policy on HIV/AIDS put a strong emphasis on changing the negative individual perception about testing for HIV/AIDS through awareness raising strategies such as the mass media campaigns, sensitization seminars as well as forums and workshops which in turn reduce the magnitude of the perceived barriers of testing for HIV in ANC and enhance the likelihood of testing and taking the recommended preventive action.

The Tanzania Policy on HIV/AIDS is for the sole purpose of reducing the new HIV infection by encouraging voluntary counseling and testing of HIV/AIDS while striving to eradicate HIV/AIDS related stigma and enhancing the positive perception and gender participation in the fight against HIV/AIDS.



KEY:

-  Mild Influence
-  Strong Influence

Figure 1: Conceptual framework

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Descriptions of the Study Area

This study was conducted in Morogoro Municipality in Morogoro Region, Tanzania. The region is divided into six administrative districts, namely Kilosa, Kilombero, Ulanga, Mvomero, Gairo, and Morogoro. Morogoro Municipality is located in northern part of Morogoro Region at $06^{\circ} 49'20''$ south of Equator and $037^{\circ} 39' 55''$ east to the Greenwich. It comprises of 19 Wards, out of these four Wards were purposively chosen for this study, the Municipality covers an area of 260 square kilometers and is bordered to the east and south by the Morogoro Rural Districts and to the west by Mvomero District. According to 2012 population and housing census Morogoro Municipality inhabits 315 866 people, 164 166 female and 151 700 male (URT, 2013). Morogoro Municipality was purposively selected on the basis that is among Municipalities with a good number of antenatal clinic centers in the country. Furthermore, the distribution of couples living with HIV/AIDS in region is higher (3.6% HIV prevalence rate among couples/partners) for all scenarios, both HIV-positive, a man HIV-positive women negative and a woman HIV-positive, man negative thus, put at risk infants and children (URT, 2012).

3.2 Research Design

Cross-sectional research design was used in this study. The design allows data to be collected at a single point in a time (Olsen, 2004). This design was chosen on the basis of its merits in involving groups of people who differ in the variable of interest,

but share other characteristics such as socio-economic status, educational background and ethnicity; it allows researchers to look at numerous things at once, e.g. Age, income and gender. They often used to look at the prevalence of something in a given population, while it does not involve manipulation of variables. A cross-sectional design is also suitable for describing characteristics that exist in a population and in examining the relationship among variables (Bailey, 1994).

3.3 Study Population

The sampling frame for this study was all households in the study area. Key informants including Midwives, Nurses as well as Gender advocacy officer formed a part of the sampling frame.

3.4 Sampling Procedure

Purposive and simple random sampling techniques were used to select surveyed wards and respondents respectively. Four wards were purposefully selected to participate in the study on the basis that they have enough ANC stations. Similarly, key informants were purposefully selected to participate in the study. The unit of analysis was an individual of child bearing age experiencing or had experienced matrimonial life and pregnancy.

3.5 Sample Size

According to Kothari, (2004) the sample determination formula was used as follows:

$$n = \frac{z^2 pq}{d^2} \dots\dots\dots$$

(1)

Where:

n =sample size in the study area when population > 10 000.

z = Standard normal deviation, set at 1.96 (2.0 approximate) corresponding to the 95% confidence interval level.

p = Proportion of the target population (50% if population is not known).

q = 1.0 – p (1-50) (1-0.5) = 0.5

d = degree of accuracy desired, (set at the 95% equivalent to 0.05)

Therefore:

$$n = \frac{(2)^2(0.5)(0.5)}{(0.05)^2} = 4 (0.25)/0.0025 = 400$$

Based on the formula, the sample size for this study could have been 400 cases. But due to fund and time limitations 30% of the cases were selected for this study. Therefore, 120 households from the four selected wards were chosen to participate in this study. Thus, a total of 30households was selected from each ward. Additionally, 10 key informants such as nurses, midwives and gender advocacy officers were selected purposefully. The selection of 120 respondents was based on the fact that a sample of 30 respondents, irrespective of the population size is the bare minimum for studies in which statistical data analysis is to be done (Bailey, 1994).

3.6 Methods of Data Collection

Both primary and secondary sources of data were used in this study. For primary data a structured questionnaire was developed and administered to the selected respondents, while for qualitative data collection, a key informants' checklist of items for discussion was developed. The checklist sought to gather additional and technical information about the researched variable from people who are knowledgeable about the HIV testing scenarios in antenatal clinics. A pilot study involved 12 respondents and two key informants was conducted in 2 wards (Mwembesongo and Uwanja wa taifa) prior to the actual survey to test the credibility and accuracy of the questionnaire and key informants interview guide. Secondary data were reviewed from government publications, books, reports and web pages to enrich findings from primary data.

3.6.1 Primary Data

Both qualitative and quantitative data were collected as part of primary data, a structured questionnaire containing both closed and open-ended questions was used to collect both qualitative and quantitative data additionally key informants guide was used to supplement additional information to the collected data.

3.6.2 Secondary Data

Secondary data from various sources such as the Tanzania Commission for AIDS (TACAIDS), National AIDS Program (NACP), journals, books, research papers, internet and SUA library were used to enrich the findings from the primary data. Secondary data included the trend in delivery in health facilities such that, the

number of pregnant women delivered in health facilities vis- a- vis the estimated number of pregnant women and estimated number of men accompanied their wives for HIV testing in antenatal clinics.

3.7 Data Collection Tools

3.7.1 Structured Questionnaire

A Structured questionnaire containing close and open ended questions was used for collection of primary data both qualitative and quantitative. The questionnaire was designed to focus on key issues, including social demographic characteristics of the respondents, awareness on HIV/AIDS testing in antenatal clinics, challenges for HIV/AIDS testing in antenatal clinics, the importance of having husband tested in ANC with their pregnant wives as well as factors for husbands' reluctance to get tested with their wives in the ANC.

3.7.2 Key informants interview guide (KIIs)

Key informants interview guide was used to collect data from knowledgeable people such as nurses, midwives, doctors and gender specialists. Informants were asked to give their views on various issues about husband response to accompany their pregnant wives for HIV/AIDS testing in antenatal clinics, hurdles for HIV testing in antenatal clinics among couples as well as the importance of testing during prenatal care.

3.8 Data Processing and Analysis

Data collected were edited, summarized, coded and analyzed using the Statistical Package for Social Sciences (SPSS) version 19 computer software in conformity with the study objectives. Both descriptive and inferential statistics were done. Descriptive statistics such as frequencies, averages, percentages, minimum and maximum values were computed in the analysis of objective one, two and four where cross-tabulation, chi-square, One-Way Anova and Kruskal-Wallis test were used to test the associations and comparison between groups and variables such as social demographic characteristics and awareness on HIV testing in antenatal clinics, tendencies of HIV testing in antenatal clinics as well as trends in antenatal clinics attendances among pregnant women as well as women and their partners in each surveyed ward. Multiple linear regression model was applied in the analysis of objective three.

In evaluating factors influencing husbands' reluctance to accompany their pregnant wives for HIV/AIDS testing in antenatal clinics, multiple linear regression model was adopted. Therefore, variables estimated in the model were those thought in advance to be capable of influencing husbands' reluctance to accompany their pregnant wives and get tested for HIV in antenatal clinics. A total number of times couples had tested for HIV/AIDS in antenatal clinics during the last pregnancy was set as the dependent variable while the independent variables included respondent's age, education level of respondents, Occupation of respondents, Average monthly income, Frequency of conception, Distance from the household to the nearest antenatal clinic station and Awareness on HIV/AIDS testing in antenatal clinics.

The regression equation:

$$\text{Ln } Y_i = \alpha + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5 + \beta_6 X_6 + \beta_7 X_7 + \varepsilon \dots \dots \dots$$

(2)

α	=	Intercept when all independent variables are equal to zero.
Y_i	=	Number of times partners tested for HIV/AIDS in ANC
X_1	=	Respondents' age
X_2	=	Education level of respondents
X_3	=	Occupation of the respondents
X_4	=	Average monthly income
X_5	=	Frequency of conception
X_6	=	Distance from the HH to the nearest ANC station
X_7	=	Awareness on HIV/AIDS testing in antenatal clinics
$\beta_1 - \beta_7$	=	Coefficients of determination of independent variables
ε	=	Stochastic disturbance (Error term)

3.9 Limitations of the Study

- (i) Some of the respondents refused to be involved in the study, others decided to quit in the middle of enumeration for several reasons and some were not at their households during the day of promise while others especially women demanded that the researcher should seek permission from their husband to enumerate them. This forced the researcher to lengthen the data collection session and hence spend an extra amount of money to accommodate printing of the distorted questionnaires and paying for transport fares to revisit those who were not available during the arranged date of enumeration.

- (ii) Some of the respondents especially key informants were interviewed while working, this was considered to be the problem due to the fact that it narrowed the possibility of getting more clarification of the questions which were asked by a researcher.

- (iii) Some respondents demanded for compensation before the interview believing that most HIV /AIDS issues are funded by donors, this had taken a lot of the researcher's time to explain that the information sought were for academic purposes and that no donor fund is being disbursed for such particular activity

CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

4.1 Demographic Characteristics of Respondents

4.1.1 Age

Findings from the study as presented in Table 1 show that 43.3% of respondents involved in this study were between the age of 30 and 39 years while 30.8% were between 20 and 29. On the other hand, 24.2% were aged between 40 and 49, while 1.7% of the respondents were at 50 and above years of age. The mean age was 34.1 years while the maximum was 53 and the minimum was 20 years. These patterns are similar to those of the national population census, which shows that majority of Tanzanians aged between 0 and 40 (URT, 2013). Furthermore, this implies that, the sample is reliable and reflects the correct patterns of the population structure in the country.

4.1.2 Sex

The selected sample for the study comprised of 120 respondents of which, 67.5% were female and 32.5% male. Therefore, majority of respondents were female compared to male. According to experience this is because of the beliefs that reproductive roles after conception are reserved only for women. On other hand, some of the male respondents pretended to be less informed about the study topic and insist their wives should be enumerated also some of the male respondents decided not to participate in the study and some had chosen to quit at the middle of enumeration for a number of reasons.

4.1.3 Education level

Results presented in Table 1 presents data on educational attainment of the respondents. The data indicate that there is high 91.7% literacy rate in the entire sample whereas, 44.2% of the respondents attained secondary education while 40% had attained primary education compared to 8.3% illiterate.

4.1.4 Occupation

Occupation of an individual can influence the willing participation of partners in PMTCT during antenatal care, the purpose was to determine the economic activities done by the respondents and establish whether they influence husband response to accompany their pregnant wives for HIV/AIDS test in ANC. For instance, men devote much of their time in chores of their occupation rather than participate in prenatal care like to accompany their pregnant wives to antenatal clinics. Results in Figure 1 show that, almost half 49.2% of the respondents were involved in small businesses while, 40.8% of the respondents were in formal employment. On the other hand, 6.7% and 3.3% of the respondents were engaging in farming and casual labour respectively.

4.1.5 Household average monthly income

Results from the study indicate that, the majority 65% of the households were below 190 000 Tanzanian shillings monthly income, while 20% of the households were between 200 000 and 390 000 Tsh. on other hand, 5.8% were between 400 000 and 590 000 Tsh and 5% were ranging between 600 000 and 790 000 Tsh, 2.5% were between 800 000 and 990 000 Tsh. Furthermore, 1.7% of households were above 1 000 000 Tsh.

Table 1: Demographic characteristics of respondents (n = 120)

Variable	Categories	Frequency	Percent
Age	30 – 39	52	43.3
	20 – 29	37	30.8
	40 – 49	29	24.2
	50 &>	2	1.7
Sex	Female	81	67.5
	Male	39	32.5
Education	Secondary school	53	44.2
	Primary school	48	40
	Illiterate	10	8.3
	Post-secondary	9	7.5
Occupation	Small Business	59	49.2
	Employed	49	40.8
	Farming	8	6.7
	Casual laborer	4	3.3
Month Income	<190 000	78	65
	200 000-390 000	24	20
	400 000-590 000	7	5.8
	600 000-790 000	6	5
	800 000-990 000	3	2.5
	1 000 000 &>	2	1.7

4.2 Awareness Status of HIV/AIDS Testing

4.2.1 Attendance to antenatal clinic by women

Results from the study as presented in Table 2 indicate that a total of 10 respondents had sixth times attended antenatal clinics during their last pregnancy whereby, 40% of the respondents were from each Kihonda and Sultani wards and 20% were from Sabasaba. Study results further indicate that 45 respondents had attended ANC center five times during their last pregnancy, whereas 35.6% and 24.4% of the respondents were from Sabasaba and Kihonda respectively while, 22.2% were from Mafiga.

Furthermore, 56 respondents had attended four times whereby, Mafiga and Sultani wards had 32.1% of respondents each and 19.6% and 16.1% of respondents were from Kihonda and Sabasaba respectively. Besides, 8 respondents had attended ANC three times during their last pregnancy whereas, 44.4% of the respondents were from Kihonda and 33.3% were from Sabasaba while, 22.2% were from Mafiga.

Furthermore, 7% of the respondents attended ANC three times below the minimum requirement of four times that a pregnant woman is required to attend to ANC this was attributed by economic constraints and frequency of conception among others. This study observed that, pregnant women prefers government owned antenatal clinic stations than private owned one, which are plenty. For example, in Kihonda Ward women were to travel to Mazimbu Hospital, which is approximately 5 kilometers, they have to pay for transport (Bodaboda) which is extremely expensive (2 000Tsh.), hence attend below the minimum requirements, it has also been observed by this study that, respondents who had attended below the minimum

requirement conceived for more than three times. Despite the discussion above, a Kruskal-Wallis test revealed that attendance to the ANC by pregnant women did not differ significantly among surveyed wards ($\chi^2 = 3.150$) and ($p > 0.05$).

Table 2: Antenatal clinic attendance by women (n = 120)

Frequency of attendance	Mafiga		Kihonda		Sabasaba		Sultani	
	n	%	n	%	n	%	n	%
Thrice	2	22.2	4	44.4	2	33.3	0	0
Fourth	18	32.1	11	19.6	9	16.1	18	32.1
Fifth	10	22.2	11	24.4	16	35.6	8	17.8
Sixth	0	0	4	40	2	20	4	40
Kruskal-Wallis test	$\chi^2 = 3.150df = 3$				p-value = 0.369			

4.2.2 Antenatal clinic attendance by partners/spouse

Results from the study as presented in Table 3 show that, a total of 49 respondents were at least once accompanied by their partners/spouse to ANC whereby, 28.6% of the respondents were from Sabasaba ward and 26.5% from Mafiga. On the other hand, 24.5% and 20.4% were from Kihonda and Sultani correspondingly. Study results also indicate that 27 respondents were at least twice accompanied by their spouse to ANC, of these 37% of the respondents were from Sultani and 33.3% was from Sabasaba while, 14.8% was from Kihonda and Mafiga each. Furthermore, study results indicate that 9 respondents had thrice accompanied to ANC by their spouse whereby, 44.4% of the respondents were from Mafiga and 22.2% from each Kihonda and Sultani while, 11.1% of the respondents were from Sabasaba ward. This is contrary to 35 respondents who had never accompanied by their spouse/partners to ANC whereas, 34.3% of the respondents were from Kihonda while 17.1% of

respondents were from Sabasaba. Despite the discussion above a Kruskal-Wallis test revealed that attendance to antenatal clinic by partner/spouse did not differ significantly among the surveyed wards ($\chi^2 = 3.149$) and ($p > 0.05$).

Table 3: Antenatal clinic attendance by partners/spouse (n = 120)

Frequency of attendance	Mafiga		Kihonda		Sabasaba		Sultani	
	n	%	n	%	n	%	n	%
Never	9	25.7	12	34.3	6	17.1	8	22.9
Once	13	26.5	12	24.5	14	28.6	10	20.4
Twice	4	14.8	4	14.8	9	33.3	10	37
Thrice	4	44.4	2	22.2	1	11.1	2	22.2
Kruskal-Wallis test	$\chi^2 = 3.149$		def = 3		p-value = 0.369			

4.2.3 Awarenessstatus of HIV/AIDS testing

Results from the study show that, the majority (78.3%) of respondents involved in this study were aware of HIV/AIDS testing in antenatal clinics whereby, 80.9% respondents were female and 19.1% male. On the other hand 21.7% of the respondents were not aware of HIV/AIDS testing in antenatal clinics, 80.8% was male and 19.2% women. These results therefore, suggest that women are more aware of HIV/AIDS testing in antenatal clinics compared to their counterpart. According to Emem *et al*, (2007) this is because of the attitude and belief by the community that reproductive role after conception are reserved for only women, men always feel that provision of finance for ANC registration and delivery fee are the most important roles in supporting their pregnant wives. These findings are congruent with the study by Eijik *et al*, (2006) which found that, women are more aware of HIV/AIDS scenarios than their counterpart, also these results comply with findings from NACP

where the turn up of pregnant women who tested for HIV/AIDS in antenatal clinics has risen from 30% in 2007-2008 to over 90% in 2010 (URT, 2012). Nonetheless a chi-square test revealed that there was statistically significant influence of sex to awareness on HIV/AIDS testing in antenatal clinics ($\chi^2 = 35.252$) and ($p < 0.01$).

Chi-square test further reveals that, there was statistically significant relationship between age of the respondent and awareness of HIV/AIDS testing in antenatal clinics ($\chi^2 = 20.898$) and ($p < 0.01$) whereas, almost half 49% of the respondents between 30 and 39 years were aware of HIV/AIDS testing in antenatal clinics, similarly 17% of respondents between 40 and 49 years were also aware contrary 50% of respondents aged between 40 and 49 years who were not aware of HIV testing in antenatal clinic. Furthermore, 7.7% of respondents at 50 years and above were also not aware.

Results as presented in Table 4 further indicate that, 45.7% of respondents who completed secondary education were aware of HIV/AIDS testing in antenatal clinics and 38.3% of respondents with primary education were also aware. Additionally 46.2% of respondents with primary education were not aware; similarly to 38.5% of respondents with secondary education also, 11.5% illiterate were not aware. Despite the discussion above a chi-square test revealed that there was no statistically significant influence of education level of respondents to HIV/AIDS testing awareness in antenatal clinics ($\chi^2 = 1.559$) and ($p > 0.05$).

Results from a study further indicate that more than half 51.1% of the respondents engaging in small and medium business were aware of HIV/AIDS testing in

antenatal clinics, while 42.6% of the respondents in formal employment were, contrary to this 46.2% of the respondents engaging in business and 30.8% in formal employment were also not aware. However, a chi-square test revealed that there is no statistical significant relationship between occupation of the respondents and awareness on HIV/AIDS testing in antenatal clinics ($\chi^2 = 6.481$) and ($p > 0.05$).

Table 4: Awareness on HIV/AIDS testing in antenatal clinics (n = 120)

Demographic Characteristics	Not aware		Aware		χ^2	p-value	
	n	%	n	%			
Sex	20 – 29	5	19.2	32	34	20.99	0.000***
	30 - 39	6	23.1	46	48		
	40 – 49	13	50	16	17		
	50 and above	2	7.7	0	0		
	Male	21	80.8	18	19.1		
Female	5	19.2	76	80.9			
Education	Illiterate	3	11.5	7	7.4	1.56	0.669
	Primary	12	46.2	36	38.3		
Occupation	Secondary	10	38.5	43	45.7	6.48	0.090
	Post-secondary	1	3.8	8	8.5		
	Farming	4	15.4	4	4.3		
	Formal employment	8	30.8	40	42.6		
	Business	2	7.7	2	2.1		
	Casual Labour						

Note ***= Significant at the 99 % level of confidence; **= Significant at the 95% level of confidence

4.2.4 Tendencies of HIV/AIDS testing in ANC

Results from the study revealed that 3.3% of respondents had twice accompanied by their spouse/partners for HIV/AIDS testing in antenatal clinics, results further

indicate that 35 (29.2%) of the respondents were once accompanied by their spouses/partners to antenatal clinics and get tested for HIV/AIDS, Sabasaba ward got a larger number of respondents who were once accompanied by their spouse for HIV test where by 11 (36.7%) of the respondent were tested with their spouses. This is contrary to 81 (67.5%) of the respondents who were never accompanied by their spouses to antenatal clinics for HIV/AIDS testing with Kihonda ward leading in figures where by 22 (73.3%) of the respondents had never tested, this is attributed by the fact that the ward is too big and rapidly expanding than the ability of social services to accommodate the increased population. A Kruskal-Wallis test revealed that tendencies in HIV/AIDS testing in antenatal clinics did not differ significantly among surveyed wards ($\chi^2 = 1.339$) and ($p > 0.05$)

Table 5: Tendencies in HIV/AIDS testing (n = 120)

Frequency of testing	Mafiga		Kihonda		Sabasaba		Sultani	
	n	%	n	%	n	%	n	%
Never	21	70	22	73.3	18	60	20	66.7
Once	7	23.3	8	26.7	11	36.7	9	30
Twice	2	6.7	0	0	1	3.3	1	3.3
Kruskal-Wallis test	$\chi^2 = 1.339$ df = 3				p-value = 0.720			

4.3 Challenges to HIV/AIDS Testing in ANC

The Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS was first introduced in Tanzania in the year 2003. Later in 2007 only 10% of health facilities were providing the core components of PMTCT, HIV/AIDS testing to

partners/couples inclusive (URT, 2012). The study assessed whether challenges associated with HIV testing in ANC are responsible for inadequate turning up of partners in ANC for HIV/AIDS testing. Therefore, respondents were asked to give their opinions on what they think are the challenges in HIV testing in ANC. Results from the study therefore, indicate that 27.5% of the respondents were of the opinion that occupational demands posed a serious hurdle on HIV testing in ANC and 19.2% of respondents pointed out that ANC encounter competition from other facilities when it comes to HIV testing. Since most of them cannot survive the competition people have turn their attention to other facilities (Health centers, VCT and Laboratory) which offer the same service. This was supported in key informant interview:

Despite the fact that attending to ANC and take an HIV test is mandate for pregnant women but their husband are free to refuse to test even if they accompany their wives, our Hippocratic oath forbids us from forcing our clients to services they don't want therefore, most of them always say they will test somewhere else since HIV/AIDS testing is not limited in ANC only, with the current technological advancement you can even get yourself tested at your household if you are used to that testing device. (Midwife from Mafiga Health Center).

On the other hand, another respondent was quoted saying:

Now the trend is shifting from testing them at the health facilities (VCT and ANC) to testing them at their particular households because the turn up to these facilities has been not promising, many International NGOs and even TACAIDS have been doing

that for a while, something which impede partners' turn up for HIV test in ANC.(A nurse from Sabasaba).

On the other hand, 16.7% of respondents claimed that they do not trust the practitioners so they could not risk getting tested for HIV in ANC and have everyone know about their status soon after testing. One respondent was quoted saying:

Most of the nurses and midwives are not trust worth, it happened that my neighbour went for test with his wife at our ANC center and lucky enough, they were not contracted HIV. From that day on whoever partners that are reluctant to get tested for HIV in that station, she will refer to them, even Mr (anonymous) and his wife tested last week and they were not positive what are you scared of, with this tendency people have been asking if Mr Anonymous was found HIV+ would she spares the secret. (Gender advocacy officer).

Study results furthermore, indicate that, 14.2% of the respondents claimed inadequate number of practitioners is among the challenges that hinder HIV testing in ANC, this finding concurs with the study by Nyamtema *et al.* (2012).This is also supported in key informant interview:

In HIV testing, we need more than nurses and midwives, of course we need many experts ranging from the psychotherapist/counsellor to doctors and laboratory technicians, but the situation in many of the ANC in this country does not comply with this, many of them are full of nurses and midwives who takes all duties from taking the blood sample, testing for possible infections and providing psycho-social

support while you must be a psychiatrist or a counsellor to do it. I think this also discourage couples from opting to test in ANC.(A nurse from Kihonda pharmacy).

Furthermore, study results indicate that 10% of respondents were of the opinion that lack of education among people about the importance of testing posed a grim threat on HIV testing in antenatal clinics. Rwechungura (2003) argued education to be a key factor which contributes to the sustainability of all social services, its absence may contribute too many influences which may lead the community to suffer health and health related problems, HIV/AIDS in particular. Moreover, 6.7% of the respondents lamented inadequacy of ANC centers as a major obstacle to HIV/AIDS testing in ANC. This is congruent with findings from NACP whereby, inadequate numbers of ANC station has left a substantial number of pregnant women without pre-natal services. On the other hand, 5.8% of the respondents blamed poor facilities in many of the ANC in Morogoro.

Many of the ANC stations do not have enough space, and many have combine both prenatal and post-natal services at the same place. If a mother is on the waiting desk she can simply hear what is going on inside the counselling room which divulge the privacy part of it. Even the chair on which clients have to sit waiting to their turn are in horrible condition as you have seen, how can someone seat for half an hour waiting on the bench and some of them carry their babies or they are pregnant, they need a comfortable chair and friendly environment to compensate the waiting time, but that will remain a puzzle as the authority keeps on overlooking it, even the

building structure is very poor, do not attract people how can you tell someone to get tested in a dilapidated building like this.(Anonymous).

Table 6: Challenges to HIV testing in antenatal clinics (n = 120)

Variable	Frequency	Percentage
Occupational demands	33	27.5
Competition from other facilities	23	19.2
Untrustworthy practitioners	20	16.7
Inadequacy of practitioners	17	14.2
Lack of education	12	10
Inadequacy of antenatal stations	8	6.7
Poor facilities in antenatal clinics	7	5.8
Total	120	100

4.3.1 Testing out of ANC routine

Results from the study indicated that 63 couples were once accompanied by their spouses for HIV/AIDS test out of ANC routine whereby, 17 (27%) was from each Sabasaba and Sultani while, 16 (25.4%) and 13 (20.6%) from Mafiga and Kihonda respectively had also tested for HIV/AIDS once out of their ANC routine. On the other hand, 7 respondents were tested for HIV out of the routine twice whereas, 57.1% was from Sultani and 28.6% from Sabasaba, 14.3% from Kihonda. Furthermore, only 1 couple from Mafiga Ward had tested for HIV out of the ANC thrice during the last pregnancy.

Results further indicate that, a total of 49 respondents had never tested for HIV/AIDS during their last pregnancy out of the ANC routine whereby, 32.7% was from

Kihonda and 26.5% was from Mafiga, on the other hand, 22.4% and 18.4% were from Sabasaba and Sultani Wards respectively. Nonetheless, One-way Anova test revealed that HIV/AIDS testing contrary to the routine did not differ significantly among surveyed wards ($F= 1.492$) and ($p > 0.05$).

Table 7: HIV/AIDS testing out of ANC routines (n = 120)

Frequency of testing	Mafiga		Kihonda		Sabasaba		Sultani	
	n	%	n	%	n	%	n	%
Never	13	26.5	16	32.7	11	22.4	9	18.4
Once	16	25.4	13	20.6	17	27	17	27
Twice	0	0	1	14.3	2	28.6	4	57.1
Thrice	1	100	0	0	0	0	0	0
One way Anova test	F= 1.492		df = 3		p-value = 0.221			

4.3.2 Preference for HIV/AIDS testout of ANC

Results in Table 8 presents the reason as to why couples opt to test for HIV contrary to ANC routine. Respondents were asked to give their opinion on why couples preferred to test for HIV/AIDS out of ANC routine. Therefore, study results indicate that, quota 25.8% of the respondents argued that they are not sure if the results will remain private therefore, they opt to get tested for HIV out of ANC routines.

Sometimes men who accompany their wives to ANC refuse to get tested on the basis that, they do not want their records to be kept that they had tested, thus prefer to test where they are not known. (Midwife-Mafiga health centre.)

On the other hand, 24.2% of the respondents opined that congestion of clients at most of ANC stations pushed them to undergo HIV test contrary to the routines.

Most of couples prefer testing out of ANC routine because of congestion in most of our ANC centers, for example, at this station we are receiving more than 40 pregnant women a day, imagine if they are accompanied by their partners will this space accommodate them comfortably? Also you need an appointment for the next visit at the station, they cannot skip the congested day and arrange another day something which is not if they decide test for HIV elsewhere. (Nurse-Mafiga).

Findings from the study further indicate that 22.2% of the respondents suggested that poor customer care in most of the ANC station has made couples disagreeing to get tested.

In most of the ANC stations servants are women sometimes they yell and use profanities against the clients, normally men needs to be respected in the presence of their wives and HIV testing in ANC is not a mandate for men so if they cannot calm their clientele how will this goal be achieved. (An official from TACAIDS).

Additionally, 15% of respondents argued poor facilities to be the main reason why couples prefers not to test for HIV in ANC while, 12.5% of the respondents were of the opinion that long distance to ANC station hinder testing in ANC.

*Most of the pregnant women prefers government owned ANC stations because they are free of charge for example from Kihonda to Mazimbu hospital, which is preferred by many, is approximately 5 km and cost about 2000 Tsh by **Bodaboda** now imagine if is husband and wife therefore, most of the couples must prefers*

anywhere near because HIV testing is absolutely free even in private owned facilities. (Said a nurse from Kihonda).

Table 8: Preference for testing contrary to ANC routine

Variable	Frequency	Percent
Fear over violation of privacy of results	31	25.8
Congestion of customers	29	24.2
Poor customer care	15	12.5
Poor facilities	18	15
Long distance to antenatal station	15	12.5
Total	120	100

4.4 Men's Reluctance to get Tested with their Pregnant Wives

Study findings as presented in Table 9 show that majority (26.7%) of the respondents were hesitant to get tested for HIV with their wives in ANC due to their relative lack of education on the importance of testing especially during prenatal care; this is supported with the information from key informant interview:

If men could have been attending ANC with their wives from the beginning at least, we could have an enormous portion of them educated about the importance of testing during prenatal care, but this is newly introduced, as time goes we will have the number increased. (Anonymous).

Another respondent was quoted saying:

Though the issue of HIV/AIDS pandemic is well covered but, media did not do enough to educate people on the importance of having husband tested with their pregnant wives in ANC. It's unfortunately that they continue repeating the same messages every day while AIDS multiply itself from time to time, every day materialize a new subject that need to draw their attention therefore, there is no need of repeating messages of 1990s if we are all intending to secure the population.(Nurse from Sultani area).

On the other hand, 20.8% of the respondents involved in this study were of the opinion that men are resistant to get tested with their wives in ANC due to fear of knowing their HIV status results, this is supported in KII.

Knowing your negative status, especially when you did not even develop any symptoms will make your life harder and guarantee the possibility of dying earlier due to trauma. If you have tested in response to a certain campaign or influence of friends will escalate the effects of trauma and harden the situation that is why we are advising people to volunteer testing out of their own will.(An official from TACAIDS).

Findings presented in Table 9 indicate that 20% of respondents responded that men resist accompanying their pregnant wives and get tested for HIV in ANC because of the patriarchal system. On the other hand, 16.7% opined poor cultural beliefs to explain men's reluctance, this concurs with the findings by Kwambai *et al.* (2013); Bhatta, (2013) both argued that culture specifically, patriarchal system in Africa and some Asian countries regard pregnancy and delivery as a female domain.

The Patriarchal system has manipulated men, sometimes there might be no reason why they should not accompany their wives and get tested in ANC, but since the system gifted them unquestioned power to decide anything saying no is going to be their best option. (A gender advocacy officer).

Findings as presented in Table9 further indicate that 12.5% of the respondents claimed that men are reluctant to test for HIV in ANC because their wives are already tested while 3.3% argued that the task is reserved for only women. This is also supported in KKIs.

Men are hesitant to take an HIV test and leave it to their wives, they will do their best to avoid testing and always had an excuse on the day of appointment. I remember visiting a household finding a man and his wife, when I asked a man to get tested he said my wife had tested last month and she was negative why should I also get tested, do I look like infected? He asked and insists that he is not going to test because he did not develop any symptom and believe he did not contract HIV yet. (A nurse from TACAIDS Mobile VCT).

Table 9: Factors for husbands' reluctance

Variable	Frequency	Percept
Lack of education	32	26.7
Fear of HIV positive result	25	20.8
Patriarchal system	24	20
Poor cultural beliefs	20	16.7
Testing through their wives	15	12.5
Task is reserved for only women	4	3.3
Total	120	100

4.4.1 Regression analysis of factors influencing mens' reluctance

To test the effects of various factors which were hypothesized to influence husbands' reluctance to accompany their pregnant wives for HIV/AIDS testing in antenatal clinics regression equation was estimated. Respondents' characteristics (age, occupation and education), household monthly income, distance from the household to the nearest ANC station and awareness on HIV/AIDS testing in ANC were the predictor variables estimated in the model. Therefore, the equation examined the influence of the mentioned predictors to the dependent variable 'total number of times partners tested for HIV/AIDS in ANC' in Morogoro District.

4.4.2 Regression analysis results

Results in Table 10 shows the majority of the individual parameters attached to the model were statistically significant at ($p > 0.05$). Consequently, respondents' characteristics, for example age, occupation and education were all statistically insignificant. These results therefore, suggest that age had not notably influence men's reluctance to accompany their pregnant wives and get tested in ANC. Education level as well as the occupation of the respondents on the other hand

indicated a positive relationship to the independent variable, but their effects are not significantly notable, ipso facto partners who are experiencing prenatal care irrespective of their age, education level and occupations are having absolutely equal opportunity to get tested for HIV/AIDS in antenatal clinics.

Average household monthly income was found to have no statistically significant influence to the dependent variable contrary to the study expectations. This is because in the surveyed wards except for Kihonda, there were at least two ANC centers and in most of them HIV/AIDS testing was absolutely free of charge (free health services for pregnant women and children under 5 years of age) even if clients were required to pay for other services in case the ANC station is private owned. Though, this predictor found to be statistically insignificant ($p>0.05$) it is available for further investigation and researches.

Findings as presented in Table 10 further indicate that, there was no statistically significant influence of the distance from the household to the nearest ANC center to husband reluctance opposite to the study anticipations, this is attributed by the fact that all surveyed wards are located in Morogoro municipality where ANC stations are plenty. It had also being noted that the maximum distance from household to the nearest ANC station is 1 kilometre.

On the other hand, frequency of conception was significant ($p<0.01$) and carries the anticipated influence to the dependent variable implying that HIV/AIDS testing among couples in antenatal clinics is subjective to frequency of conception. It had been noted by this study that, men's willingness to get tested for HIV/AIDS with

their pregnant wives in antenatal clinics was very positive at only the first two pregnancies. The regression analysis results further indicate that there was statistically significant influence of awareness on HIV/AIDS testing in ANC ($p < 0.01$) to men's reluctance to accompany their wives for HIV testing in antenatal clinics. This implies that men's awareness, better explain their reluctance for getting tested for HIV in antenatal clinics.

Table 10: Results of regression analysis for men's reluctance

Independent variables	β coefficient	Std. Error	t	Sig.
Constant	-0.476	0.356	-1.336	0.184
Respondent age	0.132	0.084	1.574	0.118
Education level	-0.19	0.042	-0.466	0.642
Respondents occupation	0.084	0.068	1.224	0.224
Average monthly income	0.000	0.000	0.497	0.620
Frequency of conception	-0.192	0.049	-3.961	0.000***
Distance to ANC station	0.165	0.253	0.650	0.517
Awareness on HIV testing	0.477	0.119	4.018	0.000***

Note ***= Significant at the 99 % level of confidence; **= Significant at the 95 % level of confidence

4.4.3 Overall evaluation of the model

The adjusted R^2 value of 0.224 implies that 22% of the variation in HIV/AIDS testing in antenatal clinics among couples and partners were explained by the independent variables in the model. However, it also implies that there are some variables which significantly influence husbands' reluctance to accompany their

pregnant wives and get tested for HIV/AIDS in antenatal clinics but were missed during the model estimation. Such variables may be investigated in further researches.

Results presented in Table 11 show that the F-value of 5.917 was significant at the 99 % level of confidence ($p < 0.01$) it also indicates that all predictor variables estimated in the model equation were well fitted and have an influence to the dependent variable.

Table 11: Overall model evaluation

Anova table	Sum of squares	df	Mean Square	F	Sig.
Regression	9.609	7	1.373	5.917	0.000***
Residual	25.982	112	0.232		
Total	35.592	119			
R	R-Square	Adjusted R-Square	Std Error of estimate		
0.520	0.270	0.224	0.482		

Note: *** = Significant at 99% level of confidence

4.4.4 Multicollinearity and singularity test

The regression model was tested for the Multicollinearity, this refers to the relationship among independent variables estimated in the model. Multicollinearity exists when the independent variables are highly correlated ($r > 0.9$) whereas, singularity occurs when one independent variable is actually a combination of other independent variable. Testing the model on multicollinearity was done by using tolerance and Variance Inflation Factor (VIF) test built in regression of each independent variable. Therefore, the higher the inter-correlation of independent variable the more the tolerance approaches zero, thus suggest for multicollinearity.

Results presented in Table 12 therefore, indicate that tolerance values do not approach zero and VIF values for independent variables are below 10 which validate that there is no multicollinearity in the model (Gujarat, 2004; Pallant, 2011).

Table 12: Collinearity test of the model

Predictors	Collinearity test	
	Tolerance	VIF
Respondents' age	0.446	2.243
Frequency of conception	0.505	1.979
Education level	0.912	1.097
Main occupation	0.941	1.062
Average monthly income	0.860	1.163
Distance to the nearest ANC	0.899	1.112
Awareness of testing in ANC	0.809	1.236

4.5 Importance of Having Couples Tested in ANC

Results from the study as presented in Table 13 indicate that majority 55.8% of the respondents maintained that HIV/AIDS testing among couples in the ANC is important because, the arrangement could be made earlier for a mother to deliver in a health facility in case she had contracted HIV. This is commended in KII.

HIV testing for both parents in Anais introduced for the mutual purposes of reducing trans- infection among parents (father and mother) and a baby (during or post-delivery). If it happens that a mother is infected with HIV/AIDS then by any means a baby has to be safe and free from infections as well as if one parent is having HIV should not transmit to the other, that's the secret behind (A nurse from Sultani).

Results from the study further indicate that, 23.3% was of the opinion that HIV testing in ANC facilitates administering medication (ARVs) earlier if it happened one or both parents are infected with HIV. On the other hand, 15.8% of the respondents involved in this study were of the opinion that testing in ANC is important because it helps in arranging the future plans, in case one couple is infected arrangement could be done to emphasize on safe sex, abstinence or be faithful in case both parents are not infected. Additionally, results indicate that, 5% of respondents opined that HIV testing in ANC bring trust among couples. This was also lamented during key informant interview:

Most of women thought their husbands become infidels when they become pregnant. The preliminary thing to prove them wrong is by their husband to accept accompanying them and get tested for HIV/AIDS in antenatal clinics. The fact that men are always hesitant to get tested with their wives proves their infidelity and attunes their wives expectations of them. (Nurse from Kihonda).

Table 13: Importance of having husband tested in ANC

Importance of having husband tested	Frequency	Percentage
Arranging to deliver in health facility	67	55.8
Early administration of medication	28	23.3
Arranging future plans	19	15.8
Enhance trust among partners	6	5
Total	120	100

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

The study investigated husbands' response to accompany their pregnant wives for HIV/AIDS testing in antenatal clinics. Based on the findings of this study and specific objectives, the following conclusion can be drawn.

5.1 Conclusion

Study findings indicate that majority of respondents are aware of HIV/AIDS testing in antenatal clinics however, this does not mean that majority of them are comprehensively aware of the importance of HIV/AIDS testing during prenatal care. This therefore, implies awareness of testing is not yet translated into HIV testing and counselling in antenatal clinics. This is justified by the poor turn up of partners for HIV testing in antenatal clinics. Additionally, women were found to be more aware compared to their counterpart however, this study is concluding that, their awareness did not add any value to HIV testing during prenatal care, women might have been exposed to HIV testing as an optional part of their ANC visits whence failed to transform awareness into actual testing. This is justified by observation made by the researcher that although women were aware of HIV testing during prenatal care, they failed to give robust replies when asked about the importance of having them tested with their husband.

The study identified occupation demands, inadequate number of practitioners, lack of education especially on the importance of testing during prenatal care as well as the

inadequacy of antenatal clinic stations among others, as factors that posed a grim threat on HIV/AIDS testing among couples in antenatal clinics, it should be noted that men are always hesitant in nature when it comes to HIV testing, with these challenges it becomes even harder to persuade them to go for testing with their wives during prenatal care. The fact that most of the female respondents had undergone testing during prenatal care should not lead into a conclusion that, these challenges are less potential because, it is a mandatory for a pregnant woman to undergo HIV/AIDS test in antenatal clinics, and this has been a reason for a good number of pregnant women who tests for HIV during prenatal care.

Furthermore, this study has identified fear over violation of privacy, congestion of clients, poor customer care and long distance to ANC stations mostly preferred as the major reasons for husbands' reluctance to accompany their pregnant wives for HIV/AIDS testing in antenatal clinics, this is justified by the poor number of men who attended ANC for HIV testing with their pregnant wives, this study has observed that, men's readiness to test for HIV with their wives in antenatal clinics was limited to only the first two pregnancies.

5.2 Recommendations

In order to enhance men's participation in PMTCT services and preventing the possibility of HIV new infections, the following recommendations are given based on the findings of this study.

5.2.1 Policy level recommendations

The HIV/AIDS epidemic is really complex, thus only a combination of approaches can succeed its reduction. It is increasingly clear, that people are to be at the centre of strategies to control and combat the spread of HIV/AIDS. Partnership between people, health organizations and other responsible authorities should build across-national boundaries where a down-top approach should be a sine qua non of the awareness raising campaigns to sensitize the community to give vital consideration to the alarming HIV prevalence. Contrary to the current situation whereby the prize-fight against HIV/AIDS is reserved for responsible government authorities, leave alone international NGOs predominated by the western oriented curricular which cannot be translated by an ordinary African. Ugandans have been successful in campaigns against HIV new infections because they have employed a down-top approach. Furthermore, the National policy on HIV/AIDS should be updated and made flexible to manoeuvre with emerging challenges when HIV/AIDS pandemic multiply itself.

The government should also make sure that, enough funds are relocated to awareness raising campaigns and the focus should be rural dwellers where access to media, health education centres and health services are very limited. Contrary to the current situation where seminars and workshops on awareness raising are privileged to the same people (the government officials).Furthermore, the government should ensure that health practitioners (Doctors, Midwives and Nurses) are well equipped with accurate knowledge and skill on HIV/AIDS regardless of whether they are the government employees nor otherwise.

5.2.3 Recommendation for NGOs

Since majority of couples/partners are aware of HIV/AIDS testing in antenatal clinics, but yet cannot translate their awareness into HIV testing in ANC. Therefore, there is an urge for NGOs and development partners working on HIV/AIDS in Tanzania to intensify their activities and funds in sensitizing the community to adhere to PMTCT intervention. Moreover NGOs should design their curricula, teaching and facilitation manuals to reflect the real situation in Africa and Tanzania particularly.

5.2.4 Recommendations for individual people

HIV/AIDS related stigma is one of the key challenges in the prevention and control of the epidemic. In Tanzania, like other countries south of the Sahara, stigma against HIV/AIDS remains very strong and plays a major role in fuelling HIV infection. In our community HIV related stigma tends to be firmly linked in people's minds to sexual behavior which again is regarded as 'promiscuous' behavior. This attitude puts PLHAs into unnecessary hostile and embarrassing situation, they face discrimination and sometimes neglect. Worse still, stigma leads to secrecy and denial that tends to hinder openness about HIV and prevents people from seeking counseling and testing for HIV, this leaves hundreds of thousands of apparently healthy looking people who are infected with HIV transmitting the infection to hundreds of thousands of uninfected people. Therefore, in fighting to eradicate stigma, every effort shall be put into breaking the long, deadly silence on HIV related stigma by all sectors at all levels. This involves individual being, health workers, political and government leaders, religious leaders, families as well as PLWHAs.

5.2.5 Areas for future research

The findings presented in this study are the results of a survey conducted in one district which cannot be representative of the total population of the country. Therefore, there is a need for more studies on the same subject, especially in rural areas where the number of antenatal clinics stations does not reach a substantial number of pregnant women and couples in general. Findings also indicated that only few variables which explain men's reluctance were estimated in the model this implies that the remaining variables are available for further researches to bring to the light factors which influence husband reluctance to get tested with their pregnant wives in antenatal clinics.

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APPENDICES

Appendix 1: Questionnaire for Individual Respondent

I, **Joachim Godfrey** a student at Sokoine University of Agriculture currently I, am doing a research on “**Husbands response to accompany their pregnant wives for HIV/AIDS test in antenatal clinics**” in Morogoro district. The information given here in will help to accomplish such a work and will be used for academic purposes only. Please be assured of privacy and confidentiality

Questionnaire Serial number.....

District.....Ward.....Street/village.....

.....

Date of interview...../...../..... (dd/mm/yyyy)

Name of the Respondents

(optional).....

Please circle the letter besides your appropriate answer

1. Age in complete years (.....)
2. Sex
 - a. Male b. Female
3. What is your highest level of education?
 - a. Primary b. Secondary c. Post-Secondary d. Illiterate
4. What is the highest level of your spouse/partner’s education?
 - a. Primary b. Secondary c. Post-Secondary d. Illiterate
 - (Others specify).....
5. What is your occupation?
 - a. Farming b. Business c. Employed d. casual labor e. others
 - (Others specify).....
6. How many hours do you spend at work a day?.....
7. How many days do go to work in a week?.....
8. What is your average month income
 - (Tsh.....)

9. What is the occupation of your spouse?
a. Farming b. Business c. Employed d. casual labor
 (Others specify).....
10. What is the distance from your household to the nearest Antenatal care clinic (in walking minutes)?
11. What is the distance from your household to the nearest Antenatal clinics (In Kilometers)?
12. How many times did you/your wife conceived?
13. Are you aware of HIV/AIDS testing in antenatal clinics?
a. Yes b. No
14. How many times have you attend antenatal clinic alone during your last pregnancy?
- | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
15. How many times have you attended antenatal clinic with your spouse/partner during your last pregnancy?
- | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
16. How many times have you tested for HIV with your spouse during your last pregnancy?
- | | | | | |
|---|---|---|---|-----------------------|
| 0 | 1 | 2 | 3 | 4other (specify)..... |
|---|---|---|---|-----------------------|
17. How many times have you tested for HIV/AIDS with your spouse during your last pregnancy out of antenatal clinics routine?
- | | | | | |
|---|---|---|---|-----------------------|
| 0 | 1 | 2 | 3 | 4other (specify)..... |
|---|---|---|---|-----------------------|

18. If Qn. 16 is applicable why your preferences to other health facilities over ante natal care clinics?

- a. long distance to ANC
- b. poor customer care
- c. congestion of customers
- d. Practitioners are not trust worthy
- e. Poor facilities
- f. other (specify).....

19. What do you think are the challenges associated with HIV testing in antenatal clinics

- a. Lack of specialized practitioner
- d. Occupational demands
- b. No ANC in my residential area
- e. Practitioners are not trust worthy
- c. Other facilities available on the same task
- f. others (specify).....

20. What do you think are the reasons as to why husbands are reluctant to get tested for HIV with their pregnant wives in Antenatal clinics?

- i.
- ...
- ii.
- ...
- iii.
- ...

21. What do you think should be done to get husband tested for HIV with their wives during pregnancy

- i.
- ...
- ii.
- ...
- iii.
- ...

22. Do you think are the importance of having husband tested for HIV?

i.

...

ii.

...

iii.

...

THANK YOU IN ADVANCE

Appendix 2: Key informants Interview Schedule

I, **Joachim Godfrey** a student at Sokoine University of Agriculture, currently I, am doing a research on “**Husbands response to accompany their pregnant wives for HIV/AIDS test in antenatal clinics**” in Morogoro district. The information given here in will help to accomplish such a work and will be used for academic purposes only. Please be assured of privacy and confidentiality

Prior information

Serial number.....

District.....Ward.....Street/village.....

.....

Date of enumeration...../...../..... (dd/mm/yyyy) Health center

Name of the Respondents.....Position/status of the

Participant.....

1. Explain what factors influencing men’s reluctance to accompany their wives for HIV test in antenatal clinics
 - i.
.....
.....
 - ii.
.....
.....
 - iii.
.....
.....

2. Explain what are the importance of having husbands tested for HIV with their pregnant wives in Antenatal clinics

- i.
.....
- ii.
.....
- iii.
.....

3. Explain what are the challenges associated with HIV testing among partners in antenatal clinics

- i.
.....
- ii.
.....
- iii.
.....

4. Explain what do you think should be done to improve the number of husbands attending antenatal clinics with their pregnant wives for HIV testing

- i.
.....
- ii.
.....
- iii.
.....

5. Do you have anything to add concerning the above discussion?

.....
.....
.....
.....
.....

THANK YOU IN ADVANCE