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Defining Male Support During and After Pregnancy from the Perspective of HIV-positive and HIV-negative Women in Durban, South Africa

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Abstract

Greater male support during pregnancy and in the postpartum period may improve health outcomes for mothers and children. To develop effective strategies to engage men we need to first understand the ways that men are currently engaged and the barriers to their greater involvement. We conducted in-depth interviews in isiZulu with 30 HIV-positive women and 16 HIV-negative women who received prenatal care from a public clinic in Durban, South Africa. Interviews were audiotaped, transcribed, translated, and coded for analysis. While less than a quarter of women reported that their partners accompanied them to the clinic, they described receiving other material and psychosocial support from partners. More HIV-positive women reported that their partners were not involved or not supportive, and in some cases direct threats and experiences with violence caused them to fear partner involvement. We need to broaden the lens through which we consider male support during pregnancy and in the postpartum period, and acknowledge that male involvement may not always be in the best interest of women. Engaging supportive partners outside of the clinic setting and incorporating other important social network members are important next steps in the effort to increase support for women.

Keywords

Male support; HIV prenatal; postpartum; South Africa

INTRODUCTION

Greater male support during pregnancy and in the postpartum period may improve communication between couples, provide opportunities for men to learn about the health needs of mothers and babies, and provide psychosocial support to women.[1] However, we understand very little about the kind of support that men provide during and after pregnancy, and the effects of such support on maternal and infant health outcomes.[2] To develop effective strategies to engage men more in health care provided to women, we need to understand how men are involved and the barriers to engaging them in supportive ways.

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The focus on male involvement during pregnancy has taken on new significance in the context of HIV/AIDS, particularly in sub-Saharan Africa where 35–40% of pregnant women are infected with HIV/AIDS in settings like the one in South Africa where this study was conducted.[3] Given the success of prevention of mother to child transmission (PMTCT) clinical trials, there has been great attention and effort to expand access to PMTCT programs. In many African settings women's low uptake of PMTCT programs remains a persistent challenge. It is now widely acknowledged that partner support is critical for the success of PMTCT.[4–7] Research has shown that greater male involvement, defined most commonly as male attendance at the prenatal clinic and/or HIV testing among male partners, leads to greater uptake of HIV testing among women,[8,9] greater uptake of antiretrovirals, [10,11] increased condom use,[12] and increased communication about sexual risk between partners.[13,14] Male support is also one of the most important correlates of HIV infected women's infant feeding choices and men's support influences women's adherence to their infant feeding methods.[15–18]

There are a number of barriers to increasing male involvement. Men report that they do not feel welcome and comfortable in prenatal clinics, and in some settings there are policies that restrict men's access to clinics.[1] There is also the perception among some men that pregnancy and child rearing are women's responsibilities.[19] And finally, time constraints have been identified as a key barrier to men's involvement.[20] A number of strategies have been implemented to try to overcome these barriers. Offering services for men at alternative times and alternative locations, [21] developing a policy to routine offer HIV testing to men in maternity wards, [6] formally inviting men to participate in PMTCT programs through a letter, [22] and social marketing and community mobilization are strategies used to increase male involvement.[23] Most of these strategies have been met with limited success.

The research that has been conducted on male support in the context of prenatal care, and PMTCT specifically has narrowly focused on male attendance at clinics and male uptake of HIV testing. We need a broader understanding of the kind of support that men provide during pregnancy and in the postpartum period, and the effects of such support in order to identify other ways that we can engage men during this time period. The purpose of this study was to describe the different type of support that men offered to their HIV-positive and HIV-negative partners during and after pregnancy, and to identify the reasons that some male partners were not involved in their partner's care.

METHODS

This study was conducted as part of a larger clinical trial in Durban, South Africa. The South Africa HIV/AIDS Antenatal Post-test Support Study (SAHAPS) is designed to evaluate a model of care in which clinical and psychosocial care are integrated for HIV-positive and HIV-negative women during the prenatal and postpartum period. The integrated model of care is being compared to the standard HIV counseling and testing that women receive during pregnancy according to the World Health Organization (WHO) and U.S. Centers for Disease Control and Prevention (CDC) guidelines (see Table 1 for comparison). Details of the SAHAPS intervention design have been published elsewhere.[24]

Study site

The SAHAPS study is being conducted in a public clinic in Umlazi Township, the second largest township in South Africa. The population of Umlazi is estimated at 400,000, although some estimates suggest there may be as many as 1 million persons living in the township. HIV prevalence among women attending the prenatal clinic is 42%. There are about 9,000 first visit prenatal attendees per year in the clinic. Approximately 25% of women are primagravidas and the average gestational age at the first visit is 28 weeks. Sixty

percent of the women at the prenatal clinic have attended school for at least 8–10 years. The clinic has had a PMTCT program in place since 2002. Women are offered HIV testing at their first prenatal visit. If women test positive for HIV, they are enrolled in the PMTCT program. HIV infected women are counseled about safe infant feeding options, encouraged to make an independent choice on preferred infant feeding method, given further information and access to free formula if they opt to use replacement feeding.

During this part of the study period from July through December, 2007, the HIVNET 012 protocol was in place to prevent transmission of HIV from mothers to infants.[25] The HIVNET 012 protocol emerged from a study in which it was demonstrated that a short intrapartum/neonatal regimen of Nevirapine (NVP), a retroviral agent, given to the mother at the onset of labor and to the infant within 72 hours of life reduced the risk of perinatal HIV transmission among breastfeeding women in Uganda by 47% at 14–16 weeks and by 41% at 18 months compared to a short intrapartum/neonatal regimen of AZT.[26] This simple, safe regimen was endorsed by international organization and adopted as the standard of care in resource-limited countries, including South Africa.

The data presented in this article were collected during the formative phase of the project to inform the development of the SAHAPS counseling protocols. All women were older than 18 years, had been tested for HIV during their most recent pregnancy, had delivered within the past year, and were able to identify a primary sexual partner, defined as someone that they had been with for at least 6 months and to whom they felt committed above all other partners. Women were recruited at the clinic when they returned for an immunization visit.

We used criteria based sampling, a purposive sampling method, to insure representation of women who had experiences that we needed to understand more about in order to develop the counseling protocols. HIV status was the first criteria we used for sampling. We sampled 30 HIV positive women, and 16 HIV negative women. Among the HIV positive women, we sampled women according to whether they had/had not disclosed their HIV status to a partner, what infant feeding method they initiated, and whether they were using contraceptives. Our counseling protocol for HIV positive women was tailored for women who made different decisions about disclosure, infant feeding and contraceptive uptake. We sampled HIV-negative women according to whether they were currently using contraceptives. We interviewed every eligible woman until we reached our targets within each specific criterion.

The interviewers used a semi-structured interview guide that outlined the major topics for discussion and listed suggested probes. Topics that were covered in all interviews included experiences with antenatal services, including HIV testing, family planning decisions, and the role of partners and others in the prenatal and post-natal period. HIV positive women were also asked about HIV status disclosure and infant feeding. The questions regarding male partners were open- ended and integrated throughout the interview. For example, when HIV positive women described their infant feeding decision making process, if they did not mention partners being involved, interviewers were trained to probe on this. We did not use an a-priori definition of partner support when interviewing women because we wanted to elicit an understanding about the different ways that men were involved from the perspective of women. This approach enabled us to describe the range of support that men provided to their partners at different points in the pre- and postpartum period, and to probe on reasons for the non-involvement of partners.

The interviews were conducted in a private room within the prenatal clinic. All interviews were conducted in isiZulu by staff trained in qualitative research methods. The staff provided women with information about the study and with an opportunity to ask questions

prior to collecting written informed consent. Women were told that the services they receive at the clinic would not be affected if they declined to participate in the research. The interviews were audiotaped, transcribed into isiZulu and translated into English for analysis. No personally identifying information such as name, phone number or address was collected on the women. Deductive, or topical, codes and inductive, or interpretive, codes were developed and applied in Atlas. ti (version 5.2). Deductive codes were applied to index the interviews by the topics that were covered, including partner involvement. We read and wrote reflective memos on all deductive code reports. We developed inductive codes to identify emerging ideas within the topic of partner involvement. For example, we developed and applied inductive codes to identify text related to psychological and instrumental support that men provided, and another inductive code to identify reasons for non-involvement of partners. Matrices were then constructed to facilitate comparison of male support between HIV-positive and HIV- negative women. All women provided written informed consent. The study was approved by the institutional review boards at the University of North Carolina at Chapel Hill and the University of KwaZulu-Natal.

RESULTS

Women described emotional and instrumental support from partners in both the prenatal and postpartum periods. The role of male partners varies in important ways by women's HIV status. One third of the women living with HIV reported that their partners had been supportive during or after the pregnancy, whereas 10 of the 16 HIV-negative women reported some support from a partner during this same time period. Below we describe the types of support men provided to women in the prenatal and postpartum period, and a description of male partners who were not involved and/or not supportive of women. On average the women in our sample were 28 years old (range 18–38 years) and had an average of 11 years of education (range 0–15 years). Women had two children on average (range 1–5). Four of the 46 women we interviewed were married, 17 were cohabitating with their primary partner, and 25 of the women had a primary partner who was living separately from them.

Male involvement during pregnancy

Male partners provided a range of different types of support to women during pregnancy. Women talked a lot about the instrumental support that their partners provided them to facilitate their access to the clinic and to provide them with food or money for food while they waited for their prenatal appointment. This was common among HIV-positive and HIV-negative women.

> "If he didn't come with me, he'll come during lunch to give me food. He lives around here. Sometimes he'll come here in the clinic from work to give me nice things." (HIV-negative, Age 19, Not living with partner, 1 child)

The partners of HIV- positive women also talked about how their male partners reminded them of their PMTCT-related appointments.

> "He read my clinic card to find out about my following visit to the clinic. He said 'Aren't you supposed to go to the clinic today?' I said 'I am'...He accompanied me to the taxi and said, 'The reason why I'm doing this is because I know if I let you go alone to the taxis, you just won't go to the clinic.' He said 'If I was not working I would have accompanied you to the clinic." (HIV-positive, Age 22, Living with partner, 2 children)

While women mostly talked about the instrumental support that men provided in the form of resources and reminders, seven of the women also described emotional support from their male partners, including comforting them when they learned their diagnosis.

Male invovlement in the postpartum period

Women also described ways in which their partners provided them with instrumental and emotional support in the postnatal period as well. A quarter of the women interviewed mentioned that their partners bought diapers, clothes, formula and other items required for the baby, while less than a quarter said that their partners helped with the basic care of the children. This woman described how her partner cared for the baby,

> "The baby would wake up at night for him to change the nappy and when he (the baby) wanted to pee when he was no longer comfortable with the nappy, he (the father) would take out the nappy and accompany him to go and pee. Sometimes he would return early from work when he worked a 6–2 shift, if he came back and the babysitter had not washed the baby, he would take him and wash him. You know everything…he was a real father to his children." (HIV-positive, Age 30, Living with partner, 3 children)

HIV-positive women also talked about the role of their partners in helping them make decisons related to prevention of mother to child transmission of HIV, including decisions about infant feeding.

> "We discussed and agreed with my partner that I was going to breastfeed my baby for 6 months. Yes, we both discussed it. I asked him if I could breastfeed the baby and he said I can for that period of six months. Yes, because at home they would ask me why am I not breastfeeding the baby? He was involved while I was pregnant because at the clinic they said that I should follow a healthy diet. He tried by all means to get what I needed. Yes, he used to ask me 'Is everything okay?' I'll say 'No, I don't have a problem' If I were to have a problem, from there he'll say 'Hey hey hey, you must go to the clinic' and I'll say 'No need to get worked up.' He'll say 'Go to the clinic right now.' He's a very sensitive man." (HIV-positive, Age 22, living with partner, 2 children)

This same woman described how her partner also encouraged her to take their child to the clinic for HIV testing:

> "Since I was attending the clinic, he'll ask me 'Have you tested the baby?' I'll say 'no, I haven't, how could I not tell you that.' Today he said 'Go and get the baby tested.' He kept asking me when am I going to the clinic because he knew that I was attending sessions with the counsellors. He said 'when are you going to the clinic?' He said 'now that you've finished sessions with the counselor, you should try to go and get the baby tested this coming week." (HIV-positive, Age 22, Living with partner, 2 children)

Male attendance at the clinic

Less than a quarter (n=10) of all the women reported that their partner accompanied them to a prenatal or postpartum clinic appointment. Of these ten women, six said he went with her to get the pregnancy test, two said he accompanied her for the child's immunization visits, and the partners of two HIV-infected women accompanied them when they went to collect their antiretrovirals. Time was a barrier to men attending clinic appointments as described by this woman:

> "I had everything I needed, he used to do everything for me. He also came to check for me. [Do you think that there's some more he could have done to assist you?]At

> that time, I don't think there's more that he could have done. He also made sure that they bring me food, you see ehhe good food that I needed to eat. [Did he accompany you to the clinic?] No, he's working, he cannot afford to do that. [But do you think he would have accompanied you?] He would if he wasn't working. " (HIV-positive, Age 34, Living with partner, 1 child)

There were also characteristics of the clinic and procedures within the clinic that created an environment in which it was difficult for men to attend with their partners. First, services are provided on a first come first serve basis, so women arrive starting at 6am to register for the appointments and often wait several hours for their services. Second, once women have registered they are required to change into their nightgown. They sit in the waiting room in their nightgown. Finally, the waiting room of the prenatal clinic is very small. Often there was insufficent space to accommodate all women waiting for services, so women stood in the waiting area or waited outside until they could get a seat in the clinic. The combination of these three factors created an uncomfortable setting for men to wait for long periods of time with their partners.

Men who were not involved

Not all partners were supportive of women in pregnacy or during the postpartum period. In some cases, women talked about wanting parners to be more engaged, and in other cases it was clear that women chose not to engage their partners in their care or the care of their children because they had experiences with violence and other negative experiences with their partner. There were HIV-positive and HIV-negative women who expressed some regret that their partners were not more involved. Often they were frustrated by attempts to demand more support from partners, particularly financial support for childcare.

> "What's lacking is support… like supporting the baby, he doesn't have support…I sometimes ask myself if is because I can do things myself? I think it's because he used to work a long time ago and now he's not"...He's a good person but when it comes to supporting with the children, he's not good but I keep my patience under such situation….because if I leave him and go somewhere, I'll be making a wrong move. " (HIV-negative, Age 32, Not living with partner, 5 children)

Seventeen of the 30 HIV-positive women we sampled had not disclosed their status to their partner, and thus had not involved their partner in any PMTCT related decisions. When asked their reasons for non-disclosure the majority said that they feared how their partner would react.

This fear was clearly justified for some, as two of these women said their partner had previously threatened to kill them if they tested positive.

> "My baby's father said if he gets HIV I would be the one to blame but he is the one that used to tell me how much he loved girls and that he was once with 3 ladies in the same room. So he usually says if he could test positive he would know that it was all because of me. He says he would kill me. [He says he would kill you?] Yes, he says he would kill a person who would infect him with it [HIV]. [When did he say that?] Before I tested, and before I even thought of getting tested." (HIV-positive, Age 24, Not living with partner, 1 child)

In the absence of, or in some cases in addition to, support from partners, women talked about relying on other people in their lives to help during their pregnancy and in the postpartum period, including most often mothers, sister and other female friends or confidants.

DISCUSSION

The women we interviewed described a range of ways in which their male partners were involved in the care of themselves and their babies during pregnancy and in the postpartum period. The strength of our approach is that we did not start with an a priori definition of male support. We asked women in an open-ended way about how their partners were involved in their pregnancy and postpartum experiences, and through their narratives we see a much broader involvement of men that extends beyond the traditional public health markers of clinic attendance and uptake of HIV testing. If we had only asked about male attendance at clinic appointments, or male uptake of HIV testing, we would have emerged with a very different impression of men's engagement.

Less than a quarter of the women we interviewed reported that their partners accompanied them to a prenatal or postpartum clinic appointment. This low proportion of male attendance is consistent with what has been reported in other studies from sub-Saharan Africa.[27–30] While very few men accompanied their partners to the clinic, both HIV-positive and HIV-negative women described instrumental and emotional support that men provided to them to facilitate their access to the clinics, to support them while they waited at the clinics, to purchase basic requirements for the baby, and to console them when they learned their diagnosis. Importantly, HIV positive women with supportive partners also described how men were involved in decisions related to PMTCT including facilitating their infant feeding choice, encouraging infant HIV testing, and encouraging them to adhere to HIV treatment. We need to know more about these supportive partners, so that existing PMTCT programs can identify and engage these men as allies in the care of women and their infants.

Unfortunately, not all men were engaged and supportive of their partners. More HIV-positive women than HIV-negative women in our sample reported that their partners were not involved or supportive. It is not clear from these interviews whether these partnerships were less supportive to start with or whether the HIV diagnosis and the pregnancy caused strain within these partnerships.

Our sampling may have limited what we found regarding the type and extent of male support in this setting. The women we interviewed were few in number and purposively sampled. Interviewing women who chose not to test for HIV, women who do not have a primary sexual partner, and younger women may reveal very different experiences regarding male involvement. Second, we interviewed women only once in the postpartum period. It is possible that women's recollection and attitudes toward their partners changed throughout their pregnancy or after birth, and these cross-sectional data are not able to reflect those changes over time. Finally, we described involvement of men from the perspective of their female partners. It would be useful to talk with male partners themselves to describe in more depth their attitudes and opinions on involvement and on barriers to participation.

Despite these limitations, the findings have important implications for research and practice. First, when developing strategies to engage male partners it is important to identify and understand the different type of partnerships that exist within a specific context. In our sample, less than 10% of the women we interviewed reported that they were married to their partner, and over half were not living with their primary partner. The low marriage rate in this sample is not atypical for South Africa. Census data confirms that there has been a steady decline in marriage rates over the last four decades. In 2001, less than 30% of African men and women over 15 years of age in South Africa were in marital relations.[31] As Mark Hunter describes, men's rising unemployment and the ongoing expectations of families for bride wealth has made marriage largely a middle class institution.[32] These trends have important implications for the types and stability of partnerships in this setting. While a

direct causal relationship between declining marriage rates and increased number of partners has not been established, it is likely that the decline in formal marital relations has had an impact on men's commitment to their female partners and the children of those partnerships.[33] Efforts to engage men in the care of their partners and children need to take into account the different types of partnerships that exist in a setting, and how these differences may affect women's expectations of their partners.

Second, it is critical that we broaden the lens through which we consider male involvement. To narrowly limit our consideration of male involvement as male attendance at clinics overlooks important ways that men are engaged. There are clear benefits associated with male clinic attendance in that it provides an opportunity for joint counseling on risk reduction, family planning, and infant care. It is also an opportunity to encourage men to test and learn their HIV diagnosis, and in the case where the partners are HIV infected, an opportunity to counsel the couple on the timely access of treatment. However, efforts to encourage greater male attendance at prenatal and postpartum clinics have been met with limited success. We need additional research to identify promising approaches to engage men as partners and as fathers during pregnancy and the postpartum period outside of the clinical setting.

Finally, we need to acknowledge that male involvement may not always be in the best interest of women. Some women in our sample had valid reasons for not involving their partners, including previous experiences and threats of violence. Furthermore, over half the women we interviewed were not living with their primary partner. Women in our sample talked about soliciting support from other individuals in their social support networks, including mothers, sisters and other female confidants. Building the social support that women need to maintain their health and the health of their children involves more than engaging men. Finding ways to encourage and involve other important supportive individuals during pregnancy and the postpartum period is another important area for future research.

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Table 1

Content of counseling provided in the South Africa HIV/AIDS Antenatal Post-test Support Study (SAHAPS) as compared to standard WHO/CDC HIV Counseling and Testing

SAHAPS (counseling provided by nurse-midwives)	**WHO/CDC HIV Counseling & Testing (counseling provided by lay counselors)**
Video prior to meeting with counselor to prepare women for decisions that they will have to make	NA
Pre-test counseling session	**Pre-test counseling session**
Information on PMTCT	Information on PMTCT
Prepare women for test	Prepare women for test
Risk assessment	NA
Discuss implications of results	NA
Post-test counseling session	**Post-Test counseling session**
Delivery of results	Delivery of results
Identify sources of support	Identify sources of support
Sexual risk reduction	Sexual risk reduction
Referral for partner testing	Referral for partner testing
For HIV positive women	For HIV positive women
Information on PMTCT (Infant feeding and ARV)	Information on PMTCT
Discuss disclosure plans	Discuss disclosure plans
Structured discussion tool assessing violence	NA
Disclosure role plays	NA
Mediated disclosure option offered	NA
1st Postpartum counseling session (6 weeks pp)	NA
Revisit risk reduction decisions/experiences	
Introduction/referral to legal services	
For HIV positive women	
Infant feeding counseling	
Revisit disclosure decisions/experiences	
2nd Postpartum counseling session (10 weeks pp)	NA
Revisit risk reduction decisions/experiences	
Family planning counseling	
For HIV positive women	
Revisit infant feeding decisions/experiences	
Revisit disclosure decisions/experiences	
Access to ongoing support groups in the clinic	NA
Access to onsite legal services	NA