

THE RELATIONSHIP BETWEEN FACTORS THAT INFLUENCE MEN, AGED 20-
50 YEARS' PERCEPTIONS AND THEIR PARTICIPATION IN PMTCT
PROGRAMMES IN GWANDA URBAN.

By

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ABSTRACT

Abstract

Perception may negatively or positively influence men's participation in PMTCT, which can lead to a rise in the morbidity and mortality rates among family members (father, mother and babies). The purpose of the study was to examine the relationship between the factors that influence men's perceptions and their participation in PMTCT (Prevention of mother to child transmission of HIV) at Gwanda Urban. Health Belief Model was used to provide a theoretical framework. Eighty men aged 20 to 50 years were selected using simple random sampling. An interview schedule consisting three sections demographic, men's participation in PMTCT programmes and men's perceptions of PMTCT was developed. Data was analysed using Pearson correlation coefficient test and simple regression analysis. The study findings showed a Pearson coefficient test of ($r = .285, p < .05$). this shows that there was a weak positive correlation between men's participation and men's perception of PMTCT. The results of the study show that the men's perceptions have a weak effect on the men's participation in PMTCT programme. R squared indicates that the men's perception of PMTCT accounts for 8% variance in men's perception in PMTCT programmes. It was recommended that clients be empowered to be responsible for making decisions about their health.

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CHAPTER 1

Background and Organizing Framework

Problem Statement

Healthcare worldwide is influenced by factors arising from cultural beliefs and customs (WHO, 2000). PMTCT has become the major element, among the preferred strategies and has been adopted as a national response to address and combat the HIV epidemic (MOHCW, 2007). The inception of PMTCT programme aimed at 100% success rate. This was done as a step in achieving the millennium Development Goal 4 and 5, by 2015.

Spousal support in PMTCT is paramount, which mainly include positive communication on rights of both men and women on their reproductive health (MOHCW, 2006). In the achievement of adult responsibility, gender difference was portrayed in ideas which underline the male capacity for agency, (Smeltzer, Bare, 2000). “Men’s hearts are different because they accomplish what they desire” men are seen as not being satisfied or motivated with what they have, but women are easily motivated, (Knight, 2000). This is further illustrated by the men’s poor participation in PMTCT, meaning that they are not easily motivated, even if it means their life. By virtue PMTCT involves the fetus (baby), mother and most importantly the father.

According to MOHCW, (2006), Zimbabwe has made recommended strides in the prevention and control of HIV and AIDS. This achievement was evidenced in the results of a Zimbabwe Demographic Health Survey (2006), which revealed a reduction in HIV prevalence to 18% from 24% in 2004. The above mentioned strategy is a response to a national action to achieve the global set Millennium Development Goals, by 2015 which is rapidly approaching, (MOHCW Annual Report, 2006).

According to MOHCW (2006) and partners “Men are heads of families and want to be in charge of decision making in reproductive health”. Anything that takes away this authority from men was perceived by the men as suspicion and can lead to their failure to motivate their spouses to participate in PMTCT programmes, as well as adopting a general negative attitude or insensitivity to it (MOHCW; UNAIDS, 2006). Whereas in an HIV prevention Strategic Framework of 2007 – 2010 men are viewed as sexual partners that play the initiating role, establish and halt sexual relationships for the sake of safe sex practices (MOHCW, 2007).

The major objective for partner involvement in PMTCT is to promote joint decision-making on relevant issues (MOHCW, 2006). Family support according to MOHCW, (2006) plays a pivotal role and at the same time facilitates coping with HIV and AIDS status, disclosure and adherence to treatment. Men involvement in this regard will prevent stigma, which will further create positive attitudes, HIV prevention, treatment, care and support, thereby ensuring the 100% success rate as per strategy.

Mbizvo and Basset(2007), carried out a study on “The case for increased participation”, and concluded that if one fails to target men in PMTCT programmes, that weakens the impact of the programme. The study further proposed that when targeting women’s reproductive health there must be a linkage with men, especially considering couples to seek for medical attention together. The low uptake of PMTCT services by males at Gwanda Hospital, has clearly indicated that this center is far from reaching the country’s strategic target of 100%. This triggered the need to investigate on the factors and perceptions associated with this kind of participation on the PMTCT programme.

Participation by men in PMTCT programmes has been poor in Gwanda, despite the fact of its urbanization. In PMTCT, couple participation is encouraged, however very few men turn-up for the services. This was evidenced by only 38 men, testing for HIV in 2007 (Jan –

Dec 2009) while 1379 women were tested, (MOHCW, 2008). The investigator was therefore concerned about men's health and their participation in health activities as the men constituted the bulk of the economic growth, which may determine the health status of a country. Men's lives need to be safe-guarded, to reduce the rate of orphaned children, which was currently at 1,600,000 (Save the Children, 2007).

Personal perceptions are often considered as those peculiar ideas by individuals from societies, which are insufficiently well informed about facts of modern medical science, (Smeltzer & Bare, 2004). The health practitioners use the concept of perception to mean those conceptualizations that help us understand odd health related behaviours and poor participation in preventive measures (Thorne, 2007). Despite this misconception, however it was the investigator's conviction that individual perceptions, still have a positive impact of one's participation in health issues. The information given above has shown lack of interest for participating in PMTCT by men. Therefore, it was against this statement that the research was carried out, on the perceptions and participation of men aged 20 – 50 in PMTCT services.

Purpose of the Study

The purpose of the study was to determine the relationship between factors that influence men's perceptions and their participation in PMTCT programmes.

Theoretical Framework

Polit and Hungler (2005) states that having a problem linked to a theoretical context enhances the meaningfulness of a research study. The design , data collection strategies, data analysis and interpretation of findings flow from that conceptualization. Constructs from Becker's (1974) Health Belief Model provided a framework for this study.

The Health Belief Model by Becker was adopted and used to guide the study. This model was used to assist clients in altering behaviour that increase risk for specific diseases. The model was preferred because of its key concepts namely perceived susceptibility, perceived severity, perceived benefits and cues to action (Essex et. al, 2002).A variant of the model includes the perceived benefits of the treatment, the prognosis of the condition. Constructs of mediating factors were later added to connect various types perceptions with predicted health behaviours. Perceived susceptibility is a person's perception that a health problem is personally relevant or that a diagnosis is accurate. This happened even when one recognises person's susceptibility, actions occur unless the individual perceives the severity to be more serious to have devastating organic or social implications (UNAIDS, 2005).

In this instance, the perceived benefits are the beliefs of a patient that given treatment cure, the illness or help prevent the spread. In this study Health Belief Model was used to elicit men's perceptions on the uptake of PMTCT programme, this model further provided the idea about the perceived benefits of involvement in PMTCT programme. This model's major process was interaction between the health practitioner and the clients, as perceived benefits vary from one person to another participation in PMTCT whether good or bad. The perceptions which resulted from the interaction (Health education, counseling), be followed by the action taken, thus increases the male uptake of PMTCT programme.

The Health Belief Model (Becker 1974).

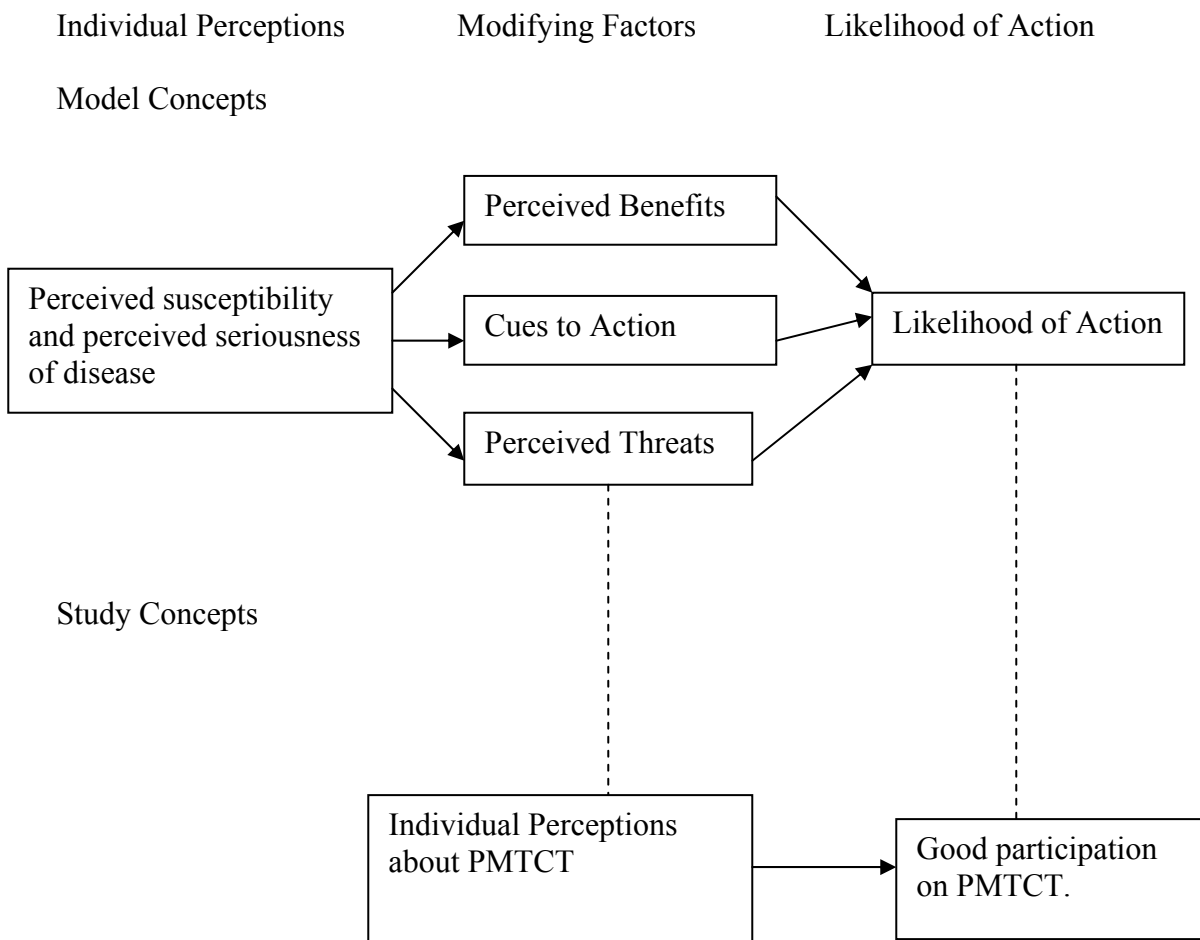


Figure 1: The Health Belief Model adopted and modified from Becker (1988) Model

Wikipedia Online 2008.

Conceptual Definition of Terms

Perception – A process of human transactions with environment which gives meaning to one's experience, represents one's image of reality and influences one's behaviour, (Dabies, 2000).

Male Participation – Male enrolment into the PMTCT programme, (MOHCW, 2003).

PMTCT – Prevention of mother to child transmission of HIV.

Likelihood of action – activities initiated or performed by the individuals to achieve, maintain or promote maximum health (Lipson & Steiger,2006)

Objectives of the Study

The objectives of the study were

1. To establish how men participate in PMTCT PROGRAMME at Gwanda Urban.
2. To identify factors that influence men's perception of PMTCT activities at Gwanda Urban.
3. To determine relationship between men's perceptions and their participation in PMTCT services.

Research Questions

1. How do men participate in PMTCT programme at Gwanda ?
2. What are the factors that influence male perceptions of PMTCT programme at Gwanda Urban?
3. Is there any relationship between males' perceptions and their participation in PMTCT programme?

Significance of the Study

The findings will be used as an invaluable tool to Nursing Practice, as the strategy of PMTCT is aiming at 100% success rate (MOHCW, 2003), the findings will be used to reveal the existing gaps between how men perceived PMTCT and how they participated. Findings will help by adding to the existing body of knowledge in nursing and questions raised from the study, will stimulate future researches.

CHAPTER 2
LITERATURE REVIEW
INTRODUCTION

A review of relevant literature is conducted to generate a picture of what is known and unknown about a particular situation (Burns & Grove, 2005). In this chapter the relevant literature on male's perceptions in relation to their participation in PMTCT is reviewed. The health belief model will be discussed where literature on how it has been used will be reviewed. The gaps and new knowledge will be identified and how these can be filled. This chapter will be concluded with a summary.

PMTCT is an important program in the prevention of HIV transmission from mother to the infant (WHO, 2006) to achieve the Millenium Development Goal 4 and 5 (MOHCW, 2006). PMTCT will then be achieved with the use of National Aids Policy, Infant Feeding Policy, Reproductive Health Policy and other relevant basic Human rights (MOHCW), 2006). According to SAFAIDS/UNAIDS (2003) report, the majority of men in the Sub-Saharan Africa have a chance of getting infected with HIV. This is further confirmed by National AIDS Control Program (2000), which found out that there is a high incidence of risky behaviour among the Zimbabwean men. This was further eluded by Latif and Emmanuel (2002) who indicated that 92% of the HIV infections in the country are transmitted through heterosexual contact. Latif and Emmanuel (2002) further carried out a study in Harare to examine social behavioral factors associated with HIV infection among male workers in Harare. Where high risk behaviour was noted among men who tested negative and positive, 73,1% reported STI while 55,5% were reported having paid for sexual act.

Men's Participation In PMTCT

Participation is a variable that can involve a variety of levels and differs on the degree of empowerment (Merrily & Johnson, 2001). UNAIDS, (2000) defines participation as a process by which people take an active and influential hand in shaping decision that affect their lives. Participation by males in PMTCT is important, not only as a means to good pregnancy reproductive and sexual health, but also improves the health status of the country. (Samuel, et. al, 2006). Males further indicated that there are a number of factors beyond their control that hinder the participation in PMTCT. Wars, transmission, ecological and economic disruptions, directly affect participation in PMTCT by males, in this case males will be participating in other issues such as the socially prescribed roles (Samuel et al 2006). Large scale epidemics, their related illness and death can lead to poor participation. England and Evans, (2003); Tlou, (2000); UNAIDS, (2000) and Merrily and Johnson, (2001) agreed that, in stable society without generalized epidemics, affect male participation or in cases of emerging biomedicine where a lot of experimental researchers are being carried out, discourages males from participating as the males will be fearing the unknown. Studies done in Tanzania by Kilewo (2001) and Chandisarewa et al (2006) revealed that male participation is affected by social background, culture or religion, educational levels, societal roles and age disparity of partners. This also applies in a Zimbabwean situation as indicated by Chandisarewa, et. al. (2006).

The researcher in the same study concluded that “Prenatal and postnatal clinics in Tanzania are usually not male friendly”. This meant that men were not encouraged to participate from the initial stages of counseling for PMTCT which made it difficult for them to participate as the process continues (Kilewo et. al., 2001).

In Thailand the participants confirmed receiving HIV prevention counseling at enrolment covering partner communication, partner HIV testing, condom use and other services like male circumcision (MOHCW, 2006). The programme proved to be very successful because their partners participated well in any health related issues. (Kilmarx et. al., 2002). Male involvement is assumed the major solution to PMTCT programme which when facilitated, through community sensitization and friendly services to men can be of help. Furthermore, PMTCT is facilitated by knowledge levels, attitudes and beliefs as cited by Kowalczyk et. al., (2002).

The PMTCT project in Kaemba, Zambia, successfully persuaded men to be involved in the programme (Kilewo, 2001). This was achieved by involving male community leaders who directly talked to fellow men. As it was done by Burke et. al. (2009), where men preferred to receive information from other men who are peer or older. Health information from female partner is less trusted than information from a male (Burke et. al., 2009). The reports by a local reporting centre (Partner) indicated that at Kenyatta Hospital, more than half of the male partners of tested pregnant women were also tested. The report indicated a great achievement in PMTCT programmes (Partner, 2001). Jackson (2002) further added that topics about circulating taboos such as sex during pregnancy, condom use to married couples during pregnancy and many others are encouraged. Traditional myths and misconceptions need to be corrected as they have a great impact on the success of the PMTCT programme.

In Rwanda most women had knowledge about HIV and modes of transmission (Kilmark, 2002). However, a barrier still remains, as it is known that men dominate in sexual decision-making (Liechty, 2005). This clearly indicates that there are other factors that hinder

PMTCT success besides knowledge about the transmission, which the investigator needs to dig much deeper to find out.

According to a study done in Nigeria by Moses et al(2009) observed that for PMTCT to be successful, above optimal levels, involvement of male partners must be recognized as a necessary component. The male partner is to be involved, and educated together with his spouse, to provide necessary support whenever the need arise. Involving the partner will not only provide support and encouragement, but will also improve adherence to program ethics. In the same study it was realized that community awareness on PMTCT programs is paramount as it can assist the male partner together with the family to successfully fight against stigma and discrimination for desired results. (Moses et. al., 2009).

In a study by Chandisarewa et. al. (2007), it was revealed that low rate of HIV testing among male partners remains a major challenge for the PMTCT programme in Zimbabwe. Innovative approaches to promote male involvement are urgently needed. Gender-based issues are to be addressed, male friendly ANC units are to be created, couple counseling and activities to promote VCT among men are to be lobbied for and highly considered to realize good participation of males in the whole program (MOHCW , 2006)

Chinkonde, Sundby and Martinson (2009) in Lilongwe identified that women needed to be empowered, economically supported to access HIV treatment and care with their partners, to benefit the whole family. This therefore suggests that the male partners as they spend a fortune trying to balance work and family demands for medical care which results in unintentionally ignoring of health concerns resulting to failure to participate in the PMTCT programme.

For the participation of male consumers to increase, there is need to integrate PMTCT fully into existing Primary Health Care activities (MOHCW, 2003). Hence the need to further educate the public especially men concerning their role and responsibilities as well as the benefits of involvement. The participation of men is not well documented in the studies, except that some researchers drew some recommendations from the studies on women participation in PMTCT (MOHCW, 2006 report). Southern African AIDS Training Programme (2000) indicated that there is need to explore further the men's participation in PMTCT in the context of fatherhood. These fathers need to be educated that PMTCT does not only mean giving birth to healthy babies but also to live healthy so that they raise these children and watch them grow.

Participation of men in the HIV programme and the subsequent intervention is a strong positive force for change, for the control of HIV. Provision of equal education and economic opportunities to males and females is paramount in reducing the risk of contracting HIV and promotion of good participation. The advance of technology and knowledge among consumers of health services as a result of availability of information technology and other sources of information increase the uptake of interventions which has some known risk (Kilmark et. al., 2002). These known risks can be the same as in PMTCT programme. In PMTCT, use of nevirapine in pregnancy and the issue of resistance, add to the fear of participation and this programme may be viewed with suspicion (Moses et al , 2009). Samuel et. al. (2006) identified that possible future failures of previously effective therapies due to viral evolution or social disorganization can also affect male participation in PMTCT, this can be so because male fear to be victims of that failure rate. A study in the United Kingdom concluded that cultural influences and religious background were found to have a negative impact on men,

wishing to visit voluntary testing centres (Thorn et. al, 2005). Cultural influences will further affect male participation in PMTCT negatively, whereas there are some churches which do not allow condom use.

Some funding partners have adopted the broader definition of Prevention of Parent-to-child transmission of HIV rather than PMTCT. This further recognizes that women alone, cannot prevent transmission of HIV to their children. A woman may have been infected by her partner, so both parents have responsibilities for their unborn child (Kilewo et. al., 2001). Experience has shown that many women refuse HIV testing or abandon medical care because they fear revealing their HIV status to husbands, (Chandisarewa et. al., (2007). The study further indicated that testing of both parents, increased knowledge and understanding of a man, allows him to take increased responsibility for his own health, his wife or other sexual partners and family. It also allows the burden of anxiety, decision making as to disclose, decision over treatment, infant feeding and future care to be shared between the man and the women.

Involving men in PMTCT services has been a global challenge which resulted from non disclosure within couples and lack of use of PMTCT services (Roberts & Denhill, 2006). The increased male participation in Manicaland Province at Virginia Rural Health Centre, has proved it possible since it was tried, tested and it succeeded, (EGPAF, 2009). Upon this success, a set of events was recorded for future use namely “Ndizvo Zvandiri ”which means “that is what I am”. The recording included ways how male involvement can be ensured in antenatal clinics. If males are involved, the ways of how to teach them, concerning their health will be easier. By doing so the males and their partners will be assisted on how to prevent stigma as they disclose their HIV status (ECPAF, 2009).

Factors Influencing Men's Perceptions in PMTCT Programme

Garfield, Kauffman and Davis (2006) cited that socio-cultural changes that affect men's roles as fathers certainly will continue as it affects their perceptions towards the success of PMTCT program. This is further enforced by Fontanarosa and Cole, (2006) who indicated that the promotion of health and prevention of disease is important to both partners. The hard lessons experienced through prevention remains the most effective, but the most difficult. Lackritz, Shaffer and Luo, (2002) added that psychosocial, financial and physical support is vital in the success of PMTCT, as the above mentioned factors, are the major components in the PMTCT strategy.

Few researches have been carried out and implemented which resulted to minimal evidence based information as cited by Garfield, Kaufman and Davis (2006). This therefore indicates that very little has been done on male participation. Sewankambo (2008) in Uganda, examined why males place themselves at the risk of contracting HIV. He discovered that men believed that the sexual pleasure outweighs any health risk, the local custom allowed risky behaviours, such as that of polygamy and wife inheritance. In a study in Zambia on condom use by men revealed that attitudes and subjective norms accounted for 44% and 75% respectively, (SAFAIDS (2008). In the same study it was found that men have considerable power over sex and they are criticized for having several partners, and are expected to take a lead in sexual matters. MOHCW (2006) indicated that men's abuse of this power is the primary factor behind the HIV epidemic and hence the need to involve them actively in PMTCT. Shaffer and Luo, (2002) echoed the same sentiments that men with HIV, infect the wife, then to the baby. Therefore, increasing the focus on male, PMTCT helps to reduce the HIV and men have a right to learn how to protect themselves from the HIV infection.

According to Kigong (2000) only 15% of females and 14% of males had knowledge about PMTCT. Lack of knowledge on sex, sexuality and its consequences was evident. Studies in Uganda and Botswana revealed that there were low knowledge levels in PTMTC. In which male community leaders were involved so that they can pass on the education to their peers to improve levels of participation in PMTCT.

A study among couples, where problem and prospects were studied, a total of 3240 couples were enrolled 56% came for results whilst 44% did not turn up (Chandisarewa et al, 2006). This study indicated that men supported the idea of couple counseling, but highlighted some pertinent issues to be attended to, which included lack of communication, making it difficult to introduce the topic of testing at home. Some fear the discordant results, which can lead to a divorce. It was further pointed out that some fear revealing their past, present and future infidelities, whereas some do not prioritize HIV testing (Chandisarewa et. al., 2006). Much effort can be made to correct the cited problems. If not addressed appropriately, the cited problem can be a barrier to voluntary counseling and testing, which will further discredit PMTCT.

Kilewo, Kwesigabo, Gomoro, Lugalla, Mhalu, and Biberfeld, (2008) studied perspectives about mother-to-child transmission of HIV on pregnant women, men and PMTCT service utilization in Zambia and Botswana, where low male participation was noted. The aim was to learn more about the uptake and needs regarding mother-to-child transmission of HIV prevention programme in Africa. Men were found to be marginalized and not prepared to support their spouses, partners or sisters in participating in the programme. Socio-economic and personal relationships play a pivotal role in enabling men to participate. The above-mentioned findings support Zimbabwean findings in which Campbell and Mbizvo,

(2004) found out that, men did not perceive voluntary testing and counseling as a priority. Men are further believed to have better access to media and other sources of information, which automatically keeps them as better informed always, compared to women (Burke, 2009). Men sometimes think that participating in PMTCT after being informed, advantages the wife and the child to his own expense, which on second thought decides to concentrate on other issues thereby ignoring the health issues. According to MOHCW, (2006) men have other priorities besides their health, their HIV status and that of the partner or spouse.

A study revealed that the members of health team were escorting their relatives to antenatal clinic, but the relative could not be encouraged to participate in PMTCT despite the HIV status. This relates to the fact that these staff perceptions about the programme are passed on to the consumers of health services (Chandisarewa, 2006). These attitudes can be manifested throughout the counseling session or during the educational talk which can make the client decline the participation.

Men's Perceptions of PMTCT and Participation in PMTCT

Perceptions of PMTCT have been evaluated and documented in many studies. Perceptions can in a way affect or influence participation of PMTCT, indirectly or directly. How one perceives the benefits of participation can facilitate the decision to participate, (Lackritzetal, 2002). This therefore means that the level of participation depends on how one perceives the benefit or the threats of PMTCT. The advantage of an HIV test can be a deciding factor on how to reduce chances of transmission by use of ARVs during pregnancy, labour or delivery and to make an informed decision on infant feeding options, positive living and promotion of an environment for acceptance of HIV as an important social issue, (Liechty, 2005).

How one perceives HIV testing and ARV prophylaxis may have a negative impact on the participation in PMTCT. The barriers may include that the client may fail to come to terms with the positive test results, which will lead this client to live in anxiety and will be closely watching for the development of signs and symptoms of HIV, (WHO, 2006). Stigma may be experienced if the results are shared with family, friends and may result in marital problems (M.O.H.C.W, 2006). Negative perceptions of the programme such as poor service quality, lack of necessary resources such as treatment, can have a negative impact on the programme's success (Feldman et. al. 2002).

“It is a noble idea to protect one's offspring from HIV” (Mcguire et. al., 2005) commented but PMTCT provides protection to both parents together with their child. Garfield et. al., (2006) cited that the parents are to live in order to care for the child till old enough to care for him/herself, (WHO, 2006). This is where the importance of safeguarding the life of the parents comes in, since they are the primary caregivers to the child.

According to Samuel et. al. (2006) in a study carried out to determine the influence of HIV positive parents on the use of Zidovudine (AZT) revealed that, despite potential benefits of AZT ,parents are not actively participating in preventing prenatal transmission. The man may discourage the woman, not to accept the recommended drug therapy. The study's aim was to identify factors that influenced the uptake of AZT when women become pregnant, as well as to give it to their newborn babies. Taking of AZT was greater appreciated to women who believed together with their husbands that AZT was effective in treating HIV, AZT prevents perinatal transmission of HIV and that their care provider viewed taking AZT positively. It was then concluded that the evaluation of health care practitioners' attitude about the taking of AZT, significantly influenced the intent to take AZT. In this study, health care

practitioner's role is crucial through the cited perceptions and their subsequent participation in PMTCT.

A study in Uganda revealed the sad scenario, where people were getting infected as a result of poor negative perceptions. The study aimed at finding out the history of HIV testing, opinion of HIV risk, willingness to participate and attitudes towards the provision of PMTCT services. This study was strongly supported by Chandisarewa et. al. (2006): Fieldman et. al., (2002) and Mbizvo et. al., (2004) who found that over 85% sexually active men believed that there was no risk of contracting HIV. The above mentioned studies have very informative findings though there are a number of limitations. This clearly shows that knowledge about HIV/AIDS even though important is not the sole factor that influences behavior change.

With the few results that were discussed, clearly indicates how people negatively perceived HIV and AIDS. While these perceptions continued, they were fueling the spread of the epidemic and stigma continued to be stirred up, which is assisted to germinate through the nurturing of a positive diagnosis. There is urgent need to deal with perception or to improve perceptions, which in turn has a positive bearing on the participation in PMTCT.

Theoretical Framework

The Health Belief Model guided this study. This theory views health as the outcome variable of the Health Belief Model. This is achieved through taking a positive stance in disease prevention. The main components include person, environment, health and nursing. A person is a unique total system whose care was the focus of nursing. A person is also a social being who is likely to be affected by socio-psychologic variables which affects the uptake of preventive measures for the illness. Health is a dynamic experience of the human being which

can be adjusted by the factors in the environment after certain pressures are used to achieve the desired results. (Stanhope & Lanchaster, 1992).

Nursing is the process of human interaction between a nurse and client, where each perceives the problem differently but through communication about the specific health problem, set goals can be achieved. Environment is an open system with permeable boundaries, permitting exchange of matter, energy and the information with human beings (Stanhope & Lanchaster, 1992). The cues to action refers to advice from other reminders through the doctor's instructions and mass media campaigns which further changes the perceived threat of a health problem to a positive perception thereby increasing participation in the prevention of a problem (Jackson, 2002)

Factors influencing men's perceptions of PMTCT was the independent variable whereas participation in PMTCT was the dependent variable under study, and men aged 20-50 were the sample under study. The well-planned interviews were lead to positive perceptions to attain a desired goal of good participation.

The community participation in health activities is encouraged through Primary Health Care. The goals are achieved through human interactions. This interaction influence how one views the health programme (perceptions). Making informed decision, which is a goal directed alternatives, is acted on to answer the question (participation in PMTCT). Client's participation in own preventive programmes, is affected by negative or positive perceptions whereas the client has the right to accept or reject care offered by nurses. Becker believed that client's participation in care is affected by various factors like perceived threats and equally the nurses' and clients' perception affect client's participation in the programme. The participation

of both nurse and client in decision making, suits well with the counseling & testing as part of PMTCT. The concept identifies the perceptions and how they are interrupted to facilitate participation.

The Human rights bill in conjunction with the Zimbabwe patients charter emphasizes on the individual right to actively participate in their health care, (MOHCW, 2001); (CDC, 2000). This largely depends on the education given to the client by the healthcare personnel. Perception is a concept in the framework that is the primary focus, which is later influenced by other factors. Perception serves to identify various factors that may affect human interactions. It is against this background of perceptions in nurse-client interactions (counseling and education) that the theory was found suitable for utilization in the PMTCT study.

Summary

Literature on perception and participation was reviewed. Relationship between the two variables was also reviewed. A number of studies which were conducted examined perceptions as they relate to participation in different health programmes that are offered by various authorities. Findings revealed the important role of health worker has in giving information and failure to give appropriate information lead to imposition of decisions on clients. Most of the studies indicated the need to involve men and women and to embark on more researches about men's health and how they perceive health programmes, which this study examined in relation to the male participation in PMTCT.

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CHAPTER 3

METHODS

Introduction

This chapter stretched from identification of a research design, up to the final stages of how data was analysed, the target population, sample size, data collection and analysis, sampling procedures, research variables, conceptual definitions, research instrument and ethical considerations were discussed in detail.

Research Design

According to Burns and Grove (2005), a research design is the entire strategy for the study from identifying the problem to the final plans for data collection. Polit and Hungler (2004) defined a research design as it specified the type of a research approach. In this study, a quantitative, descriptive correlational study was conducted. According to Burns and Grove (2005), descriptive studies explored and described the phenomena in their real situation for example in which real client's perceptions, knowledge, attitude and practices towards PMTCT was described. Burns and Grove (2005) also indicated that quantitative studies provided a strong internal validity of the results. In choosing this design its strength in increasing overall validity of the results was considered.

Sampling Plan

Sampling involves selecting a group of people, events, behaviors or other elements with which to conduct a study (Burns & Grove, 2005). The sampling plan involved a process of making selection, which attempted to increase representativeness, thereby decreasing systematic bias and sampling error (Polit & Hungler, 2004). In this study the sample was

selected, among the women who were attending antenatal and postnatal clinics. After selection the contact details of the husbands were obtained and the husbands were visited for interview, if in agreement. In this study the desired sample was 80 and the accessible population was the husbands of the women attending ANC and six weeks postnatal visits. Eligible participants were husbands of all pregnant women and those attending six weeks postnatal clinic, during the study period and resided in Gwanda town. Clients below the age of 18 were excluded as they needed, a consent from parents or guardian to take part in the study. Women with pregnancy complications were also excluded as the fatherly care, can be mistaken for participation in PMTCT thereby giving incorrect results.

Exclusion Criteria

The eligible participants who decline to participate and those who were very ill, were excluded from the study. Excluding those who met the exclusion criteria was done, to respect their right to refusal or not to expose them to unnecessary stress. Women, who are term, were excluded, since they were coming weekly to clinic to prevent the risk of repeat inclusion into the study. Those who could not speak or understand Ndebele and English were excluded from participating in the study.

Inclusion Criteria

Those eligible were expected to be capable of understanding Ndebele or English. They were expected to be willing to participate, between the ages of 20 – 50 years, must be in good health and only for those who resided in Gwanda Urban.

Sample Size

A sample is a subset of a population in which the size of the sample is determined by a number of factors such as power, effect size and the significance level of the statistic used. Gwanda Urban has a population of 140 933 with 53% constituting women of childbearing age (census, 2002). Calculations of sample size was based on significance level of 0.01, which means that there was an allowance of one percent chance of making an error, when one is declared a significance difference. (Burns & Grove (2005). The table by Lipsey (1990) was used to calculate the sample size. The effect size of 0.5, was used in the calculation of the sample size. Effect size is the difference or strength of a relationship found in a sample (Polit & Hungler, 2004). Medium effect size of 0.5 was found suitable for calculations of the sample size. The smaller the effect size, the larger the necessary sample size. The larger the sample size the more representative it is of the population. Power is the capacity to detect difference or relationships that actually exist in the population. It is the capacity to accept or reject the null hypothesis, (Polit & Hungler, 2004). The minimum acceptable power for a study is 0.80 (Burns & Grove, 2005). The power of 0.80 was used for sample size calculations. Although 65 subjects were found on calculations based on the Lipsey (1990) table calculations, 15-20% of the subjects were added to cater for the attrition and mortality during the study. In total 80 participants were interviewed.

Sampling Procedure

The sample was drawn from the accessible population using the simple random sampling, where women attending ANC and PNC, who met the criteria were asked to pick a number from the box. Using the formula, $K_{th} = \text{total population} / \text{sample size}$, e.g. $K_{th} = 200/80$ This meant that every client who picks a paper with a number which was a

multiple of two, and was meeting the inclusion criteria, was asked to give details of the spouse, who was interviewed, if in agreement. A pilot study was conducted to check for the adequacy of the sampling frame.

Variables

Three variables were measured, these were demographic, participation in PMTCT and factors influences perceptions PMTCT programme. The independent variable was the factors influencing perceptions of men's of PMTCT programme. The information that was asked from the subjects was, what they know about PMTCT, what prevent its success and what facilitate its success. The dependent variable looked at the participation of men in the PMTCT programme. This included information on how one is participating and which activities is he active on, such as involvement in male circumcision, condom use in pregnancy and undertaking HIV testing.

Men's Participation in the PMTCT Program

Participation in PMTCT conceptually meant the enrolment in the PMTCT programme. Participation in PMTCT was measured using a questionnaire and the level was marked by means of a score on the Likert Scale.

Factors Influencing Perception of Men about PMTCT Programme

Factors on Perceptions of the PMTCT conceptually meant the external and internal factors that influence one's view of the program. Perceptions of PMTCT was measured using a structured questionnaire and was rated on a Likert scale.

Demographic Variable

The demographic variables of this study were the personal information of the participation to the study.

Instrument

An instrument is a device that investigator uses to collect data (Polit & Hungler, 2004). In this study the investigator developed the instruments for data collection based on a number of sources. Much of the influence was on a Likert scale. Perceptions and participation in general were from Nunnally (1978), Riccio (2000), Mikhail (2000), Mbizvo (1997) and Septor (1992).

The perceptions of PMTCT interview schedule was developed with fourteen (14) items, to measure human interactions, communication and self-perception. Participation in PMTCT interview schedule with ten (10) items was developed to measure level of participation.

The interview schedule comprised of three (3) sections, that is Section A, B and C. Section A captured socio-demographic data of participants, Section B perceptions on PMTCT, section C participation in PMTCT. Self-report involved direct report of information by a person who was being studied. The advantage of self-report is that of directness and versatility, hence is less time consuming (Polit & Hungler, 2004). Its disadvantage was that it was difficult to ascertain whether the information was true. Content validity of the instrument was met through the use of panel of experts, experienced nurses and midwives, researchers and lecturers in the Department of Nursing Science. Validity and reliability was assessed

through a pilot study. The views about perceptions on PMTCT were captured until saturation was reached.

Reliability

Reliability refers to the degree of consistency with which an instrument measures the attributes it is designed to measure (Polit & Hungler, 2004). A reliable measure , maximises the true score and minimizes the error scores. A pilot study was done prior to the major study to test for reliability and validity of a design. Reliability testing focuses on three aspects, which are stability, equivalence and homogeneity. In this study consistency in the responses to questions was ensured by explaining the instruction to each and every subject in English or Ndebele.

Validity

Validity refers to the degree to which an instrument measures what it is supposed to measure (Polit & Beck, 2006). Cook and Campbell (2000) describe four types of validity namely statistical conclusion, internal, construct and content. Validity of the questionnaire was examined by a panel of experts from Department of Nursing Science. Construct validity examines the fitness between the conceptual and operational definitions (Burns & Grove, 2005).

Pilot study

Pilot study refers to a smaller scale version of the main study (Polit & Hungler, 2004). A pilot study was conducted before the major study, in order to develop and refine the methodology and men similar to those of the main study were chosen. According to Burns and Grove (2005), a pilot study allows refinement of questioning technique, sequencing or

procedure of recording. The pilot study allows for assessment of the reliability and validity of the instrument.

Dependent Variables

The interview schedule was adapted from the works of Nunnal (1978), Riccio (2000), and Mikhail 2000. The interview schedule contained 10 (ten) declarative statements measured on Likert Scale. The intention was to assess how men were participating in PMTCT. Values were placed on each response with a value of 2 on the most positive response. The total minimum score was 0 (zero) representing passivity, 5 represented the moderate and the maximum 10 representing extreme activity or participation. The components addressed include:-

- Item 22 Opinion on universal HIV testing
- Item 23 Drug (ARVs) administration
- Item 24 General opinion about PMTCT
- Item 25 Integration of PMTCT into routine ANC
- Item 26 Universal administration of ARVs in areas of high prevalence and poor participation
- Item 27 Enrolment in PMTCT
- Item 28 HIV testing
- Item 29 Quality of PMTCT programme

- Item 30 HIV – PMTCT during pregnancy
- Item 31 Husbands or partner involvement in PMTCT
- Item 32 Use of condoms during pregnancy and lactation

Independent Variables

Factors Influencing Men's Perceptions of PMTCT Programme

The interview schedule was adapted from the work of Mbizvo (1997), Septor (1992), Osgood, Succi and Tannenbaun (1957). The interview schedule contained 14 declarative statements that were measured on a Likert scale. The purpose was to measure a variable as perceived by the respondents. The accuracy of factors on perceptions was measured on Likert Scale where 0 represented No, 1 represented Yes. The minimum possible total score was 14, representing poor perception and maximum possible total score was 28 representing best perception. Below 14 indicates poor perceptions, which can be made better. Above 15- 19 indicates better perceptions 20-28, indicates good perceptions. Items that were assessed included item 1 – 21, nurse/midwife and client interaction item 12 client's perception about staff nurses or midwives attitude towards HIV positive pregnant women and their spouses, item 23 benefits of participating in PMTCT, item 24 and 25 role of client versus nurse/midwife, and items 26 to 31 self perceptions of HIV risk.

Demographic Variables

Demographic Questionnaire

The interview schedule captured socio-demographic data of the sample. Seven items were included, were age, marital status, level of education, parity, occupation, family income and religion.

Data Collection Plan

The data was collected over a period of 4 (four) weeks in April 2010. Physical visits were made to the study sites, for the purpose of data collection. Screening questions were administered to potential subjects, provided they meet the sample criteria. Potential subjects were approached and requested to participate in the study by giving their informed consent. The data was collected from respondents through the interviews.

Human Rights Considerations

Permission to conduct this research was obtained from the Medical Research Council of Zimbabwe. Provincial hospital authorities, were asked for permission to enter premises, in writing prior to carrying out the study Verbal approval was sought from the Matron-in-Charge. Essential information was provided to the subjects for informed consent. Each questionnaire had a consent for asking permission from the client, to participate in the study. The consent was explaining the reasons for carrying out the study and emphasized on voluntarism of participation by client and being free to withdraw anytime of the study. In cases of illiteracy, a witness was encouraged to sign also.

After consent has been obtained from the subjects, screening questions were administered. Reason for exclusion to those who were not meeting the criteria were explained.

Demographic data was collected from clients. Interviews were conducted to obtain data on variables in a private and comfortable room, where appropriate. Each interview took 15-20 minutes, in order not to delay the clients. The subjects were thanked for participation and cooperation. Data was reviewed for completeness before leaving the interview room.

Data Collection Procedure

Once the consent was obtained, demographic data was gathered from subjects through interviews, in a private place, using structured interview. Study data was gathered from 4 (four) subjects a day through interviews and recorded on questionnaires. Questionnaires and forms were reviewed for completeness. Clients and staff were thanked for their participation and cooperation. Data was locked away, to maintain confidentiality. The procedure was followed on daily basis until the required subjects were recruited and data was collected.

Data Analysis

The investigator developed a codebook in which all collected raw data, was entered. This data was edited for clarity and completeness.

Demographic Variables

Quantitative data analysis was done using descriptive statistics, that is, frequencies, percentages, measures of central tendency e.g. mean, mode, median, standard deviation and ranges presented in table form.

Men's Participation in PMTCT

A software package, statistical package for Social Sciences (SPSS) was used to analyze descriptive statistics of participation in PMTCT. Data was presented in tables .

Factors on Men's Perception of PMTCT

The statistical package for Social Sciences was employed to analyze descriptive statistics of perceptions of PMTCT programme. The data was presented in tables .

Relationship between Perception and Participation in PMTCT

Inferential statistics was used to determine the relationship between the independent and dependent variables based on the findings.

CHAPTER 4

RESULTS

SUMMARY

This chapter presents the results of the study and highlights of the major findings will be presented. Eighty respondents participated in the study. The response rate was 100%. Data was collected using an interview schedule.

The purpose of the study was to examine the relationship between factors that influence men aged 20-50year's perceptions and their participation in PMTCT at Gwanda Urban. The study answered the following questions-

1. How are men participating in PMTCT programme at Gwanda Urban?
2. What are the factors that influence men's perception of PMTCT programme in Gwanda Urban?
3. Is there any relationship between men's perceptions and their participation in PMTCT programme?

Data was collected during the month of April 2010. Data was analysed using Statistical Package for Social Sciences. Descriptive statistics were used to describe demographic information, perceptions of men and their participation in PMTCT. The inferential statistics , Pearson Product Moment Correlation was used to test the relationship between the two variables (men's perceptions and their participation in PMTCT). Simple linear regression was used to examine the strength of the relationship between the variables. The data was presented in tables.

Sample Demographics

Table 1:1 Shows the ages of the clients who participated in the study. The age range was between 20-50years. The age of the respondents had a mean of 38 years. Table 1:2 shows that five(6,4%) respondents were aged 20-25years, eight (10%) respondents were aged 26-30years, sixteen(20%) were aged 31-35years, nineteen(23,4%) were aged 36-40years, twelve (15,2%) were aged 41-45years and twenty(25%) were aged 46-50 years.

Fifteen (19%) spouses were aged 20-25years, twenty-two (27,5%) were aged 26-30years, twenty(25%) were aged 31-35 years, nine (11,4%) were aged 36-40years, 8 (10%) were aged 41-45years, 6 (7,1%) were aged 46-50years. Age disparity of respondents and their spouses ranged from 0-5, 6-10, 11-15, and 16-20 years. Out of eighty respondents, 66 (82,5%) were married, 12 (15%) were single, 1 (1,3%) divorced and 1 (1,3%) was widowed. The respondents belonged to different denominations where five(6,3%) were Catholics, forty-eight(60%) were from the protestants, seven (8,8%) were from the Pentecostal, two(2,5%) were from seventh day Adventist ,nil were from moslem and eighteen(22,5%) did not belong to any church.

Table 1:3 shows some demographic characteristics namely employment status ,monthly salary ,level of education and the number of children, one had. Sixteen (20%) respondents were not employed, fifteen (18,8%) were employed but not skilled and twenty-eight (35%) were skilled professionals had. The monthly salary of below \$100 was 27 (33,8%) respondents, thirty(37,5%) were getting \$100-\$200 and twenty-three(28,8%) were getting \$200 and above. Among the respondents eighteen (22,5%) attained primary education, fifty-three(66,3%) up to secondary level, eight(10%) went as far as tertiary level whereas one(1,3%) reached the University level. Thirteen (16,3%) respondents had no children,

sixteen(20%) had one, fourteen(17,5%) had two children and thirty-seven(46,3%) had three and above children.

Table 1:1 Sample demographic

(N= 80)

Variable	Frequency	Percentage
<u>Age</u>		
20	1	1,3
21	2	2,5
22	1	1,3
23	1	1,3
26	1	1,3
27	1	1,3
28	3	3,8
29	1	1,3
30	2	2,5
31	2	2,5
32	3	3,8
33	4	5,0
34	4	5,0
35	3	3,8
36	3	3,8
37	2	2,5
38	5	6,3
39	5	6,3
40	4	5,0
41	1	1,3
42	3	3,8
43	2	2,5
44	1	1,3
45	5	6,3
46	2	2,5
47	6	7,5
48	4	5,0
49	1	1,3
50	7	8,8
TOTAL	80	100

Table 1:2 Sample demographic data

(N = 80)

Variable	Frequency	Percentage
<u>Age In Years</u>		
20-25	5	6.4
26-30	8	10.0
31-35	16	20.0
36-40	19	23,4
41-45	12	15,2
46-50	20	25.0
<u>Wife Ages</u>		
20-25	15	19.0
26-30	22	27,5
31-35	20	25.0
36-40	9	11,4
41-45	8	10.0
46-50	6	7,1
<u>Marital Status</u>		
Married	66	82,5
Single	12	15.0
Divorced	1	1,3
Widowed	1	1,3
<u>Religion</u>		
Catholic	5	6,3
Protestant	48	60.0
Pentecostal	7	8,8
SDA	2	2,5
Moslem	0	0.0
Other	18	22,5

Table 1:3 Sample demographic data
(N= 80)

Variable	Frequency	Percentage
<u>Level of education</u>		
Primary	18	22,5
Secondary	53	66,3
Tertiary	08	10,0
University	1	1,3
<u>Occupation</u>		
Unemployed	16	20,0
Self-employed	21	26,2
Unskilled	15	18,8
Skilled	28	35,0
<u>Salary in US\$</u>		
Below 100	27	33,8
100-200	30	37,4
200 and above	23	28,8
<u>No of children</u>		
Nil	13	16,3
One	16	20,0
Two	14	17,5
Three and above	37	46,3

Men's Participation in PMTCT

The first question on how men are participating in PMTCT programme was answered using frequencies and categories. The second study question about the factors that influence men's perceptions of PMTCT programme in Gwanda Urban, was answered based on recorded frequencies of certain attitudes and factors that were observed during the antenatal and postnatal visits over a four week period at Gwanda Provincial Hospital. To answer the third question, a Pearson Product moment correlation test was used, to determine the relationship.

Table 2:1 shows that majority (77,5%) have tested for HIV, while only(22,5%)have not tested. Seventy-two(90%)respondents agreed with the statement which was firm about being knowledgeable in order to appropriately choose the feeding options, while eight(10%)were not in agreement. Forty-seven(58,7%) disclosed their HIV status to the family members, which is a way of participating in PMTCT programme. Thirty-three (41,3%)did not disclose due to some reasons. Sixty-nine(86,2%)were enrolled into the PMTCT programme in various categories , while only eleven(13,8%)were not enrolled. A number (51,3%) have once or more accompanied their wives to antenatal clinic despite their HIV status. Sixty-three (78,8%)have discussed PMTCT with their spouses. Seventy-four(92,5%)agreed to be involved in the programme for its success and also sixty-four(80%)agreed to have used a condom in pregnancy and while their wives were breastfeeding, as part of PMTCT programme. Recorded numerical values for responses were such that a higher number reflected good participation while lower numbers reflected poor participation. Table 2:2 shows that the total score was 10.The majority (90%) scored 50% and above, while only 10% scored below 50%. A likert scale was used to rate the amount of participation in which the minimum scores(0-4)

indicated poor participation while 5-6 indicated moderate participation, while 7-10 meant good participation ,as shown in Table2:3.

Table 2:1 Men's Participation in PMTCT

(N= 80)

<u>Variables</u>	<u>Frequency</u>	<u>Percentage</u>
<u>Have tested for HIV</u>		
Yes	62	77,5
No	18	22,5
<u>Feeding Options</u>		
Yes	72	90.0
No	8	10.0
<u>PMTCT an investment</u>		
Yes	35	43,8
No	45	56,2
<u>Disclosure</u>		
Yes	47	58,7
No	33	41,3
<u>Enrolled</u>		
Yes	69	86,2
No	11	13,8
<u>Accompany</u>		
Yes	41	51,3
No	39	48,7
<u>Discuss</u>		
Yes	63	78,8
No	17	21,2
<u>Practice</u>		
Yes	36	45.0
No	44	55.0
<u>Involved</u>		
Yes	74	92,5
No	6	7,5
<u>Use of condoms</u>		
Yes	64	80.0
No	16	20.0

Table 2:2 Men's Participation in PMTCT

(N= 80)

Variable	Frequency	Percentage
<u>Total scores out of 10</u>		
1	2	2,5
2	1	1,3
4	5	6,3
5	8	10,0
6	11	13,8
7	17	21,3
8	17	21,3
9	13	16,3
10	6	7,5
Total	80	100

Table 2:3 Men's Participation in PMTCT

Level of participation	Range	Frequency	Percentage
Poor	0-4	8	10,1
Moderate	5-6	19	23,8
Good	7-10	53	66,1

Factors that influence men's perception of PMTCT programme.

Table 3:1 shows data on the factors that influence men's perception of PMTCT programme. Seventy-three (91,3%) respondents were free to talk about HIV to health-workers while only seven (8,8%). Only six (7,5%) indicated that they were given scanty information, whereas one (1,3%) was not sure whether that information was enough or not. Seventy-one (88,8%) agreed that they were allowed to express their views about the PMTCT programme, while only five (6,3%) were not sure about whether they were given chance to air their views. Seventy (87,5%) believed that their decisions about PMTCT were valued by health-workers, while seven (8,8%) indicated that their decisions were not valued. Fifty-seven (71,3%) disagreed that the health-workers insult those enrolled in the PMTCT programmes, ten (12,5%) were not sure whether those enrolled are insulted. Sixty-five (81,3%) perceived PMTCT programme as beneficiary to the family and society. Majority (75%) disagreed that the health-workers make decisions about their health. Sixty-eight (85%) believed that nurses were concerned about the health of their babies and the family at large. Sixty-four (80%) viewed PMTCT programme as very important as anyone is at risk of acquiring HIV infection, whilst (16,3%) viewed PMTCT as not important and that they were not at risk. Sixty-eight (85%) saw it fit, to be involved in PMTCT programme even if one had one partner and eleven (13,8%) viewed it as a waste of time. Forty-eight (60%) agreed that there are no barriers of participation in PMTCT programme, if one has a positive perception about the programme. Twenty-four (30%) agreed that there are barriers to participate in PMTCT programmes. Seventy-eight (97,5%) had a positive attitude of the PMTCT programme and willingly participated. Sixty-six (82,5%) disagreed on that culture was hindering PMTCT participation.

Table 3:1 Men's perception of PMTCT

N=80

Variables	Frequency	Percentage
<u>Free talk</u>		
Disagree	7	8,8
Agree	73	91,2
<u>Enough information</u>		
Undecided	1	1,3
Disagree	6	7,5
Agree	73	91,2
<u>Express my views</u>		
Undecided	5	6,3
Disagree	4	5,0
Agree	71	88,8
<u>Decisions about my health</u>		
Undecided	3	3,8
Disagree	7	8,7
Agree	70	87,5
<u>Insult HIV positive women</u>		
Undecided	10	12,5
Disagree	57	71,3
Agree	13	16,2
<u>Benefits of PMTCT to my family</u>		
Undecided	5	6,3
Disagree	10	12,4
Agree	65	81,3
<u>Decision About My Health</u>		
Disagree	20	25.0
Agree	60	75.0

Table 3:2 Men's perception of PMTCT

N=80

Variables	Frequency	Percentage
<u>Response for my baby</u>		
Undecided	1	1,3
Disagree	11	13,7
Agree	68	85,0
<u>Risk of HIV</u>		
Undecided	3	3,8
Disagree	64	80,0
Agree	13	16,2
<u>One partner</u>		
Undecided	1	1,3
Disagree	68	85,0
Agree	11	13,7
<u>PMTCT to the society</u>		
UNDECIDED	8	10,0
Disagree	4	5,0
Agree	68	85,0
<u>Barrier in PMTCT</u>		
Undecided	8	10,0
Disagree	48	60,0
Agree	24	30,0
<u>Happy participant</u>		
Disagree	2	2,5
Agree	78	97,5
<u>Good programme</u>		
Undecided	1	1,3
Disagree	1	1,3
Agree	78	97,4
<u>Culture and PMTCT</u>		
Undecided	5	6,3
Disagree	66	82,5
Agree	9	11,2

Table 3:3 shows that total scores were 30, where two scored 16, one scored 18, two scored 21, three scored 22, ten scored 23, eleven scored 24, sixteen scored 25, twenty-three scored 26, seven scored 27 and five scored 28. Table 3:4 shows that there was no respondent with poor perceptions, three (3,8%) had moderate perceptions, while seventy-seven (96,2%) had good perceptions.

Table 3:3 Men's perception of PMTCT

(N=80)

Scores out of 28	Frequency	Percentage
16	2	2,5
18	1	1,3
21	2	2,5
22	3	3,8
23	10	12,5
24	11	13,8
25	16	20,0
26	23	28,5
27	7	8,8
28	5	6,3

Table 3:4 Men's perception of PMTCT

N= 80

Men's perceptions	Range	Frequency	Percentage
Poor	0-14	0	0.0
Moderate	15-19	3	3,8
Good	20-30	77	96,2

Relationship between factors that influence men's perceptions and their participation in PMTCT.

Table 4 shows the Pearson's correlation coefficient indicating the relationship between men's perceptions and their participation in PMTCT . $r = .285^*$, $p < .05$. This shows that there was a weak positive correlation between factors that influence men's perceptions and their participation in PMTCT.

Table 5 shows the regression analysis of the relationship between factors that influence men's perceptions and their participation in PMTCT. The regression coefficient was 8%.

Table 4 Pearson's correlation Matrix

N=80	Y
	1000
X	.285*

*P < .05 **p < .01 ***p < .001

X = Factors influencing men's perceptions of PMTCT

Y = Men's participation in PMTCT

Table 5 Regression Analysis

Variance	B	SEB	BETA
X	.247	.094	.285*
Constant	.922	2.332	
R=.080	F=6.906		

*P< .05 **P< .01 ***P< .001

X=Men’s perceptions and their participation in PMTCT.

N=80

CHAPTER 5

DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS

This chapter presents the discussions, strengths limitations, implications and recommendations that are on the study findings. Relevant literature was used as a frame of reference during discussion of findings.

Summary

The purpose of this study was to establish the relationship between the factors influencing men's perceptions and their participation in PMTCT programme. A descriptive correlational study was used. A sample size of 80 respondents was used. The study answered the following question and objectives:

1. How do men participate in PMTCT programme at Gwanda Urban
2. What are the factors that influence men's perception of PMTCT in Gwanda urban?
3. In there any relationship between men's perception and their participation PMTCT programme?

The study findings indicated that men are increasingly changing their perceptions from negative where (96.2%) 77 had good perceptions. This change was due to a number of factors that influence men's perception which are age disparity, level of education, occupation, financial status, parity, culture, disclosure, health want attitude and lack of communication between couples.

The change of perceptions positively influenced good participation in PMTCT programme, where 53 (66.1%) participated in a good way, 19 (23.8%) participated moderately and only 8 (10%) poorly participated.

The mean score on participation was 7.135. Out of 80 respondents 27 scored below the mean 53 (66%) scored above the mean. The mean score in men's perception was 23.4, (22.5%) 18 scored below the mean while 62 (77.5%) scored above the mean, 3.8% had moderate perceptions while the majority 96.2% had good perceptions about the PMTCT programme.

The Pearson Product moment correlation test showed that there was a weak positive correlation ($r = .285$), between factors influencing men's perceptions and their participation in PMTCT programs. The results of this study showed that the factors influencing men's perceptions have a weak positive influence on the men's participation in PMTCT programme R^2 indicated that the factors influencing men's perception of PMTCT, accounts for 8% variance in the men's participation in PMTCT activities. In this study, the findings weakly supported the premise that as level of perception increases men's participation increases.

Sample Demographics

The sample demographics includes the ages which ranged between 20 – 50 years with a mean age of 38 years. The study was focusing on the men of child bearing age as it was cited by WHO (2006) that the programme is important to achieve MDG 4 and 5. The PMTCT programme can be made a success if men of childbearing age are made aware of their responsibilities for their families and urban children as it was cited by Kilewo et. al. (2001). According to WHO, (2006) childbearing age is from 15 – 49. The study focused on men aged 20 – 50, because those from the age of 15 – 17 cannot consent and those at 18 – 19 are still at school and have no experiences in family issues as compared to girls of the same age. Age disparity of couples as mentioned by Roberts and Denhill, (2006), led to non disclosure within couples resulting in non participation in PMTCT programmes. Roberts and Denhill, (2006) indicated that the more the difference in years the more fear the women has to disclose their

HIV status to the partners. The study found out that 43 (53.8%) couples had an age difference of 0 – 5 years, 20 (25%) had age difference of 6 – 10 (17.5%) had age difference of 11 – 15 and 3 (3.7%) had age difference of 16 – 20 years. The more the age difference the more the disruption in communication which includes disclosure, as cited by Chandisarewa et. al. (2006) and Kilewo (2001). According to the study findings a few (3) 3.7% had an age difference of 11 - 20 and majority 43 (53.8%) had an age difference of less than 10 years and they had good participants well in PMTCT programmes. Out of the 80 respondents 66 (82.5%) were married 12 (15%) were single, 1 divorced and 1 (1.3%) was widowed. This was confirmed by Fontanarosa and Cole, (2006) who indicated that PMTCT is important and it involves both partners and they further added that lessons experienced through prevention remains the most effective but they are the most difficult. Education was found to influence willingness to participate in treatment decision. The young and educated were forthcoming (England & Evans, 2006) as they are exposed to technology like internet and media. This further answers the dilemmas, perceived threats and the benefits. Among the respondents 18 (22.5%) attained primary education, 53 (66.3%) secondary level, 8 (10%) tertiary level and 1 (1.3%) reached university level. In total 62 (77.6%) reached secondary level and above. Lackritz, Shaffer and Luo, (2002), cited that financial and psychological support are vital in the success of PMTCT programme. In this study 16 (20%) were not formally employed but self-employed they were earning more than the formally employed through gold panning and money change transactions 27 (38.8%) earned below US\$ 100 while 53 (66.2%) earned US\$ 200 and above. This made it easy for the men to support their spouses and children there by participating in various activities of PMTCT programme.

During the study it was revealed that even without legal partner, PMTCT is paramount and it is possible to participate in PMTCT programmes. The study findings revealed that the

respondents were from different denominations where only 5(6.3%) belonged to Catholic where condom use is discouraged. Even though some were not Christians now but they once belonged to some churches and have ceased to attend due to work demands e.g. full gold panning. The findings revealed that 29(36%) had 0 – 1 child, 51(64%) had 2 and above children. The findings support earlier findings as it was found by Chandisarewa et. al., (2007), that as the number of children increase the knowledge and understanding of men about family issues increase and allow him to take increased responsibility for his own health, wife and children. Through the demographics a number of factors were identified as a way to address objective 2, age disparity, marital status, level of education, financial and employment status which are religion and parity. The above mentioned factors affect the men's participation negatively or positively.

Men's Participation in PMTCT

The study findings confirmed what was cited by Merily and Johnson, (2001) that participation differs according to the degree of empowerment. Seventy-seven point five percent (77.5%) have tested for HIV, while 47(58.7%) disclosed their HIV status. This was after 73(91.3%) agreed that they were empowered with enough information. These findings reinforce the fact that the PMTCT programme be incorporated in routine ANC as it can be convenient to offer all services under one roof especially that the ANC be made friendly. As this has succeeded in Thailand when men were confirmed receiving HIV prevention counseling which includes partner communication, partner HIV testing condom use and male circumcision (MOHCW, 2006). The findings confirmed that for the informed choices the couple needed to be knowledgeable as it was cited by Chandisarewa and others, (2007), that if one is given enough information it deals with anxiety, allow decision making as to disclose treatment, infant feeding and future care, 72(90%) agreed on the fact that one needed enough

for in order to effectively choose the appropriate feeding option Samuel et. al. (2006) indicated that the men participated due to previous success in treatment to some members of the community. The findings revealed that 69(86.2%) of the respondents verbalized to be enrolled in various PMTCT programmes, because they have seen the treatment working for others. In comparison to 2003 National survey. As part of the participation 41(51.3%) had escorted their wives to ANC and 63(78.8%) have discussed PMTCT with their spouses. Only 36(45%) could use abstinence for PMTCT. The findings offer support to UK findings which recorded low participation which was attributed to stigma and cultural influences (Thorn et. al., 2005). Eighty percent of the respondents agreed to have used condoms for PMTCT. These findings confirmed that men are educated on their role, responsibilities as well as the benefits of involvement (MOHCW, 2006). In total the participation was good 72 (89.9%).

Factors Influencing Perception of PMTCT

The study findings were not in agreement with Sewankambo, (2008), who discovered that men believed that the sexual pleasure out-weighs any health risk as 91.3% were free to talk about HIV/AIDS 88.8% were allowed to express their views. Eighty percent 64 (80%) agreed that everyone is at risk of HIV despite the number of partners one had. This showed that they had a positive attitude towards the PMTCT programme. The findings further revealed that in this study educational level influenced the men's perceptions of PMTCT as those who had higher levels of education were exposed to various incidences, including through the media, which later changed their perceptions to positive. This further led to good participation in various PMTCT programme, 65(81.3%) perceived PMTCT as beneficiary as the respondents verbalized that there will be long life for their babies, health monitoring for self, reduction in morbidity and mortality due to HIV and AIDS. Perceptions about the quality of programme were positive. This was supported by positive clients. The attitude of midwives

towards HIV positive clients was said to be positive 57 (71.3%). The awareness of benefits of participating in PMTCT for the family and society was high 65(81.3%). The majority of men felt the PMTCT programme was important 78 (97.5%) in which men participated willingly. Contrary to the findings, there were barriers which were identified. The barriers were stigma, confidentiality issues and conflicting roles of fatherhood (work and social). This barrier had a minor effect to the findings since only a few verbalized. Feldman et. al. (2002) cited that poor service quality and lack of necessary resources such as treatment can negatively affect participation in PMTCT. The dollarization of the economy has slightly improved, the health system as the basic necessities are now available on shelf and the nursing staff are given an extra incentive to boost their esteem. This therefore improves the quality of service offered.

The study findings identified disclosure, lack of knowledge, age disparity of couples, educational levels religion, health-worker and client attitude communication between couples political instability and culture are factors that influence men's perception of PMTCT which further affect their participation in the programme. The above-mentioned findings supported Samuel et. al. (2006) findings that a number of factors beyond men's control hindered their participation in PMTCT which are wars, economic disruptions, large scale epidemics, related illness and death, and emerging biomedicine where experimental researchers are being carried out.

Relationship of Factors Influencing Men's Perception of PMTCT and Participation in PMTCT

The statistical analysis using Pearson's correlation coefficient showed a positive linear relationship of factors influencing men's perception of PMTCT and participation in PMTCT, which was significant ($r = .285, p < 0.5$). This meant that as men's perception of PMTCT increases the participation in PMTCT also increases. Regression analysis indicated that men's

perception of PMTCT accounts for 8% variance in men's perception of PMTCT. The study findings weakly supported the premise that as men's perception of PMTCT increases the men's participation in PMTCT programme increases contrary to the above findings, Kilmarx et. al. (2002) believed that attitudes and beliefs affect participation in health care.

Theoretical Framework

Health Belief Model guided the study. Becker proposed that accuracy of perception increases effectiveness of one's actions (Becker, 1974). One's perception of something is sometimes affected by a number of factors, which can later lead to participation or non participation (Essex et al. 2002). Perceptions are among the essential variables in nursing situations, a process of human interaction with the environment which gives meaning to one's experience, represents one's image of reality and influences one's behaviour.

The study findings where the Pearson Correlation coefficient found a linear relationship of men's perception of PMTCT and participation in PMTCT which is significant ($r = .285, p < .05$) confirms Becker's assumption. This is so because men's perception of PMTCT improves the participation in PMTCT also increases. This shows that Becker's Health Belief Model can be effectively in nursing or midwifery practice.

Practice

The primary focus of this study was to find out how men were participating in PMTCT and how men's perception of PMTCT affect their participation in PMTCT. Health Belief Model modified by Becker can be incorporated into nursing and midwifery practice as a guiding framework for individualized care. This would create a good environment for change in patient care thereby increasing participation in health related issues.

Research

An in-depth research particularly examining the area of participation in PMTCT is necessary. It is suggested that more studies are to be done in order to work on evidence based practice, for future progress in the context of available resources.

Education

On education the aspect of counseling should receive more attention for therapeutic reasons on patients. This should be done in the context of continuing education for midwives. The confidentiality aspect should be addressed through education. The midwifery education must aim at producing competent practitioners who aim at empowering the clients so that they take a facilitative role in health improvements and maintenance.

Recommendations

The recommendations that are suggested are based on the findings of this study are as follows:

1. Responsibility of health should lie with the individuals, emphasis can be through empowerment and wider dissemination of information to facilitate decision-making and action.
2. Confidentiality maintenance in education, practice and research must receive due attention so that clients feel secure in the hands of midwives.
3. The benefits of both parents must be clearly spelt out besides reducing chances of infection to the baby so as to encourage participation in PMTCT.

Limitations

Limitations are restrictions in a study that may decrease the generalisability of the study (Burns & Grove, 2005).

1. This instrument used for measuring factor influencing men's perception of PMTCT and their participation was developed by the investigator and was not subjected to parametric tests so reliability and validity could have been adversely affected despite all measures taken to strengthen them.
2. The study only targeted husbands of the pregnant women who were attending Gwanda antenatal and postnatal clinics, and excluded other men who were receiving care or who are in the community (Gwanda Urban). It is difficult to generalize the findings to all men.

Summary of the Study

This study was investigating on the level of men's participation in PMTCT programmes and how it is affected by the perceptions. The male participation in PMTCT programme was good (89.9%). The purpose of the study was to determine whether a relationship existed between men's perception and their participation in PMTCT programme in clients between 20 – 50 years of age, attending antenatal clinics. Becker's Health Belief Model was used as a framework to guide the study. The model proposed that the perceptions are affected by a number of factors which later affect the plan of action (participation). The study proposed to test the hypothesis that positive perception leads to good participation. A descriptive correlational design was used. A sample of 80 subjects was selected by simple random sampling from clients who reported to the antenatal and postnatal clinics, where their husbands were approached. Face to face structured interviews were held to collect data. The instrument consisted of a structured questionnaire in three sections: demographic data, men's

participation in PMTCT programmes and factors affecting men's perception of PMTCT variables. The data was analysed using descriptive and inferential statistics. Descriptive statistics in form of frequencies and tables were used. Pearson Correlation and Regression Analysis were used. Pearson correlation showed a significant positive correlation ($r = .285$, $p < 0.05$). regression analysis showed that the men's perceptions of PMTCT accounts for 8% variance in the men's participation in PMTCT programme.

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Appendix A

Consent Form

Dear Participants

My name is Sicelesile Sibanda. I am a student at the University of Zimbabwe, undertaking a Masters of Nursing Science Degree. I am carrying out a study to determine and examine the relationship between male perception and their participation in PMTCT.

I am kindly requesting you to participate in my study. The information obtained will be treated in confidence and the study findings will be used to assist the process of perfecting the PMTCT programme. Your identity will not be disclosed and code numbers will be used for identification, so feel free to participate.

Your decision to participate or not will not affect the care given to you or your family or your relationship with the health care providers. Your participation is voluntary and you are free to withdraw anytime without any penalties. If you agree to participate may you sign in the space provided below. If you have to communicate with me or if you need any clarification my contact address is

Department of Nursing Science
PO Box A 178
Avondale
Harare
Cell: 011 586 825.

If you agree to participate please show by signing

Investigator Signature Date

Participant Signature Date

Thank you for your participation.

Witness: Date:.....

Appendix B

Interview schedule

A Demographic Data Questionnaire

- 1. How old are you?
- 2. How old is your wife?
- 3. What is your marital Status?

- 1 Married
- 2 Single
- 3 Divorced
- 4 Widowed

- 4. What level of education did you attain?

- 1 Did not go to school
- 2 Primary
- 3 Secondary
- 4 Tertiary Diploma
- 5 Technical
- 6 University

- 5. What is your occupation?

- 1 Still at school
- 2 Unemployed
- 3 Self employed
- 4 Unskilled/semiskilled
- 5 Skilled/professional
- 6 Retired/Housewife

- 6. What is your salary/income per month?

- 1 Below \$100
- 2 \$100 to \$200
- 3 \$200 and above

7. What is your religion?

- 1 Catholic
 - 2 Protestant
 - 3 Pentecostal/Apostolic
 - 4 Seventh Day Adventist/Jehova's witness
 - 5 Islam
- Other (specify)
-

8. How many children do you have?

- 1 Nil
- 2 One
- 3 Two
- 4 Three and above

SECTION B Men's Participation in PMTCT

9. I have been tested for HIV.

- 1 Yes
- 2 No

10. To prevent mother to child transmission of HIV, as parents we are to make informed choices of feeding options

- 1 Yes
- 2 No

11. PMTCT programme is an investment ,to me as I am participating in a number of activities

- 1 Yes
- 2 No

12. I have disclosed my HIV status to my family members.

- 1 Yes
- 2 No

--

I am enrolled for PMTCT and it is the right thing to do? 1 Yes

2 No

13. I have accompanied my wife to antenatal clinic?

1 Yes
2 No

14. I have discussed PMTCT issues with my wife.

1 Yes
2 No

15. I have practiced abstinence in pregnancy as method to PMTCT.

1 Yes
2 No

16. I must be involved in PMTCT program as a spouse, for it to be successful?

1 Yes
2 No

17. I cannot use condoms during pregnancy and breastfeeding to PMTCT

1 Yes
2 No

Sections C : Factors Influencing Men's Perceptions of PMTCT

18. I am free to talk to health-workers about HIV and AIDS

1 Undecided
2 Disagree
3. Agree

19. Health-workers provide enough information on PMTCT?

1 Undecided
2 Disagree
3 Agree

20. Health-workers gave me an opportunity to express my views?

- 1 Undecided
- 2 Disagree
- 3 Agree

21. Health-workers value my decisions about health?

- 1 Undecided
- 2 Disagree
- 3 Agree

22. Health-workers shun and insult HIV positive pregnant women?

- 1 Undecided
- 2 Disagree
- 3 Agree

23. There are benefits in my participation in PMTCT to my family.

- 1 Undecided
- 2 Disagree
- 3 Agree

24. The health-workers make decisions about my health?

- 1 Undecided
- 2 Disagree
- 3 Agree

25. The health-workers are responsible for my baby's health?

- 1 Undecided
- 2 Disagree
- 3 Agree

26. The PMTCT program is not important to me because I am not at risk of HIV?

- 1 Undecided
- 2 Disagree
- 3 Agree

27. There is no need to be tested because I have only one partner?

- 1 Undecided
- 2 Disagree
- 3 Agree

28. There are many benefits of participation in PMTCT to the societ.

- 1 Undecided
- 2 Disagree
- 3 Agree

29. There are barriers of participation in PMTCT?

- 1 Undecided
- 2 Disagree
- 3 Agree

30. I am happy of being one of the participants in a PMTCT programme?

- 1 Undecided
- 2

31. It is a good programme that all men should participate in it?

- 1 Undecided
- 2 Disagree
- 3 Agree

32. My Culture does not allow me to participate in PMTCT activities.

- 1 Undecided
- 2 Disagree
- 3 Agree

Appendix C

Incwadi Yemvumo

Igama lami ngingu Sicelesile Sibanda. Ngiyisifundi esikolweni sezinfundo yesibili yangaphezulu eUnivesirty yeZimbabwe. Ngiphakathi kohlelo lokuhlolisisa ubudlelwano phakathi kwemibono lokuphatheka kwabobaba ehlelweni lokuvikela abantwana kugciwane leHIV, kumama ozithweleyo.

Ngicela ubeyingxenye yabazaphatheka kuloluhlelo. Ulwazi oluzavela kuloluhlelo luzagcinwa luyinfihlo, lempumela izasetshenziswa ekuphakamiseni indlela zokuvikela ukumemetheka kwengculaza. Ibizo, lakho konke okungaveza wena, akusoze kubhalwe, kuphela inombolo ezimela ibizo zizasetshenziswa.

Ukuvuma kwakho, kumbe ukwala, ukungena kuloluhlelo akuvimbeli ukwelatshwa kwakho kumbe abemuli yekho, njalo akudilizi ubudlelwano bakho labezempilo. Ukhululekile ukungena ehlelweni kumbe ukuphuma lapho usizwa kusitsho, njalo ungatholakali ulecala ngalokho. Uma ufisa ukuphatheka kuloluhlelo sayina ezikhaleni ngaphansi. Kodwa uma udinga uncedo lokuchasiselwa nansi ikheli.

Ucingo 011 586 825

Nyiyabonga

Mfundi mdingisi Ilanga

Ophatheka Ehlelweni Ilanga

Ofakazaya Ilanga

Appendix D
Ungwalo lwemibuzo

Ubudlelwano phakathi kwemibono lokuphatheka kwabobaba ehlelweni lokuvikela abantwana
kugciwane lengculaza, kumama ozithweleyo.

Isigaba sokugala

Ngizakubuza imibuzo emayelana lawe lokuphila kwakho.

1. Uleminyaka emingaki?
2. Mingaki eyomkakho
3. Ezomtshado, uthethe yini?

- 1 Ngithethe
- 2 Angithathanga
- 3 Ngafelwa

4Sehlukana

Wacina kubanga liphi lokufunda?

- 1 Angiyanga esikolo
- 2 Emfundweni yangaphansi
- 3 Ezifundweni zeSecondary
- 4 Ezifundweni zesikolo esiphezulu
- 5 Esikolo semisebezi yazandla
- 6 Euniversity

4. Wenza msebenzi bani?

- 1 Ngilokhu ngisesikolo
- 2 Angisebenzi
- 3 Ngiyazisebenza
- 4 Ngafundela umsebenzi
- 5 Angiwufundelanga
- 6 Ngisekuphumuleni/Ngingumama wendlini

5. Uholo malini?

- 1 Ngaphansi kwetshumi
- 2 Itshumi kusiya kwamabili

3 Amabili
kusedlula

Uyakholwa ngaphi na?

1
ERoma

2 Amanye amasonto agogela impi yosindiso,
ibandla labazalwane kuKristu

3 Amaphostoli

4 Isabatha kumbe abafakazi bakaJehova

5 ITshawa

Ezinye, Landisa

6. Ulabantwana abangaki?

1 Kangilamntwana

2 Ngiloyedwa

3 Ngilababili

4 Abathathu loba kusedlula

Isigaba Sesibili

Kulesisigaba ngizabuza imibuzo emayelana lokuphakatheka kwakho ekuvikeleni umama ekudluliseleni igciwane emntwaneni exithwele.

7. Sengahlolwa igazi mayelana legciwane lengculaza?

1 Yebo

2 Hatshi

8. Ukuvikela umntwana engciwaneni leHIV,ukuze angalitholi kumama ozithweleyo, njengabazali sifanele ukukhetha indlela zokupha umntwana ukudla, ngemva kukuzwisisa.

1 Yebo

2 Hatshi

9. Uhlelo lokuvikela igciwane leHIV kumama lomntwana liyinzuzo kimi, njengoba ngiphatheka ezintweni zakhona ezinengi ezinjengokusoka?

1 Yebo

--

2 Hatshi

10. Sengitshelile abemuli ngesimo sami?

1 Yebo
2 Hatshi

11. Ngiyaphakatheka kuloluhlelo njalo luhle kakhulu?

1 Yebo
2 Hatshi

12. Ngiyake ngiphelekezele unkosikazi ekuhlolweni ezithwele?

1 Yebo
2 Hatshi

Ngiyake ngixoxisane lowangakwani ngaloluhlelo?

1 Yebo
2 Hatshi

13. Njengendlela yokuvikela ingane kugciwane leHIV bengisebenzisa ukungahlangani emacancini, umama ezithwele

1 Yebo
2 Hatshi

14. Njengobaba wemuli kufanele ngiphatheke kuloluhlelo ukuze luphumelele?

1 Yebo
2 Hatshi

15. Angisoze ngisebenzise okokuzivikela (condom) nxa umama ezithwele kumbe emunyisa ukuvikela ukumemethekisa igciwane leHIV?

1 Yebo
2 Hatshi

Isigaba Sesithathu

Kulesisigaba ngizabuza imibuzo emayelana lemibono ngaloluhlelo.

16. Ngikhululekile ukukhuluma labezempilo mayelana leHIV leAIDS?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

17. Abazempilo bayapha infundiso eyaneleyo ngaloluhlelo?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

18. Abezempilo bayapha amathupha okutsho engikucabangayo ngaloluhlelo?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

19. Abezempilo bayaqakathekisa eyami imibono ngezempilo?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

20. Abezempilo bayazonda njalo bayathethisa omama abaphila legciwane leHIV?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

21. Kulenzuzo ukuphatheka kwami kuloluhlelo emulini?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

22. Abezempilo bayenza zonke izinqumo ngempilo yami?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

23. Abezempilo bayaqakathekisa impilo yomntanami?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

24. Loluhlelo aluqakathekanga kimi ngoba angikho engozini yokuthola umkhuhlane wengculaza?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

25. Ukuhlolwa igazi akuqakathekanga ngoba ngilomfazi ayedwa?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

26. Zinengi inzuzo ngakuphatheka kuloluhlelo esigabeni?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

27. Zikhona ezivimbayo ekuphathekeni kuloluhlelo?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

28. Ngiyathaba ngokuba ngomunye wabaphatheka kuloluhlelo?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

29. Loluhlelo luhle, ukuthi bonke ababa kufanele baphatheke kulo?

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma

30. Isuntu sami asivumi ukuthi ngiphatheke enhleweni zokuvikela igciwane emntwaneni lomama.

- 1 Angilaqiniso
- 2 Angivumi
- 3 Ngiyavuma
