STRATEGIES TO INCORPORATE EMPOWERMENT PROGRAMMES FOR PMTCT INITIATIVES AMONG MULTICULTURAL RURAL WOMEN IN ZIMBABWE

by

ROSEMARY CHIGEVENGA

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DECLARATION

Name: **ROSEMARY CHIGEVENGA**

Student number: **55383394**

Degree: **98555 PhD (Psychology)**

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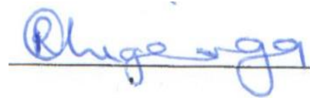

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ABSTRACT

HIV and AIDS as one of the leading causes of maternal death worldwide, has got devastating effects that have destroyed the socio-economic fabric. Prevention of Mother-to-Child-Transmission (PMTCT) programmes have been and are still being implemented worldwide but many countries have not yet attained zero prevalence rate of HIV-related maternal and infant mortality. This has motivated the researcher of this study to unearth the strategies that may be employed in women empowerment to alleviate mother-to-child transmission of HIV. The study aimed to explore strategies that can be utilised in incorporating empowerment programmes in PMTCT initiatives from a community psychology perspective. A mixed-method approach was utilised in gathering data from 4 rural districts in Zimbabwe. The study population comprised of permanent rural residents within the age ranges of 15 – 60 from different cultures, community gatekeepers and professionals working within those communities. Proportional stratified random sampling was employed in selecting 200 community members for quantitative data collection, quota sampling was used for selecting participants for 8 focus group discussions and purposive sampling was utilised for selecting 20 community gatekeepers and 20 professionals for semi-structured interviews. Data analysis was conducted using SPSS version 20.0 and thematic analysis.

Findings revealed that efforts are being put toward eradicating HIV-related maternal and infant death but some stumbling blocks make women, the primary contributors to the fruition of such initiatives, less active. The impeding factors raised included lack of formal education, harmful cultural or religious beliefs and practices, limited or distorted knowledge about PMTCT, lack of rural women's economic empowerment, low male partner involvement, lack of adequate personnel, distant or lack of antenatal clinics, poor relations between health professionals and the community as well as stigma and discrimination of HIV positive pregnant women by health professionals or significant others. In light of this, and according to the empowerment theory from community psychology, strategies were proposed targeting women empowerment concerning their sexual reproductive health. Emphasis was put on making use of locally available resources in addressing the devastating effects of HIV and AIDS especially on women and their unborn babies. Lastly, an integrated women empowerment PMTCT model was proposed.

KEY TERMS: Strategies, women empowerment, prevention of mother-to-child-transmission, community, psychological empowerment, initiatives, multicultural

(Abstract in IsiZulu)

I-HIV ne-AIDS njengenye yezimbangela ezihamba phambili zokufa komama emhlabeni jikelele, ithole imiphumela emibi ecekele phansi isimo senhlalo nezomnotho. Izinhlelo zokuvimbela ukudluliselwa kwegciwane lisuka kumama liye enganeni (PMTCT) seziqalile ukusetshenziswa futhi zisasetshenziswa emhlabeni wonke kepha amazwe amaningi awakasitholi isibalo sokushona kwabantu besifazane kanye nezinsana okuhlobene ne-HIV. Lokhu kugqugquzele umcwaningi walolu cwaningo ukuba avumbulule amasu angahle asetshenziswe ekunikeni amandla abesifazane ukunciphisa ukudluliswa kwegciwane lesandulela ngculaza lisuka kumama liye enganeni. Lolu cwaningo luhlose ukuhlola amasu angasetshenziswa ukufaka izinhlelo zokunika amandla ezinhlelweni ze-PMTCT ngombono womqondo womphakathi. Kusetshenziswe indlela yezindlela ezixubile ekuqoqeni idatha kusuka ezifundeni ezine zasemakhaya eZimbabwe. Isibalo sabantu abafundayo sasinabahlali basemaphandleni abanomphela abaphakathi kweminyaka yobudala eyi-15 - 60 abavela kumasiko ehlukene, abagcini bamasango omphakathi kanye nochwepheshe abasebenza kuleyo miphakathi. Isampuli ehlukaniswe ngokungahleliwe isetshenziselwe ukukhetha amalungu omphakathi angama-200 ekuqoqeni idatha, inani lesampula lisetshenziselwe ukukhetha ababambiqhaza ezingxoxweni zeqembu ezi-8 kanye nesampula elihloselwe ukusetshenziselwa ukukhetha abalindisango bomphakathi abangama-20 kanye nabachwepheshe abangama-20 bezingxoxo ezihleleke kancane. Ukuhlaziywa kwedatha kwenziwa kusetshenziswa uhlobo lwe-SPSS 20.0 nokuhlaziywa kwe-thematic.

Okutholakele kuveze ukuthi kwenziwa imizamo yokuqeda ukufa komama nezinsana okuhlobene ne-HIV kodwa ezinye izikhubekiso zenza abesifazane, ababambe iqhaza elikhulu ekutholeni lezi zinhlelo, bangasebenzi. Izithiyo eziphakanyisiwe zibandakanya ukungabi bikho kwemfundo esemthethweni, izinkolelo nemikhuba eyingozi yamasiko noma yezenkolo, ulwazi olunqunyelwe noma oluphazamisekile nge-PMTCT, ukungabi namandla okufukulwa kwabesifazane emaphandleni, ukuzibandakanya kwabesilisa abancane, ukungabi nabasebenzi abenele, ukude noma ukungabi khona kwemitholampilo yabakhulelwe, abampofu ubudlelwano phakathi kwabasebenzi bezempilo kanye nomphakathi kanye nokucwaswa nokubandlululwa kwabesifazane abakhulelwe abane-HIV ngabasebenzi bezempilo noma abanye ababalulekile. Ngenxa yalokhu, nangokuya ngomqondo wokuhlomisa ovela kwezengqondo emphakathini, kwaphakanyiswa amasu abhekiswe ekufukulweni kwabantu besifazane maqondana nempilo yabo yokuzala ngokocansi. Kwagcizelelwa ukusebenzisa izinsiza ezikhona endaweni ukubhekana nemiphumela emibi ye-HIV ne-AIDS ikakhulukazi kwabesifazane nasezinsaneni zabo ezingakazalwa. Okokugcina, kwaphakanyiswa imodeli edidiyelwe yokufukula abesifazane nge-PMTCT.

Amagama asemqoka: Amasu; ukufukulwa kwabesifazane; ukuvimbela ukudluliselwa kwegciwane lisuka kumama liye enganeni; umphakhati; ukunikwa amandla ngokwengqondo; imizamo; amasiko amaningi

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DEDICATION

This academic work is dedicated to my lovely son, Tinevimbo Nyadenga.

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LIST OF ABBREVIATIONS

ABC	Abstinence, Be Faithful and Consistent Use of Condoms
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APA	American Psychological Association
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BCF	Change Facilitators
CIFF	Children's Investment Fund Foundation
DFID	Department for International Development
DOI	Diffusion of Innovation Theory
EGPAF	Elizabeth Glassier Paediatric AIDS Foundation
ELA	Empowerment and Livelihood for Adolescents
EPI	Expanded Programme on Immunisation
FACT	Family AIDS Caring Trust
FGDs	Focus Group Discussions
GDA	Gender and Development Approach
HBC	Home Based Care
HBI	Healthy Beginning Initiative
HBM	Health Belief Model
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
ICRW	International Centre for Research on Women
IEC	Information, Education and Communication
LHW	Lay Health Workers
M2M	Mothers to Mothers
MoHCC	Ministry of Health and Child Care
MSF–Zimbabwe	Medecins sans Frontieres in Zimbabwe
MTCT	Mother to Child Transmission

NAC	National AIDS Council
NGOS	Non-governmental Organisations
NHS	National Health Strategy
PMTCT	Prevention of Mother to Child Transmission
RCH	Reproductive and Child Health
RCT	Randomised Control Trial
SSA	Sub-Saharan Africa
STIS	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
USAID	U.S Agency for International Development
VCT	Voluntary Counselling and Testing
WA	Welfare Approach
WID	Women in Development
ZICHIRE	Zimbabwe Community Health Intervention Research Project
ZIMASSET	Zimbabwe Agenda for Sustainable Social and Economic Transformation
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan

CHAPTER 1

INTRODUCTION: OVERVIEW OF THE RELEVANCE OF EMPOWERMENT STRATEGIES IN PMTCT INITIATIVES

1.0. GLOBAL OVERVIEW OF PREVENTION OF MOTHER-TO-CHILD-TRANSMISSION OF HIV

HIV and AIDS are amongst the most devastating epidemics worldwide leading to the loss of many lives. Various preventive measures have been put in place globally, among which is the Prevention of Mother- to- Child Transmission (PMTCT) of HIV. Programmes under PMTCT are guided by the four prongs that focus on the prevention of HIV infection among women of childbearing age, unintended pregnancies among women living with HIV and AIDS, and HIV transmission from infected mothers to their babies and lifelong care, and treatment for those infected women and their families (Hairston, Bobrow & Pitter, 2012). The importance of PMTCT to global health is the elimination of new HIV infections among unborn children and infants and keeping their mothers alive, thereby directly contributing to the attainment of three Sustainable Development Goals: Goals 3, 5 and 10 and to the 2030 agenda aimed at eradicating the epidemic worldwide. Goal 3 points toward ensuring healthy lives and the promotion of well-being for all at all ages; Goal 5 advocates for the achievement of gender equality and empowerment for all women and girls; and Goal 10 advocates for the reduction of inequality within and among countries (Webb, Cluver & Luo, 2018). The critical component of PMTCT of HIV and AIDS is providing antiretroviral (ARV) drugs to HIV-infected mothers and their new-born babies. This forms the key to changing the HIV and AIDS epidemic's unfavourable nature, especially in Sub-Saharan Africa (SSA) with antiretroviral drugs' uptake still below expected targets.

HIV and AIDS have continuously been reported as the leading cause of mortality among women of child-bearing age, and infants and children (Adane, 2012). In most countries, even those that have progressed well in PMTCT interventions, the major challenge that remains is to ensure that the interventions are effective and yielding desired outcomes. Global statistics reveal there is a reduction in the prevalence of death among women of child-bearing age and infants; however, there is still a significant number of casualties (UNAIDS, 2019).

In 2009 it was documented that 370 000 children were infected with HIV globally and over one thousand per day (UNAIDS, 2011). According to Fact Sheet (2016), this number has decreased. New HIV infections among children have declined by 50% since 2010. It has been documented that globally 150 000 children became newly infected with HIV in 2015, a decrease from a range of 250 000 – 370 000 in 2009 and 2010. However, these statistics conflict with those from the FACT Sheet, Global AIDS Update (2019), reflecting that the new infections were declining. In 2015 there were 190 000, in 2016, 180 000, in 2017, 170 000, and in 2018, 160 000. In 2019 the new infections had dropped to 150 000 (Global HIV &AIDS Statistics, 2020). The majority of these children acquired HIV through Mother-to-Child Transmission (WHO, 2012). The Children and AIDS Sixth Stocktaking Reports of 2013 highlight that by 2012, an estimated 1.5 million women of childbearing age were living with HIV annually. It was also estimated that generally without any interventions, between 15 to 45 per cent of infants born to such women become infected with HIV and the proportions will be that 5-10 per cent acquired it during pregnancy; 10-20 per cent during labour and delivery and 5-20 per cent during breastfeeding (Decock et al., 2000). The estimated number of new infections in children aged between 0-14 reflected a significant decline over the years. The UNICEF Analysis (UNAIDS, 2012), estimated that there was a 26% decline from 2001-2009,

an average of 18 000 per year; 35 % decline between 2009-2012 averaging 47 000 per year and 85% from 2012-2015 making a projected average of 74 000 per year. The Global Trend projections were targeting 90% reduction by 2015 (UNICEF, 2013).

However, according to Fact Sheet (2016), the Global statistics for 2015 reflected that new infections had declined by 50 % thus the 90% reduction target was not met though there was a significant improvement from 2010. According to the 2019 Global AIDS Update, a report at the International AIDS Society Conference in Mexico indicated that the world is failing to meet its commitment of ending the AIDS epidemic among children and adolescents. Also, the progress of reducing new infections among children and expanding access to treatment for children, adolescents and HIV positive pregnant women has notably slowed resulting in failure to meet set targets regardless of some significant gains reported in some countries.

Globally, SSA has been reported to be among the most affected areas. Prevention of Mother-to-Child-Transmission programmes were introduced long ago to reduce new childhood HIV infections. However the uptake of ARVs for PMTCT remains unacceptably low in many SSA states (International HIV/ AIDS Alliance, 2014). The World Health Organisation (WHO) (2012), highlights that of all the children who get infected globally, 90%, which is around 2 million, lived in SSA, supporting the fact that SSA is one of the most areas affected by HIV and AIDS. Indications are that HIV and AIDS have become the cause of mortality death, especially in countries where it is highly prevalent like South Africa and Zimbabwe (WHO, 2010a). It has been estimated that between 42 000 and 60 000 pregnant women died in SSA because of HIV in 2009 (UNAIDS, 2011). The estimated 350 000 children who were newly infected with HIV in SSA were 30% fewer than the 500 000 who

acquired HIV infection in 2001, and fewer children died from AIDS-related causes from an estimated 320 000 in 2005 to 230 000 in 2010 (Global HIV Response, 2011). According to the Kaiser Family Foundation (2017), 1.8 million children were surviving with HIV worldwide; there were 110 000 AIDS-related deaths and 150 000 new infections among children in 2015 indicating a notable decline of over 70% new infections since 2001.

The World Health Organisation's four prongs that guide PMTCT services are centred on women. This has historically seen PMTCT services being primarily directed at women at the neglect of men's influence on reproductive health thereby limiting both the reach and effectiveness of such services (van den Berg, et al., 2015). These authors noted that involving men as supportive partners in PMTCT has the potential of improving the health of women and children, engaging men in their own health, improving couples communication and heightening fathers' participation in child health through increased proximity to the health system and the child. Considering this, WHO has advanced male partner involvement as a priority intervention in PMTCT programmes (WHO, 2010). According to the Joint United Nations Programme on HIV and AIDS (2011), the UNAIDS Global Plan advocates for men's support and involvement in PMTCT programmes. Some countries in Africa show commitment to male partner involvement in PMTCT but lack specific guidelines.

A review of twelve African countries' policies on PMTCT revealed that all the countries noted the significance of male involvement in PMTCT. However, six of the countries that included Democratic Republic of Congo, Ethiopia, Malawi, Mozambique, Sierra Leone and Zimbabwe were vague in what they regard as male involvement (Sonke Gender Justice, MenEngage Africa, 2014). It was noted that these countries failed to clarify the care-giving roles men can or should play in their children's lives or to detailed plans on

how men can provide support to their partners. In contrast, the other six countries had policies with proactive and progressive language and included detailed strategies on how to engage men.

According to UN Women (2019), despite the progress in various aspects of the global HIV response, females, especially adolescent girls and young women, continue to be disproportionately affected by HIV. Globally, women constitute more than half of all people living with HIV and AIDS-related illnesses which are the leading cause of death amongst women of child-bearing age (UNAIDS, 2020). According to UNAIDS (2016), gender inequalities, including intimate partner violence, worsen the physiological vulnerability to HIV of girls and women, thereby blocking their access to HIV services.

WHO (2017), reiterates that HIV is not only driven by gender inequality, but it also strengthens gender inequality exposing women more to the impact of HIV. Such inequalities in some regions result in noticeable differences between the way HIV affects men and women (UN Women, 2019). The power imbalance between genders reflects that many young women fail to make decisions about their own lives. This was found in Senegal, Nigel, Burkina Faso, Cote d'Ivoire and Cameron where most married 15 to 19-year- old women had no say in their health care (UNAIDS, 2014). Intimate partner violence, inequitable laws and harmful traditional practices reinforce unequal power dynamics between men and women, limiting women's choices, opportunities and access to information, health, social services, education and employment. For instance, in some countries, women could not access sexual and reproductive health services without their partners or spouses' concurrence and had no final say in decision-making about their health (UNAIDS, 2017). Thus, HIV unevenly affects

women and adolescent girls because of their unequal cultural, social and economic status in society; hence gender inequality must be tackled to end this global epidemic.

Intimate partner violence which mainly emanates from power imbalances has also been noted as a hindrance to effective PMTCT. According to UN Women (2019), though the prevalence of intimate partner violence decreased between 2000 and 2014, it remains high across the globe affecting one in every three women (UNAIDS, 2017). It is prevalent in certain regions (UNAIDS, 2016). The fear of intimate partner violence is a stumbling block to the uptake of HIV testing and counselling, to the disclosure of HIV-positive status and to treatment uptake and adherence even among pregnant women on antiretroviral treatment (ART) as part of services to prevent mother-to-child-transmission (UNAIDS, 2020). In high HIV prevalence areas, women exposed to intimate partner violence are 50 % more likely to get HIV infection than women who are not (UNAIDS, 2020). This can impact negatively on preventive measures like PMTCT.

Promoting educational achievement among women and girls has been associated with better sexual reproductive health outcomes, including lower rates of HIV infection, delayed childbearing, safer births and safer abortions (UNFPA, 2013; DeNeve et al. 2015). Better education and empowerment for women and girls have been found to prevent intimate partner and gender-based violence (Garcia-Moreno et al. 2015). Findings from a study of some 44 countries yielded that completing secondary education significantly reduces the risk of intimate partner violence for women. Also, a girl's education is more strongly related to a reduced risk of partner violence in countries where spousal abuse is very prevalent (UN Women, 2019). Thus, efforts to promote PMTCT may become fruitful if women become empowered through enhanced formal education.

Poverty is another common factor that exacerbates women's vulnerability to HIV, and gender inequalities worsen its effects. According to UN Women (2019), poor women are usually economically dependent on men, pushing some into early marriages, and transactional and intergenerational sex where existing gender inequalities may make it difficult for them to insist on safer sexual practices. Such desperate measures expose their unborn babies to a high risk of HIV infection.

The world has committed itself to address gender inequalities as a way of HIV prevention. According to UNAIDS (2016), the world has pledged to empower girls and women with the objectives of making them recognise their rights, have access to quality education, acquire healthy lives and participate in protecting themselves from HIV. UN Women (2019), reiterates that tackling gender equality is the key to meet several sustainable development goals to be achieved between 2015 and 2030. These goals acknowledge women's equality and empowerment as both an objective and part of the solution. Also, many international pledges have been set to address gender disparities in HIV response. The UN Fast Track Strategy calls for a speedy scaling-up of existing efforts in low-and-middle-income countries to eliminate the HIV epidemic by 2030 and points at addressing gender inequality as crucial to achieving this aim (UNAIDS, 2015). UNAIDS and the African Union laid out commitments to advance African young women and girls' rights and empowerment to facilitate a Fast-Track response to the HIV epidemic (UNAIDS, 2015). The commitments included stopping HIV new infection among young women and adolescent girls, empowering young women and adolescent girls through comprehensive sexuality education, preventing HIV infections among children and keeping their mothers alive. In line with the UNAIDS Fast-Tack Strategy, in 2016 the UN General Assembly sanctioned a Political Declaration on HIV and AIDS which recognises the connection between violence and HIV and calls for an

end to all types of violence and discrimination against women and girls (UNAIDS, 2016). To eliminate the AIDS pandemic by 2030, UNAIDS has set a global target of less than 500 000 new infections by 2020 (UNAIDS, 2016). In trying to achieve this, UNAIDS has laid out prevention pillars that include comprehensive sexuality education, economic empowerment and access to sexual reproductive health services in high-prevalence areas for young women and adolescent girls and their male partners.

In 2017, the UNAIDS established the 'Start Free Stay Free' also called the Super Fast-Track Framework and Action Plan. This was developed on the prosperity of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive (Global Plan) of 2011, while further focusing on HIV prevention and treatment of children and adolescents. The Start Free Stay Free AIDS Free incorporates UN member states' goals in the 2016 Political Declaration on Ending AIDS, and it emphasised the dual elimination of both HIV and congenital syphilis. The fact that PMTCT is not 100% effective means that HIV elimination reduces the final HIV transmission rate to 5% or less among breastfeeding women and 2 % or less\among non-breastfeeding women (UN, 2017). This 2017 framework was designed to speed up action in 23 priority countries which include Zimbabwe. These priority countries were home to 87% of all children and adolescents living with HIV globally. This is where 87% of all new infections among children and 81 % of new HIV infections in adolescent girls and young women (10-24 years) occurred (UNAIDS, 2017). The framework also targeted a reduction of new infections among children to less than 40 000 by 2018 and less than 20 000 by 2020 and the reduction of new infections among adolescents and young women (10-24 years) to less than 100 000 by 2020. It also aimed to provide 1.4 million children and 1 million, 15 to 19-year-olds with HIV treatment by 2020. According to UNAIDS (2016), the framework was also committed to ensuring that 95% of

pregnant women living with HIV were receiving lifelong HIV treatment by 2018; however this target was not met for various unforeseeable reasons.

According to UN Women (2019), worldwide scale-up interventions restricted to gender inequality and HIV have not been fast enough, despite political commitments to enhance women's capacity to protect themselves from HIV infection. Translating these commitments into effective policies and programmes remains a challenge. For instance, in 2014, a survey of 104 countries found that only 57% had an HIV strategy with a specific budget for women (UNAIDS, 2015). Besides this, the UNAIDS 'Global Plan' towards Elimination of New Infections among Children by 2015 progressed well in PMTCT to avert new HIV infections among children, but its impact concerning the needs and priorities of women and girls was very restricted (UNAIDS, 2015). Even though global efforts have been put into effect, eliminating new HIV infections and maternal deaths among infants and women of childbearing ages remains unmet.

1.0.1 Background of Prevention of Mother–To-Child-Transmission (PMTCT) in Zimbabwe

Zimbabwe has been highlighted in various literature as one of the African countries worst struck by HIV and AIDS, hence its inclusion in the 23 priority countries. Although the country has seen a significant reduction in HIV prevalence, this epidemic remains the priority challenge to human development. It has been noted that the country's response to HIV and AIDS has been guided by specific policies and strategic documents, namely: National AIDS Council Act 16 of 1999, 22/2001: Chapter (15:14), Income Tax Act, Chapter 23:06, National HIV Policy of 1999, National Health Strategy (NHS, 2009-2013), Zimbabwe Agenda for Sustainable Social and Economic Transformation (ZimASSET, 2013 - 2018), Zimbabwe National HIV and AIDS Strategic Plan (ZNASP, 2015-2018), extended Zimbabwe National

HIV and AIDS Strategic Plan 2015-2020 and the National Health Strategy (2011-2015). Zimbabwe is one country that has put a commendable effort in eliminating paediatric AIDS in Africa through the partnership of its Ministry of Health and Child Care (MoHCC) with U.S Agency for International Development (USAID), U.K Department for International Development (DFID), EGPAF (Elizabeth Glaser Paediatric Foundation) and the Children's Investment Fund Foundation (CIFF) (Zimbabwe Situation, June 5, 2012). Option B+ for the prevention of mother-to-child-transmission of HIV has been adopted in Zimbabwe to enable the agenda.

According to the Zimbabwe AIDS Response Progress Report of 2014, high-quality, comprehensive PMTCT services were provided in 95% of the 1 560 health facilities in Zimbabwe and PMTCT was one of the preventive programmes that reached universal access of 93% in 2013 (Zimbabwe AIDS Progress Report, 2014). Seventy-eight per cent of pregnant women living with HIV received ARVs for PMTCT (IATT, 2015). The most significant decrease has been experienced by the nation in the number of new paediatric HIV infections from 21 000 to 9 000, around 57% (UNAIDS, 2019). This could be the effect of the nation's adoption of a national PMTCT scale-up plan (2011- 2015) which is currently functioning with the extended Zimbabwe National AIDS Strategic Plan (2015-2020). Though Zimbabwe's PMTCT situation seems promising the fact that the state has not yet attained one-hundred per cent elimination of mortality of children and women of childbearing age indicates that a lot still needs to be done in this preventive area.

The Elizabeth Glaser Paediatric AIDS Foundation (EGPAF) has been providing maximum support towards implementing comprehensive and integrated prevention of mother-to-child transmission of HIV (PMTCT) programme in Zimbabwe since 2001 (EGPAF

Annual Report, 2016). It is one of the major programme partners of the MoHCC. The Children's Investment Fund Foundation (CIFF) awarded a five-year grant to EGPAF in 2010 to accelerate the elimination of paediatric HIV and keep mothers and families in Zimbabwe alive (EGPAF, 2020). This grant was complemented by funding from the Department for International Development (DFID) and the Organisation for Public Health Interventions and Development (OPHID), enabling EGPAF to focus on scaling-up the programme and making a rapid geographic expansion. By the end of 2013, EGPAF provided direct support to 1 461 sites among Zimbabwe's 1 560 sites in all 62 districts (Zimbabwe Programme Annual Report, 2018). The scale-up was thriving. Its principal focus was on quality implementation and substantial preparations for the national transition from World Health Organisation (WHO) 2010 PMTCT guidelines, which commend initiating all HIV-positive pregnant and breastfeeding women ART for the rest of their lives (Option B+).

The Zimbabwe PMTCT trajectory started with the pilot launched in 1999 at three sites; the programme rolled out in 2002 (Perez et al., 2004). In 2006 there was a transition from single-dose nevirapine (SD NVP) to Option A. This led to an improvement in the programme in 2010, where PMTCT services were offered in 1560 ANC sites constituting 95% coverage (Mushavi, 2018). In November 2013, the Zimbabwean government launched the Interagency Task Team (IATT) which supported the B+ transition plan. Option B+ rolled out fully by the end of 2013 and the beginning of 2014. Zimbabwe also launched the Plan for Elimination of Mother- to- Child Transmission of HIV and Syphilis in Zimbabwe 2018-2022. This plan's conceptual framework has strategic intervention areas. These include increasing availability and uptake of quality Integrated Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition (RMNCAH) services as platforms for EMTCT; and early diagnosis, treatment, care and follow up on women, their partners and children (ZNASP 111 2015-2018).

It also aims to strengthen laboratory commodity and security systems, community systems for EMTCT, data and strategic evaluation for EMTCT and leadership and governance, human resources for health (HRH) and other health systems strengthening (HSS) blocks for EMTCT (Mushavi, 2018). The programme aims to increase ANC coverage to 95% by 2022, HIV testing for pregnant women to 95% or more by 2022, syphilis screening for pregnant women to 95% or more by 2022, ARV coverage for HIV positive pregnant women to 95% or more by 2022, and treatment coverage for syphilis seropositive pregnant women to 95% or more by 2022 (Global AIDS Response Progress Report, 2019). The EMTCT Plan's impact targets are that by 2022 there should be a reduction of the MTCT rate of HIV to 5% or less, reduction of new paediatric HIV infection case to 250 or less per 100 000 live births and reduction of new cases of congenital syphilis to 50 or less per 100 000 live births (The Plan for Elimination of MTCT of HIV and Syphilis in Zimbabwe 2018-2022). The overall goal is to eliminate mother-to-child transmission (MTCT) of HIV and Syphilis in Zimbabwe by 2022. The plan envisions a Zimbabwe with zero Mother- to- Child Transmission (MTCT) of HIV and syphilis. The guiding principles include that the programme should be country-led, have universal access, be gender-responsive, adopt a human rights approach and promote community engagement, equality and non-discrimination.

According to Mushavi (2018), despite all these efforts to improve PMTCT, there are bottlenecks to EMTCT. These include weak integration of RMNCAH and EMTCT services, lack of a clearly defined package of interventions for 'prong 1', and interventions for HIV negative women which results in low re-testing, low quality of services including inadequate counselling and failure to re-test due to work overload and less prioritisation of viral load for HIV positive women. Other bottlenecks comprise financial barriers to access, like user fees and lack of transport; low male partner testing which leads to increased risk of high incident

infections in pregnancy and lactating period; weak referral systems especially for HIV-positive women and vague strategies to ensure postpartum adherence and retention to ART. Also, Mushavi (2018), states that other hindrances include late ANC booking resulting from cultural and religious practices and knowledge gaps and poor uptake of RMNCAH services such as low facility delivery and PNC due to religious and cultural practices. The long distances to health facilities and other geographical barriers and stigma and discrimination lead to poor disclosure especially among adolescents and are hindrances to effective prevention of mother- to- child transmission of HIV.

The Zimbabwe government endorsed an extended Zimbabwe National HIV and AIDS Strategic Plan 2015-2020 whose vision is to have a Zimbabwe with zero new infections, zero discrimination and zero AIDS-related deaths leading towards ending AIDS by 2030. Within this framework, the nation officially launched the Start Free, Stay Free, and AIDS-Free Framework in November 2016, a super fast-track framework for eliminating AIDS among children, adolescents and young women by 2020. According to UNAIDS (2016), Zimbabwe committed itself to eliminate mother-to-child transmission of HIV to reduce maternal and child morbidity and mortality. This should be achieved by abiding by the four prongs proposed by WHO. This has seen an integration of service delivery models for EMTCT in antenatal care settings being scaled up in line with the provision of life long ART to HIV positive pregnant and lactating women to prevent HIV transmission to the baby and for the mother's health (Global AIDS Progress Report, 2018).

Efforts have been made towards accelerating early infant diagnosis and provision of Cotrimoxazole prophylaxis to HIV exposed infants and ensuring timely linkage to care and treatment for children who unfortunately come out HIV positive (Myer, et al. 2017). According to ZIMPHIA (2019), the national MTCT rate has gone down significantly to nearly

6% by 18 months post-partum. However, data suggests ongoing challenges with identification, ART initiation and viral suppression among adolescent and young adult mothers.

There are positive indications that the country can end the AIDS epidemic. Zimbabwe remains committed to achieving zero new infections, zero HIV related deaths and zero HIV stigma and discrimination. The country has also made a formal commitment towards fulfilling international obligations including the United Nations General Assembly Special Session Declaration of Commitment on HIV and AIDS (UNGASS 2001); the Maseru Declaration on HIV and AIDS; the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW); the UN Convention of the Rights of the Child; the Universal Human Rights Declaration and commitment to attain the Sustainable Development Goals (UNAIDS, 2017). The national plan has domesticated international instruments and commitments such as 90 90 90 and fast-tracking, post-2015 Sustainable Development Goals (SDG), Africa Union roadmap on local, sustainable financing and ending AIDS by 2030. In line with this, adolescents and young people have been prioritised in Zimbabwe's endeavours to revive HIV prevention (Mushavi, 2018). Some initiatives including Sista2sista and Dreams rolled out in hotspot districts in an attempt to empower young women to make informed sexual reproductive decisions (UN Women, 2016). The plan gives precedence to parenting programmes targeted at empowering parents, guardians and caregivers with HIV and gender-based violence prevention to complement the in and out comprehensive sexuality education component.

According to Ncube and Msipha (2019), rural Zimbabwe remains porous and volatile within the spheres of HIV and AIDS as a pandemic. These authors highlighted that some cultural practices being harnessed in some areas hinder interventions aimed at ameliorating

HIV. These are complemented by the scarcity of clinical or medical facilities that remain a significant stumbling block towards living the 'HIV Free Generation' vision. Traditional midwifery has also been pointed out as a stumbling block as the mothers give birth without knowing their HIV status, thus making the newly born vulnerable to vertical transmission. Duri et al. (2013), also highlight that mother- to- child transmission (MTCT) of HIV is a major problem in Zimbabwe, contributing to infant and child mortality. The situation in rural Zimbabwe has also been seen in other African states. For instance, Skinner et al. (2009) highlighted that PMTCT is a stepping stone towards eliminating new HIV infection in children. However, they noted there are stumbling blocks which hinder PMTCT programmes in rural South Africa too. Even though there is free medical access for women and children in South Africa, poor road networks underdeveloped transport system network and poor telecommunication negatively affect the implementation of PMTCT.

In Nigeria and Malawi, it was highlighted that socio-cultural barriers block full PMTCT implementation (Okoni & Lansdown, 2014). These include stigma and discrimination, perception, religious beliefs, family disruption, gender inequality, unstable pre-marital sexual relationships, unskilled birth delivery by traditional birth attendants and low utilisation of hospital delivery services. The same authors added that women become victims of domestic violence from partners and families when they enrol in the PMTCT programme, which makes them default in their adherence to PMTCT therapies or drop out from the programme.

PMTCT programmes have been implemented to assume that the primary targets who happen to be women are free to make their own decisions regarding their involvement. However, in reality, especially in African countries, mainly in remote areas, women lack decision- making power even about their sexual reproductive health. According to the

International HIV Alliance (2014), the main challenges faced by women in accessing PMTCT services include HIV stigma leading to fear of disclosure, inadequate numbers of healthcare providers, poor accessibility to HIV and AIDS services, the psychological impact of an HIV positive diagnosis which can delay uptake of drugs, and lastly lack of knowledge of HIV transmission and Antiretroviral Therapy (ART). PMTCT programmes were introduced in SSA over a decade ago. Despite international commitments to eliminate new infections in children, the prevalence of women and children accessing lifesaving treatment under PMTCT programmes remains below targets in most parts of SSA (International HIV Alliance, 2014). Low male involvement in PMTCT initiatives has also been documented as an impeding factor to eliminating new infection in children (WHO, 2012). Peacock (2009) in WHO (2012), highlighted that the majority of implementation efforts related to family planning and HIV prevention and care had been primarily directed at women without considering cultural and gender norms that impact women's decision- making.

The reality about most African women's decision-making about their sexual reproductive health is that it is deeply influenced by their partners, families, communities, social norms and beliefs about HIV and AIDS (UNAIDS, 2011). Therefore, it is against this background that the researcher sought to explore empowerment strategies that can be implemented in PMTCT initiatives as a way of improving women's involvement and eliminating HIV and AIDS-related death of children, women of childbearing age and their partners.

1.1. RESEARCH PROBLEM

The HIV and AIDS epidemic is a real socio-economic development crisis that threatens the social and economic fabric, and the political stability of nations in their entirety. Preventing HIV and AIDS transmission in pregnant women, mothers, and their children has become a crucial intervention in the global fight against this epidemic. About 211 million women globally become pregnant each year and need effective maternal and child care (WHO, 2016). Ninety-nine per cent of these pregnant women globally, are HIV-negative and need counselling, information, and services to remain so. Preventing HIV and AIDS infection in these women protects the women themselves for their own sake, and protects their children and partners. There is a risk of transmitting HIV and AIDS to children during pregnancy, childbirth and breastfeeding, and women need to be empowered to lower this risk. Mother-to-child-transmission is the primary cause of all HIV and AIDS infections in children under fifteen years of age. When effectively and appropriately implemented, PMTCT has the potential to prevent infection in the 15-35 per cent of babies who would otherwise be born HIV-positive (WHO, 2010).

Prevention of Mother-to-Child-Transmission services and initiatives may be available, but not all women, especially those from poor socio-economic and cultural backgrounds, receive the full benefit. Most PMTCT programmes are organised around the assumption that women may act independently, and have the resources to access testing, counselling, pre- and postnatal care, and alternatives to breastfeeding. Women confront several gender-based obstacles preventing mother-to-child transmission of HIV and AIDS. The programmes provided need to ensure that they are reaching as many women as possible. This means addressing not just practical issues, but also social, cultural and personal factors. People's attitudes towards HIV and AIDS are central to the success or failure of PMTCT.

PMTCT programmes are offered in Zimbabwe, but the services are not reaching all women of child-bearing age and their children regardless of their availability. This occurs due to various reasons which include but are not limited to some cultural and religious beliefs which prohibit women from fully participating in PMTCT programmes, low male involvement, lack of decision making power among women, inadequate knowledge about PMTCT programmes, lack of motivation and the negative consequences encountered by women who are HIV positive. There is a dire need for women empowerment at all levels from the personal, organizational, community, national, and global levels. It is therefore against this background that the researcher sought to examine the strategies that can be adopted in incorporating empowerment programmes in PMTCT initiatives to ensure there will be an AIDS-free generation.

1.2. AIM OF THE STUDY

The study aimed to explore strategies that can be utilised in incorporating empowerment programmes for multicultural rural women in PMTCT initiatives from a Community Psychology perspective. In trying to achieve this aim, the researcher unpacked what is happening on the ground about the PMTCT Programme in rural Zimbabwe. The main objective was to unearth the factors which rob rural women of the power to partially or fully participate in PMTCT initiatives. Possession of such an understanding helped the researcher and the participants to come up with strategies that may be adopted by the country and PMTCT implementing organisations in trying to promote women empowerment in PMTCT initiatives.

1.3. OBJECTIVES

- To explore gender inequalities in society that may impede women empowerment in PMTCT programmes.

- To assess the level of knowledge and awareness of PMTCT programmes among community people.
- To examine cultural beliefs and practices which need to be addressed in coming up with women empowerment strategies in PMTCT programmes.
- To establish if age determines the level of acceptance of empowerment programmes by rural people in PMTCT initiatives.
- To establish if rural women's level of formal education influences their participation in PMTCT initiatives.
- To explore if PMTCT implementing organisation are using any women empowerment strategies in their initiatives.
- To use the findings of the study to propose a model and empowerment strategies that may be effected in PMTCT interventions among rural women.

From these specific objectives, the researcher drew hypotheses for the quantitative part of the study and research questions for the qualitative part. Some hypotheses and research questions address the same issues. This was done to ensure that the quantitative and qualitative parts complement each other, giving a holistic picture of the research problem. Some hypotheses and research questions refer to both rural men and women as participants because PMTCT is a sexual reproductive health issue that requires both men and women's involvement to attain meaningful empowerment of women. Men and women are primary contributors to effective PMTCT interventions; hence, women's empowerment under PMTCT requires researchers also to seek men's views.

1.4. HYPOTHESES

Hypothesis 1: Gender has a significant effect on rural people's participation in PMTCT initiatives.

Hypothesis 2: Cultural beliefs and practices significantly affect rural women's participation in PMTCT initiatives.

Hypothesis 3: Age influences rural women and men's involvement in PMTCT initiatives.

Hypothesis 4: Rural women and men's PMTCT knowledge and awareness levels have a significant influence on their involvement in PMTCT Programmes.

Hypothesis 5: Rural women's level of formal education has a significant influence on their participation in PMTCT initiatives.

1.5. RESEARCH QUESTIONS

- Do cultural beliefs and practices influence the participation of rural women in PMTCT initiatives?
- Does the level of rural men and women's PMTCT awareness and knowledge influence their participation in PMTCT programmes?
- Does a redefinition of the role of the relationship between PMTCT health professionals and rural women influence the latter's participation in PMTCT programmes?
- Does male partner involvement play a role in women empowerment under PMTCT initiatives?
- What challenges do rural women experience in trying to participate in PMTCT initiatives?
- What roles can rural women and proximal agents (community gatekeepers) in the community espouse in PMTCT empowerment initiatives?
- Which empowerment strategies assist in the design of PMTCT interventions for rural women?

1.6. SCOPE OF THE RESEARCH

The principles of the empowerment theory were reviewed and applied from a Community Psychological perspective. Participants were rural women and men between 15

and 60 years of age who permanently reside in Zimbabwean rural areas comprising at least three cultural groups. Those above 49 years who are usually past childbearing age were included as they can contribute to the success of PMTCT by encouraging those of childbearing age. The primary target was women; however, men were included to get their views about women empowerment under PMTCT, as meaningful empowerment of women requires men's contribution. The contribution from men was monitored so they did not override women's involvement. Participants excluded school children as the study was done during schooldays so the researcher did not want to disturb their studies**.** The focus was on three dominant cultural groups, namely Shona, Ndebele and Shangaane. The other participants were community gatekeepers and professionals who engaged in PMTCT activities.

1.7. CONCEPT OF EMPOWERMENT, COMMUNITY AND COMMUNITY ENGAGEMENT

The concepts that form the foundation of this study need to be defined and explained in- depth. These include empowerment, community and community engagement.

1.7.1. Empowerment.

Empowerment is a fluid concept that can be defined from different dimensions, but in this context, the researcher adopted it from a psychological point of view. It takes on a different form in different people and contexts (Rappaport, 1984). Empowerment may be defined as focusing on issues of gaining power and control over decisions and resources that determine the quality of one's life or by considering structural inequalities that affect entire social groups rather than focusing only on individual characteristics (Oladipo, 2001). It may also be defined as the act of enabling people to act on their own to reach their self-defined goals (Zimmerman, 1995). Generally, empowerment occurs in different facets ranging from

economic, political, social and psychological. This study focused on the community psychological view of empowerment referring to an individual's cognitive state characterised by a sense of perceived control, competence and goal internalisation (Oladipo, 2001).. This concept was of paramount importance in the study to explore ways that could encourage women empowerment from all aspects of life, impacting their involvement in PMTCT initiatives.

1.7.2. Community

The study was conducted in different societies; therefore, the concept of community needs to be operationally defined. This concept can be defined subjectively and it is crucial to define it operationally when dealing with community issues: It is essential to consider who is included and who is excluded from membership (IOM, 1995). Individuals belong to multiple communities at any one time; thus, when initiating community engagement, such understanding must be put into cognisance (Mattessich & Monsey, 1996). From a sociological perspective, community refers to a group of people united by at least one common characteristic. It can also be viewed as systems composed of individual members and sectors with a variety of distinct characteristics and interrelationships (Thompson et al. 1990). A community can also be regarded as a living organism or well-oiled machine which needs the performance of each sector's role to function well (Fawcett et al. 1995). In a system view, healthy communities are those with well-integrated, interdependent sectors that share the responsibility to solve problems and enhance the well-being of the community. In this context, the given definitions were utilised. Thus community was used to refer to those populations from which participants were drawn. The researcher assessed how individuals within the targeted areas were interlinked and how they could be better utilised in PMTCT initiatives for the empowerment of rural women from diverse socio-cultural contexts.

1.7.3. Community Engagement

This refers to a process of working collaboratively with and through groups of people affiliated by geographic proximity, where particular interests or similar issues affect the well-being of such people. It is a powerful tool for bringing about environmental and behavioural changes that will improve the community's health and its members. It usually involves partnerships and coalitions that help mobilise resources and influence systems, change relationships among partners and serve as catalysts for changing policies, programmes and practices (Fawcett et al. 1995). Certain organising concepts guide approaches to successful community engagement. These include social ecology which looks at the interdependence of the different systems within the environment with an impact on the existence of an individual (Stolkols, 1996) and cultural influences which is the contribution of social norms and other elements of the community culture on disease prevention and health promotion.

According to Airhihenbuwa (1995), if one wishes to work with community members, there is a need for careful examination of differences and similarities in cultural perceptions so that engagement activities are appropriate for that cultural context, the so-called 'cultural sensitivity'. Other organising concepts include community participation which is the involvement of community members (Thompson et al. 1990); community empowerment which refers to the mobilisation and organisation of individuals, grassroots and community-based organisations and institutions to enable them to participate, influence and make decisions on critical issues (Rich et al. 1995); capacity building meaning the need to equip individuals and organisations with resources, knowledge and skills beyond those they possessed initially,(Fawcett, et al., 1995); coalitions which refer to formal alliances of organisations, groups and agencies that have come together to work for a common goal (Florin et al., 1993); analysis of benefits and costs of community engagement (Butterfloss, et al.,

1993); and 'stages of innovation'. Rogers coined this term in 1962 in reference to the idea that, all individuals do not adopt to innovations at the same rate or with the same willingness. These organising concepts were very relevant in the study as they guide effectively on developing empowerment strategies in PMTCT programmes.

1.8. EMPOWERMENT THEORY FROM A COMMUNITY PSYCHOLOGY PERSPECTIVE

The conceptualisation of empowerment presents challenges in its definition because it has been widely used in different areas. This led the researcher to be confined to the empowerment theory used within Community Psychology.

Zimmerman et al. (1993) note that very few investigators had attempted to test the empowerment theory which still marginal even today. Thus there is a need for further exploration of this theory on how it apply to different situations and extend it to include intrapersonal interaction and behavioural components. The intrapersonal component's underlying dimension can be interpreted as a combination of different measures of perceived control which makes it a component of psychological empowerment. It differentiates groups defined by their participation level in community organisations and activities, which is the behavioural component. Such a relationship between the two is consistent with the empowerment theory.

Psychological empowerment is contextually defined and depends on the people being studied (Rappaport, 1984; Zimmerman, in press). It may be viewed as a concept that comprises intrapersonal, interactional, and behavioural components (Zimmerman, in press). The intrapersonal component denotes how people contemplate their capacity to influence social, political systems important to them. According to Zimmerman et al. (1993), it is regarded as self-perception that includes domain-specific perceived control (Paulus, 1983),

self-efficacy, motivation to exert control and perceived competence. Furthermore, it may also comprise perceptions about the difficulty associated with trying to exert control over community problems which may mean beliefs about an individual's own capacity to influence social and political systems, or beliefs about people in general (Zimmerman & Rappaport, 1988).

The interactional component refers to the relations between people and environments that enable one successfully to grasp social and political systems. It includes knowledge about resources needed to attain goals, such as resource mobilisation (McCarty & Zald, 1978), understanding causal agents (Sue & Zane, 1980), a critical awareness of one's environment (Kieffer 1984; Freire, 1973), and the establishment of decision- making and problem-solving skills vital for actively engaging one's environment. The interactional component is very important to the construct of psychological empowerment because it links self-perceptions about control (intrapersonal component) with the actions that one takes to exert influence (the behavioural component).

The behavioural component refers to specific actions one takes to exercise influence on the social and political environment through community organisations and activities. It includes community organisation participation for example, neighbourhood associations, political affiliations, support groups, churches, religious groups, and service organisations. Besides that, it includes participation in community-related activities such as helping others cope with problems in living, contacting public officials or organising a neighbourhood around an issue. Thus, in this study, it means participation in individual and community activities which address the PMTCT cause.

According to the empowerment theory, empowerment can be analysed at different levels: individual, organisational and community. At the individual level of analysis, it is

regarded as a process by which individuals gain mastery and control over their lives and an in-depth understanding of their environment (Berger & Neuhass, 1977; Cornell Empowerment Group, 1989; Kieffer, 1984; Rappaport 1984, 1987; Swift & Levin, 1987; Schulz & Israel, 1990; Zimmerman, 1990). It also incorporates participatory behaviour, motivations to exert control and feelings of efficacy and control (Zimmerman, 1990). At the organisational level of analysis, there is evidence of shared leadership, opportunities to build up skills, expansion and effective community impact. Finally, the community level of analysis comprises empowered organisations that promote citizen participation in community decision-making and accommodate multiple perspectives in times of conflict. These levels are intertwined, and they are not constant; they are dynamic and are culturally and contextually defined. Thus knowledge of such different but interrelated levels becomes vital in addressing PMTCT issues in diverse contexts.

Psychological empowerment theory depicts that interventions that bring about genuine opportunities for individuals to participate may help them develop a sense of psychological empowerment. Such interventions' effectiveness may be noted if they take into cognisance strategies for helping individuals develop the skills vital for participation in decision-making and problem-solving. Psychological empowerment refers to the individual level of analysis; however it does not mean that individuals are solely responsible for its development (Zimmerman et al., 1993). Swift and Levine (1988) point out that an empowerment approach to prevention needs to consider environmental factors that may influence or block psychological empowerment development. This practise should begin with an environmental assessment of the opportunities to participate and create strategies that incorporate participants in the design, implementation and evaluation of an intervention. The objective of both empowerment theory and practise is to understand and strengthen processes

and context where individuals acquire mastery over decisions that affect their lives. Therefore, in this study, to attain psychological empowerment in PMTCT programmes, there is need for an environmental assessment specifically, the assessment of economic, political, social and cultural factors that either hinder or promote rural women's involvement in PMTCT programmes. This would help avoid coming up with interventions based on the assumption that all women are at free to make decisions that affect their health.

According to Olapido (2009), psychological empowerment refers to an individual's cognitive state characterised by a sense of perceived control, competence and goal internalisation. It is a multi-faceted construct portraying the different dimensions of being psychologically enabled and is perceived as a positive integration of perceptions of personal control, a proactive approach to life and a critical understanding of the socio-political environment rooted firmly in a social action framework that includes community change, capacity building and collectivity. Olapido (2009) affirms that psychological empowerment is vital. First, several economic and social empowerment programmes have failed due to lack of considering the psychological makeup of the individuals concerned. Second, the psychological aspect is a vital component of humans. As such, it must be considered in the formulation of policies directly and indirectly related to them. Last, if psychological empowerment is neglected this may result in unfavourable attitudes and behaviours elicited by the communities that may eventually derail any interventions targeting to address problems faced by humans.

The empowerment theory from community psychology brings in a change of relational terms between the professionals and the community people in need. Naidoo, Shabalala and Bawa (2002) reiterate that empowerment substitute's terms such as 'client' and

‘expert’ with ‘participant’ and ‘facilitator,’ can redefine professionals and helpers' roles. In engaging in the collaborative role, the professional learns about the participants within their contexts; gets knowledge from participants themselves; works with the participants instead of advocating for them and does not impose their skills, interests or plans on the community. Rather becomes a resource for the community. Thus, by so doing Community Psychology attempts to put the two at the same level which enhances good relations.

1.9. WOMEN EMPOWERMENT IN PMTCT INITIATIVES

Mother-to-child transmission has been regarded as the most common way children become infected with HIV. Statistics show that the number of women of child-bearing age who are HIV positive, are twice as much as men of the same age group (WHO, 2016). This means that when such women become pregnant, there is a higher chance of infecting their babies during pregnancy, labour, delivery or breastfeeding. The situation is usually like this due to lack of decision-making power among women regarding their sexual reproductive health, and such a scenario is highly prevalent among African women. This, therefore, calls for women empowerment in PMTCT initiatives. According to Hope (2007), women empowerment means that women legitimately can and should individually and collectively participate effectively in decision-making processes that shape their societies and their bodies and lives. The achievement of women empowerment can only materialise through men and women's alliance and partnership in bringing reform. Both men and women should support behaviour modification targeted towards reducing transmission of HIV and sexually related infections. Empowerment is a public health strategy which can yield improved health outcomes.

According to Willan (2004), women are biologically more vulnerable to sexually transmitted diseases and HIV than men are. They become more vulnerable as they carry the double burden of caring for significant others suffering from the HIV and AIDS epidemic, yet their sexual rights are not fully recognised. Women's biological vulnerability to STD infection is higher than that of men because the vaginal surface is larger and more susceptible to sexual secretions than a predominantly skin-covered penis. The quantity of potentially infected male sperm deposited in a female's sexual organ during the sexual act is higher than the potentially infected cervical and vaginal secretions that a male is exposed to (Family Health International, 2003). This biological vulnerability coupled with social vulnerability have a negative impact on their involvement in PMTCT initiatives.

Rowland's (1998) concept of internalised oppression stresses that black women's oppression is rooted in the disempowering way that society views them and the low social roles they are assigned. According to Rowland, women especially African women, have learned to accept oppression without questioning. This makes them more vulnerable to HIV and AIDS and less involved in PMTCT initiatives, as they cannot decide independently on what actions to take to protect themselves. Thus, women's susceptibility towards HIV and AIDS is also closely intertwined with not only their biological makeup but also their lower social status and their social and economic subordination to men. Hence there is a need to change women's mind-sets or perceptions towards sexual health which can only come through their empowerment.

In this context of crippling effects from HIV and AIDS, women also experience psychosocial vulnerability. Some of the most significant barriers to women empowerment are the stereotyped gender perceptions of women as only being mothers and primary caregivers

who cannot get into formal employment. This can also be witnessed in some PMTCT programmes that focus mainly on the child's health to the neglect of the mother. According to de Bruyn (2002), ART is withdrawn when the woman stops attending the PMTCT programme which gives the impression that voluntary counselling and testing (VCT) is only offered to prevent HIV transmission to the child indicative of the lack of power among women. The remedy to this comes through women empowerment which may be attained by changing gender relations and expectations within partnerships and community thereby positioning women to negotiate and realise their own needs and desires in preventing HIV infection.

1.10. THE ROLE OF MEN IN PMTCT INITIATIVES

Another social issue that may negatively affect PMTCT initiatives in Zimbabwe is that of low male involvement in PMTCT programmes. According to Community News (2013), Zimbabwean men have been encouraged to support their partners in implementing PMTCT which is still lagging behind other programmes on HIV and AIDS. Men have been said not to participate as they should, which has slowed down the programme (Mbanje, 2013). A Kenyan study revealed that where women are supported and accompanied by their male partners, they are more likely to consistently visit antenatal clinics (Irin/Plus News, 2009). Some men accompany their partners, but the majority do not fearing being ridiculed by their peers. However, when men are involved, PMTCT stages are followed successfully (WHO/UNAIDS/UNICEF, 2011). For male involvement to be effective, antenatal clinics have to be accessible to men and messaging around HIV testing during pregnancy needs to be equally targeted at men (Plus News, 2012).

According to De Paoli et al. (2004), the unfortunate part is that it is not easy to persuade men to attend what they regard as women’s clinics dealing with women’s issues. A

Zimbabwean research report by Zambezi et al. (2011), reflected there was low involvement of men in PMTCT initiatives for several reasons which include that there is lack of confidentiality and privacy at such clinics, peer influence against fellow men's testing for HIV, male ego, fear of the unknown, inefficiency at antenatal clinics regarded by men as time-consuming, social norms and expectations towards men which state that men must always be physically fit thus visiting a clinic was a sign of being weak, and religious factors for example the belief that HIV was a sign of being promiscuous. Given such a background, it becomes imperative to find ways of enlightening men on PMTCT issues so they will become supportive, resulting in a greater chance for women empowerment.

1.11. CULTURAL CONSTRAINS IN PMTCT INITIATIVES

Culture has been pointed out by many as one of the major hindrances to women empowerment in sexual reproductive health issues. According to the Zimbabwean newspaper (Aug 2014), many women, religious and non-religious are denied access to health services including HIV and AIDS treatment and contraceptives. Because of the patriarchal nature of Zimbabwean societies, boys and men are socialised to believe that they hold the key to all activities that women partake in, including access to health services. Rural women are more exposed to the risk of HIV and AIDS because of the limited decision- making power, lack of access to resources, unacknowledged violence like forced wife inheritance and persistence and prevalence of customary law which overrules national laws aiming at protecting women (UNFAP, UNIFEM, 2005). According to Shetty et al. (2005), HIV and AIDS and related stigma and discrimination are found in many societies. They can lead to social isolation and even lack of support from partners, family and community. Fear of such prejudice can lead some women not to participate fully in PMTCT initiatives. This can be reduced by making disclosure less difficult for women , for example by running support groups or anti-stigma

campaigns (USAID, 2003) or attempting to identify those who wish to avoid or defer disclosure, (Medley, et. al. 2004). Essentially, there is a need for empowerment strategies to be incorporated in PMTCT programmes.

1.12. MOTIVATION

Based on the findings in her Master's degree, for example that cultural beliefs and practices constrain rural women’s participation in PMTCT, the researcher was motivated to study the strategies that can be utilised to incorporate empowerment programmes in Prevention of Mother- to- Child Transmission (PMTCT) of HIV infection. HIV and AIDS has got devastating effects on the community. Because of this scenario, the researcher conducted this study on PMTCT strategies, focusing on the empowerment approach from a community psychology perspective. The approach was recommended in implementing initiatives targeted at preventing women's initial infection, infection of babies at birth, and neonatal deaths.

The findings revealed that socio-cultural factors play a significant role in hindering full participation of rural women in the Prevention of Mother to Child Transmission (PMTCT) programmes. These socio-cultural factors include gender roles that lower women's position in society, thereby leading to a lack of decision-making power among women when it comes to their sexual health like family planning, testing for HIV and AIDS, accepting an intervention and making infant feeding choices. Males, communities, and social norms profoundly influence such decisions. In many rural contexts, social norms lead to gender inequality internalised by many women, thus causing them not to take full initiatives in their sexual reproductive health. Cultural beliefs dictate to women that they are not supposed to propose safer sexual practices to their male counterparts, and that childbearing is a duty which

has to be performed regardless of one's sero-status. Most African societies and cultures emphasise that women must breastfeed their babies as failure to do that may be associated with witchcraft or may lead to the discrimination of such women as people living with HIV and AIDS. Some cultural beliefs may hinder women from delivering at antenatal clinics fearing exposing the baby to evil people and also may not accept formula feeding. Avoidance of breastfeeding may expose such women to condemnation by the community, social exclusion and marginalisation. Another factor is *lobola* payment (bride price), which robs women of their rights, including sexual reproductive health rights. These socio-cultural factors disempower women in their participation in PMTCT programmes. Confronted by such socio-cultural factors that hinder the effectiveness of PMTCT programmes, the researcher saw a need to explore strategies that can help assist in women empowerment to fully participate in such programmes hence saving their lives and that of their babies and of their partners.

Statistical analysis from Elizabeth Glaser Paediatric AIDS Foundation's (EGPAF), Country Spotlight (2014), reveals that maternal and postnatal deaths occur despite the widespread nature of PMTCT programmes Zimbabwe. This has urged the researcher to study Prevention of Mother to Child Transmission (PMTCT) of HIV and AIDS programmes to establish the nature of empowerment strategies essential for the programme's effectiveness. Also, very few studies were done in Zimbabwe on PMTCT programmes focusing on empowerment and of those, only a few attempted to test applicability of theory on implementation (Kalembo & Zgambo, 2012).This motivated the researcher to conduct a study that seeks to establish the nature of empowerment strategies that will pave the way for sustainable PMTCT programmes, especially for rural African women.

Diverse cultural groups with different cultural beliefs constitute Zimbabwe. Such beliefs sometimes constrain women in their participation in PMTCT programmes. Though such beliefs sometimes affect women in urban areas, the weight is heavy among rural women due to their socio-economic status as the majority are less educated, and others are illiterate and rely solely on their male partners for everything. It is in rural settings where traditional cultural values and norms are upheld fully. Due to this strong cultural influence in rural areas, sometimes women fail to exercise full control of their sexual and reproductive health, exposing them to loss of life or serious ill-health. Given such a scenario, one can deduce that women in such contexts lack power over their entire lives.

The discipline of community psychology is still very new in Zimbabwe and it is penetrating into the academic field. Thus such a position compels the researcher to undertake a study from a community psychology perspective as a way of trying to bring the field to the grassroots. There is limited research because in Zimbabwe Community Psychology began to be studied as a specialisation in 2012, which indicates that it is a field with a short history. People are still trying to understand what community psychology is; where it is coming from, where it is going, and its objectives.

1.13. CHAPTER SUMMARY

This chapter presented an overview of the PMTCT situation globally and in Zimbabwe. HIV and AIDS are health and social issues that affect the development of humans and communities. Literature has shown that a high proportion of women of childbearing ages have been infected with HIV which calls for interventions to prevent the transmission of this infection to unborn and new born babies. Zimbabwe through mainly the support from EGPAF, has done commendable work under PMTCT programmes; however, there is still a need to

attain 100% preventive measures. Local research has been done under PMTCT but little has been done in relation to the empowerment of women under such programmes. With its emphasis on valuing diversity and empowerment, Community Psychology can play a significant role in making women play a prominent role in preventing mother-to-child-transmission of HIV infection. The rural community was chosen as a unit of analysis because in the rural areas women's disempowerment is most evident. The researcher expected this thesis to contribute meaningfully to PMTCT programmes and cover the gap left by PMTCT initiatives in Zimbabwe.

1.14. OUTLINE OF THE THESIS

Chapter 2 will review research done under PMTCT using the empowerment theory mainly from a psychological perspective.

Chapter 3 will lay out in-depth the theoretical underpinnings of the Empowerment Theory from a Community Psychology perspective and will also give an in-depth review of the minor theories and models namely Bronfenbrenner's Ecological Model, Strength Perspectives and the Theory of Learned Helplessness.

Chapter 4 will describe the research methodology utilised illustrating how the strengths and weaknesses of the research design and research instruments were fused to benefit the study.

Chapter 5 will present the procedure followed in conducting the pilot study and the findings. It will also highlight how such procedure and findings helped gather data for the study. .

Chapter 6 will present the analysis and detailed findings of the study

Chapter 7 will highlight the study's limitations and give a comprehensive discussion of findings coupled with recommendations for researchers, policymakers, donor agencies, women, PMTCT implementers and the community.

Chapter 8 will give concluding remarks reflecting on the key lessons from the study.

CHAPTER 2
REVIEW OF RELATED STUDIES

2.0. CHAPTER OVERVIEW

The objective of this chapter is to review studies related to this study. Initially, the researcher wanted to review studies done under PMTCT which had utilised the empowerment theory. However because of the complexity of defining empowerment as noted in the previous chapter, the researcher could not find many PMTCT studies guided purely by the empowerment theory, only related models like the social-ecological models and many studies that focused on the barriers to PMTCT uptake or completion. Most of the reviewed studies were conducted in Africa, mainly SSA and a few from Asia. These two continents share collectivistic cultures which reflect some resemblance in how they view women. The chapter starts by conceptualising the term empowered woman to contexualise the term.

This is followed by a review of studies conducted using theories related to the empowerment theory. Such a review assisted in highlighting the gap related to the empowerment theory and led the researcher to investigate factors which hinder women's full participation in PMTCT programme like fear of disclosing one's HIV status, level of women's HIV risk perception and harmful socio-cultural factors. The final sections of the review look at studies that unearthed factors important in women's uptake of PMTCT services. These included male involvement, socio-economic factors, and peer counselling. Review of these factors helped develop the strategies for the study. The review showed that most studies mainly focused on factors that hinder women's PMTCT involvement but did not emphasise the holistic empowerment of women in PMTCT initiatives at all levels.

2.1. TYPES OF REVIEWED STUDIES AND THEIR FOCAL AREAS

Various studies conducted from 2008 to 2018 were reviewed, however the findings from this period were also related to some findings dating back to the year 2000. Most of the previous studies confirm that what used to disempower women regarding PMTCT continues to have the same effect even now. Reviewed studies came from both quantitative and qualitative research methods. These studies fall under various research designs namely descriptive research, correlational research, review studies, and interventional studies.

The subtypes found under these research designs included cross-sectional studies, cluster-randomized trials, case-control studies, randomized control trials, cohort studies, epidemiological data, desktop review studies, literature reviews and systematic reviews. From these studies the main focal areas included: measuring acceptance of condom use by male partners nature and extent of HIV-related spousal communication, association between various dimensions of women's empowerment and HIV prevention, relationship between low female bargaining power and high-risk male sexual behavior, relationship between sexual coercion, physical violence in intimate relationships and HIV prevalence and last, identification of a causal relationship between economic empowerment of women and HIV prevention.

2.2. CONCEPTUALISATION OF THE TERM 'EMPOWERED WOMEN'

An empowered woman knows her strengths and potential without fear or shame of embracing them. In their study Mclean and Modi, (2016), conceptualised empowered woman by coming up with five categories. First, valued and respected in society, economically and socially successful, supporting herself and others and conforming to prevailing social norms; second, capable, independent and self-sufficient economically; third, with a high status and

profile and at the same time capable, admired and valued; fourth, as a capable, ambitious and independent woman possessing self-sufficiency, taking care of others and herself; and last as a dynamic, capable and powerful and physically strong woman who does not conform to social norms and is not necessarily praised. Empowerment to the participants of the reviewed study, mainly meant a woman who can support herself and others by her own funds, is useful to society therefore is valued and regarded as successful.

The first and fourth categorisations were commonly used by the participants. They also echoed that women empowerment is not only meant to benefit the individuals, but surrounding family members as well. Being highly educated, employed, an entrepreneur, carefree and in some instances, being married, were some attributes linked to women empowerment. Briefly, empowerment takes more of a subjective stance rather than an objective one in that an empowered woman must perceive and acknowledge her positive contribution to her life and that of others. She should be able to regard herself as strong, possessing self-efficacy, stand on her own and act to create and sustain her empowerment.

According to Maclean and Modi (2016), interventions aimed at empowering girls and women should start by being aligned with the girls' and young women's own realities, priorities and aspirations because sometimes the women themselves will not know their level of risk. Second, programme developers must put into cognisance that such girls and young women remain integrated in their social environments, hence their empowerment must not increase their risks but must fit into their social realities. Third, interventions must also note the variations among women themselves and proceed accordingly. In addition, psychological empowerment must be taken into consideration as it boosts self-esteem and self-efficacy and enhances a resilient attitude in individuals. In support of this Golla et al. (2011), noted the

need for a multi-level approach to bring women empowerment as women evolve within a network of nested environmental systems. The approach should address social, economic and psychological assets and resources.

The research by Maclean and Modi (2016), suggests that combinations of these interventions could be considered: supporting individual adolescent girls and young women to build business and entrepreneurship skills; providing improved loans and savings mechanisms; improving sexual and reproductive health services; helping to foster girls and young women's positive relationships within and outside the family, through encouraging family dialogue and supportive familial relationships; developing safe social spaces for girls and young women outside the home; working to shift social norms through campaigns that portray more realistic and varied images of girls and young women; and working with the institutions (e.g. formal and informal education, religious institutions) with which girls and young women engage, to ensure they are supportive, inclusive, and safe. This reflects that for women empowerment to occur, advocates must involve women and incorporate all the systems surrounding them. However, it is crucial to empower the system that women have direct access to, which will afford them opportunities to seek empowerment for themselves rather than get charity.

Maclean and Modi (2016) stress that the complexities of defining empowerment sometimes end up with programmes not genuinely empowering women and girls. These complexities include various definitions of empowerment that are contextualised and the idea that empowerment can be factored through top-down development programmes. In relation to this, Sharma (2008), in her ethnography in India on the politics and practices of women's empowerment project implemented by government agencies and NGOs addressing women's

empowerment, attempted to address these two issues. In her findings, she highlighted that empowerment was being depoliticised and regulated, thus constraining women in their endeavour to improve their lives. Sharma notes that despite the state trying to control the outcomes, the programmes lead to political action against the marginalised and with some unintended results. Sharma, recommends that interventions of this nature must conceptualise empowerment to understand what empowerment means to certain women within specific contexts, which can influence the development of empowerment programmes. Henceforth, this study endeavoured to understand the realities of who is regarded as an empowered woman within a rural African context. Those realities were measured against the attributes of being economically empowered, psychologically empowered, respected and respecting others and being fully informed of one's rights. These attributes were adopted by the researcher to guide this study.

2.3. THEORY-BASED RESEARCH ON PMTCT

This section reviews studies which assessed PMTCT interventions based on the principles of certain models and theories. The reviewed studies implemented the social-ecological model, Health Belief Model (HBM), Information Motivation Behaviour Model, Theory of Planned Behaviour and Theories of social network and social support. A review of these theories will also consider the influence of gender and socio-economic factors in PMTCT programmes.

2.3.1. Social Ecological Model on PMTCT

Hampanda's (2012) literature review on PMTCT interventions in SSA from 2006–2012 focused on theoretical underpinnings which advocate for a paradigm shift to a social ecological approach addressing obstacles at all levels of society with greater emphasis on

gender inequality as a way of promoting practical impact on mother-to-child-transmission of HIV.

Hampanda reiterated that literature on PMTCT falls short of an ecological approach and analysis of structural inequality because most of the studies put much emphasis on health education and counselling at the expense of socio-economic factors that have the greatest impact on health behaviours (Frieden, 2010). The author continues that very few studies or interventions in SSA move beyond the individual or interpersonal level to explore the context of women and men's behavior and decisions regarding PMTCT utilisation; for instance, emphasis has been put on the choices and actions of infected women (Rylko-Bauer, et al. 2009). Such interventions overestimate the personal agency and control of HIV and AIDS in some contexts where women experience inequality in sexual division of power like in patrilineal societies. Hampanda (2012) echoes that neglecting higher social ecology levels negatively affect knowledge and ability to address constraints to PMTCT. The existing literature has depoliticised and decontextualised women's health-seeking behaviour leaving the burden of preventing vertical transmission on the infected mother (Rylko-Bauer et al. 2009).

Hampanda (2012) recommends that for effectively addressing social barriers experienced by women in PMTCT, there is a need for studies and interventions to go beyond the individual and interpersonal level and take into cognisance division of labour based on sexual differences, the sexual division of power and the social structures in HIV endemic nations. In addition, Glanz, et al. (2008) acknowledge the gap in the examination of imbalances in control power that women experience in family circles which may be seen in the form of physical, emotional or sexual violence in women's intimate relationships, hence

the need for research and interventions targeting multiple levels of influence which can bring effective behaviour change. This has encouraged scholars to develop the social-ecological model with the aim of deeply analysing and addressing human transactions within their physical and sociocultural environments.

According to Hampanda (2012) numerous studies have investigated the uptake of PMTCT focusing mainly on personal level factors like mothers' attitudes, perceptions, beliefs and intentions; however, there is a limited success for such interventions. One reason for such failures is that the factors raised by women in such interventions cannot be addressed through biomedical education and counselling. There is a need to consider social, structural and institutional factors. Peltzer, et.al. (2011), appreciates men's involvement in some PMTCT interventions in Sub-Saharan African as a positive move that can greatly influence its uptake. For instance, a study on couples' HIV risk-reduction in South Africa found a notable increase in PMTCT uptake and adherence when men were involved. Hampanda (2012) extends this by recommending the involvement of family interventions PMTCT programmes and addressing stigma in communities since many studies indicate that women fear disclosing their HIV statutes to family members, which becomes a barrier to PMTCT.

Institutional factors have been widely addressed in many studies, but social, cultural, public policy and political, economic factors have not well been addressed (Hampanda, 2012). Besides, poverty and socio-economic levels have not been given particular attention when addressing PMTCT issues in SSA. Rylko-Bauer, et al. (2009) suggested implementing a theoretical framework of structural justice targeting developing policies and programmes that improve women's socio-economic status, eradicating the social barriers experienced by HIV positive women and promoting effective utilisation of PMTCT.

Busza et al. (2012), conducted a literature review using their social-ecological framework as a guide in creating a review strategy for pointing out community-based approaches utilised in developing states to address barriers along the PMTCT care continuum. The guide pointed out five levels of influence: the individual and relational levels, which comprise peer and family influences; the community context, and the socio-cultural environment. Busza et. al. also acknowledge extensive evidence that there are barriers outside healthcare settings which block people’s full involvement in PMTCT, hence derailing efforts to eliminate vertical transmission of HIV. This led them to adopt a social-ecological framework in their review of community-based approaches that can be implemented at different levels. They also discovered that strategies targeting individuals within their family and community environment, like home-based care, training peer volunteers to support others and family HIV testing, improve testing, treatment and adherence vital for PMTCT. Male involvement has been highlighted in the literature as a crucial move in improving PMTCT uptake but according to Busza, (2012), interventions aiming to increase their involvement remain limited. The involvement of other significant others like in-laws, siblings and parents is also vital in improving PMTCT uptake. However, Busza, did not come across any interventions targeting those influential groups in PMTCT programmes.

Busza (2012) also discovered that interventions operating at community level like home-based care and community health worker scheme have a positive impact on PMTCT uptake; however, the drawback is that they are not fully incorporated in the formal health system. They also noted a lack of effective referral mechanisms that can lessen the work in PMTCT interventions. In addition, she also found that in a broader socio-cultural context there is much complexity in many interventions because of several factors; these include variations in interpreting key terms like empowerment, engagement and community

mobilisation. As a result, many interventions with diverse findings in different settings have emerged. It was noted that several interventions have focused on individuals, neglecting the fact that people's actions are closely connected to ever-widening social structures.

Chimphamba et. al. (2012), engaged in in-depth interviews with twenty couples exploring barriers encountered by couples living with HIV. They looked at the individual, interpersonal, organisational, community and societal levels in accessing sexual and reproductive health services using the social-ecological model. Their social-ecological model was derived from Urie Bronfenbrenner's Ecological Systems Theory (1979), Kenneth Mc Leroy's Ecological Model of Health Behaviours (1988) and Daniel Stokols' Ecological model of Health promotion (1992, 2003). The model focused on the complexities and interdependences between socio-economic, cultural, political, environmental, organisational, psychological and physiological determinants of behaviour. Chimphamba et.al. (2012) used five levels of analysis proposed by Sallis and Owen (2002), namely: the individual level and interpersonal processes which bring out social identity and role definition by significant others; the organisational level; the community-level characterised by established norms and values, standards and social networks; and lastly the societal which comprises cultural context and national policies on health. The study catchment area was a low-income area characterised by poverty, poor access to safe water, and poor communication infrastructure connected to high HIV and AIDS prevalence. The area was connected to other areas with earth roads which created poor communication network during the rainy season.

The findings indicate that across the five levels of the social-ecological model there were barriers to the use of sexual reproductive health services influenced by diverse factors. Chimphamba et.al. (2012), recommended three main areas of primary intervention: One,

services must be in proximity to the local communities and to be integrated with existing antiretroviral services; two, empowering both formal and informal gatekeepers with knowledge about sexual reproductive health with the inclusion of HIV and AIDS; and three, coordinating the flow of reproductive health, HIV and AIDS information between the Malawi Ministry of Health and formal and informal organisation. Chimphamba et.al. (2012), focused on couples in their sociocultural contexts to incorporate data from both men and women in understanding sexual reproductive health. This, therefore, reflected that the systems that surround a woman must be supportive and fully functioning if women empowerment is to become a reality in PMTCT programmes.

Concerning the peer and family level, Betancourt et.al. (2010), discovered there are many family-centred PMTCT programmes which consider the family as a whole because since it was noted that the infection of one family member affects other family members financially, cognitively, psychologically, emotionally and behaviorally. Hence, interventions that aimed to educate and provide health care services to family members and peers were effective in addressing PMTCT issues.

In another intervention, an evaluation of two models for community-based HIV Counselling and Testing (HCT), namely house-to-house testing and mobile testing sites, was conducted by Lugada (2010). A cluster- randomised control trial in Uganda compared home-based and clinical testing. It was found that the majority of the participants chose testing in-home sites. Another randomised control trial was done by Sweat et al. (2011), in Tanzania, Zimbabwe and Thailand, in which they examined the effect of conducting HIV testing through mobile testing outlets on testing uptake. The results indicated that in the three sites there was a notable increase in the number of people taking their first HIV testing. This

indicates that people preferred to be tested for HIV in their home areas where they were comfortable, which may also be regarded as an empowerment strategy. The other factor could be those being tested would be close to their immediate support system, which is the family. Thus, the systems surrounding an individual are crucial when attempting to develop empowerment initiatives for such people.

Other studies investigated the contribution of the community context to PMTCT uptake. The majority of the interventions focused on strengthening connections between health facilities and clients, home-based care (HBC) programmes and training community members like traditional birth attendants (TBA) to promote care initiation and retention. A randomised control trial was conducted in Kenya to strengthen linkages between clients and health facilities through mobile phones to sustain adherence and it resulted in 90% drug adherence (Pop-Eleches et al. 2011). Another one-year intervention was also done in Kenya where patients who did not return for PMTCT appointments were traced by phone, home visits or through friends or relatives in the community resulting in 60% of the patients returning for appointments (Thomson et al. 2011). These studies highlight that the systems that influence an individual are critical in influencing one's behaviour, hence empowerment initiatives must take that into cognisance.

Another component of the community context evaluated and reviewed was home-based care (HBC). Home-based Care has been promoted to provide adherence support to patients, promote HIV counselling and testing (HCT) within families, and promote referrals to other services. A cluster- randomised control trial (RCT) conducted in Uganda reflected that HBC interventions have the potential to be as clinically effective as a facility-based treatment, reduce health services and patient's travelling costs, and loss of working time and

with no need for childcare (Jaffar et.al. 2009). Thus, there is a possibility of empowering women through home-based care initiatives in PMTCT that are less costly and available.

Other studies evaluated the contributions of community health workers to the success of PMTCT. Community health workers are lay people taught to engage in health promotion, visit households for prevention and treatment and refer to higher levels of care as necessary. They include lay health workers (LHW), adherence support workers, lady health workers, health surveillance, health extension workers, community health volunteers or caregivers. There is variation in their work, however some of their tasks are similar to home-based care providers and others are restricted to adherence and peer support. According to Bhutta et al. (2010), these people have been used to promote behaviours relevant to PMTCT, for instance, facility-based delivery, exclusive breastfeeding and postnatal follow-up.

A Cochrane Collection review of lady health workers' delivery and child health interventions concluded that such interventions effectively promote breastfeeding, including six months of exclusive breastfeeding. In another systematic review, Bhutta et al. (2010) discovered that community health workers could increase facility-based delivery and skilled attendance, reduce maternal mortality through birth preparedness and offer counselling for postnatal depression and psychosocial support. A pre-and post-intervention comparison in Zambia where HIV-positive clients were offered training in adherence support to deliver home-based counselling on treatment guidelines resulted in a shift of roles from health workers to peer community health workers without compromising quality and with an increase in loss to follow-up (Torpey et al. 2008). Thus, the community as a system is a critical factor in influencing its members' involvement in community-based interventions, PMTCT included.

Organisation of participatory women's groups have also been used to evaluate PMTCT interventions' success. According to Rath et al. (2010), under this approach, meetings are conducted in which community members engage in an analytical cycle comprising problem identification and prioritisation, strategic planning, strategy implementation and impact assessment. In strategic planning, groups choose ways to overcome barriers. For example, lack of transportation during obstetric emergency and effect action plans. Participatory groups with the objectives of improving maternal and neonatal health have been extensively evaluated in trials in South and Southeast Asia, and they have significantly contributed to the reduction in neonatal mortality and moderate maternal depression (Manandhar et al. 2004; Tripathy, et al. 2010; Lee, et al. 2009). Lewycka et al. (2010) also conducted a cluster-randomised trial to determine this approach's applicability for SSA contexts. The findings support those found in South and Southeast Asia.

Some researchers identified three viable and likely cost-effective strategies to reduce systems-level barriers to optimal testing and PMTCT completion. These comprise decentralising testing beyond healthcare centres (Sekandi et al. 2011; Marinucci, et al. 2011), improving access to testing and treatment services, and identifying other delivery models that reduce loss to follow-up by linking testing sites to treatment centres (Ciaranello, et al. 2012; Filler et al. 2011; Rujumba et al. 2012; Tomlison et al. 2011). This means that community initiatives can lessen challenges experienced in PMTCT when there is decentralisation; however, to be effective, the concerned people need to be empowered.

Ezeanoule et al. (2013) conducted a cluster- randomised trial in which they compared the effectiveness of a congregation-based Healthy Beginning Initiative (HBI) to a clinic-based approach on the levels of HIV testing and PMTCT completion among a cohort of church-

attending pregnant women in hard-to-reach communities. They also aimed to evaluate the effect of HBI on the level of HIV testing among male partners of pregnant women and the rate of PMTCT adherence among HIV-infected pregnant women. One finding was that contrary to the common assumption that faith-based organisations are suspicious of the scientific community, the churches were more than willing to be involved in the study. The research team had to adjust and increase their target sample as many people showed a high willingness to participate. The study found that a congregation-based intervention that made use of a family-centered, culturally-appropriate approach improved the quality of maternal child health services in rural hard-to-reach communities. There was a high rate of HIV testing among pregnant women and their male partners and a higher rate of PMTCT completion among HIV infected pregnant women. This points to the idea that religion as a system also found among those nested systems in the community can play a very significant role in women empowerment under PMTCT programmes.

While the reviewed studies produced useful information, the majority of the findings are based on the review of secondary data. Thus, this study had to rely on primary data to get to the realities of the applicability of the social-ecological model in addressing challenges in PMTCT interventions. One of the studies reviewed above, used primary data to unearth the barriers encountered at each level of analysis. However, this study did not only discover the barriers but used them to propose strategies that can promote empowerment of rural women in PMTCT programmes.

2.3.2. Health Belief Model on PMTCT

Several theories were reviewed in relation to PMTCT and most focused on the individual level and constructs. The Health Belief Model (HBM) has been frequently used as

a conceptual framework for women's health-seeking behaviour and to inform interventions. Studies using this model investigated the constructs of HBM. These include perceived susceptibility used to explain mothers' acceptance of HIV testing, getting the results and developing the conviction that her infant is prone to contracting HIV through vertical transmission; also, perceived benefits which focus on mothers' knowledge and beliefs that PMTCT interventions are beneficial or defective in preventing mother-to-child-transmission (Igumbor et al. 2006). However, Hampanda (2012) noted this is not a universal construct in SSA. Another construct is perceived barriers, widely studied and is a most influential piece for PMTCT utilisation. It is defined as the evaluation an individual does of the elements that influence her decisions (Glanz et al. 2008).

Reviewed literature highlighted the fear of knowing one's own HIV status, stigma and discrimination following disclosure of one's HIV status to partner, family and community, and opposition from the male partner (Kebaabetswe, 2007; Nyasulu & Nyasulu. 2011) as some barriers to PMTCT uptake. These may include cultural and religious factors and formal education that may influence rural women's beliefs about health, especially sexual reproductive health. These factors may lead to a notable difference between rural women and their urban counterparts' beliefs about health. The latter usually possess higher formal education levels and are rarely influenced by culture and religion in making those decisions. According to Creek et al. (2009), perceived self-efficacy points to the woman's level of confidence in her ability to complete the steps necessary for PMTCT adherence. This finding was also supported by an intervention done in South Africa; however, the report did not indicate if the women's beliefs were transformed to improved health-seeking behaviours linked to PMTCT (Besser, 2010). According to Hampanda (2012), studies or interventions using the Health Belief Model often heighten knowledge through education and counselling

as motivators for mothers' action. Msellati (2009) concluded that utilising the constructs of perceived benefits and cues to action improves HIV testing during antenatal care vital for PMTCT.

There is widespread knowledge on PMTCT in many African states, but the implementation of PMTCT services is deficient in many states (Besser, 2010; Zambia Ministry of Health, National, Protocol Guidelines of Integrated Prevention of Mother-to-Child Transmission of HIV and AIDS, 2008). This may indicate that knowledge without will power and motivation is not sufficient for people to participate in PMTCT programmes. In addition, for women to be empowered for PMTCT, they need comprehensive education on such issues, reflecting that being HIV-positive while pregnant does not mean that one automatically gives birth to an HIV-positive child.

The drawback with studies utilising the Health Belief Model is their assumption that the women work independently in their participation in PMTCT, yet they are nested with several systems which determine their actions. To cater for this flaw, this study utilised the social-ecological model in trying to understand the realities of rural women in PMTCT involvement.

2.3.3. Information Motivation Behaviour Model on PMTCT

Another model utilised in PMTCT interventions is the Information Motivation Behavior mainly developed to address HIV prevention efforts even beyond PMTCT. The model focuses on behaviour change by making use of psychosocial concepts and methodologies. It stresses that HIV prevention information, motivation, and behavioural skills are critical determinants of HIV preventative behaviour. The model also focuses on increasing safe sex and adult HIV testing, constructs also found in PMTCT and tested in several studies

(Hampanda, 2012). According to Hardon, et al. (2012) and Varga and Brookes, (2008), such constructs create the foundation for PMTCT counselling initiatives during ANC throughout SSA, the lack of which lead to poor utilisation and adherence. A study done in Nyanza, Kenya proved that lack of enough counselling services for pregnant women negatively affected PMTCT service utilisation (Moth et al. 2005). Studies using this model are also limited because their findings are individual-focused, that is they view a woman as a very independent entity who works on her own in deciding whether or not to participate in PMTCT, and is free to negotiate safe sex, which may not always be the case.

2.3.4. Theory of Planned Behaviour on PMTCT

The theory of Planned Behaviour by Fishbein and Azjen has also provided constructs tested in PMTCT intervention programmes. Sometimes it was tested alone and sometimes with the theory of Reasoned Action, which is its predecessor. Many research studies have applied the constructs from the theory of Planned Behaviour, including attitude, perceived norms and personal agency. However, their primary assumption is that intention is the best predictor of behaviour. Several qualitative studies were done in SSA which explored HIV positive mothers' attitude and perceived norms regarding PMTCT (Hardon et al. 2012; Kebaabetswe, 2007; Nyasulu & Nyasulu, 2011; Varga & Brookes, 2008; Awiti et al. 2011). Usually the constructs from this model have been used to assess pregnant women's acceptance of HIV testing during ANC visits, and it has been found that the intention to accept being tested was limited by fear of knowing one's HIV status, unaffordable services and confidentiality issues, fear of stigma and discrimination (Kebaabetswe, 2007; Nyasulu & Nyasulu, 2011; Varga & Brookes, 2008). Igumbor et al. (2006) engaged in a clinic-based health intervention in South Africa in which they measured salient beliefs and behavioural intentions in the utilisation of PMTCT services. Their findings included that women

unchangingly reported low control beliefs and the weak association between PMTCT salient beliefs and behavioural intention; however, one of the study's weakness was that they did not measure actual behavioural outcomes. Some findings from this study led other scholars to advocate for utilising the empowerment theory in promoting women's involvement in PMTCT.

A recommendation from Igumbor et al. (2006), highlighted the need for an expansion and enhancement of interventions aiming to empower women to heighten behavioural intention to use PMTCT. Other researchers also supported that disempowerment of women causes underutilisation of PMTCT services (Besser, 2010). This has influenced the rise of initiatives such as Mothers2Mothers (m2m) which started in South Africa and expanded to other SSA states with one of its goals being to empower mothers living with HIV and AIDS so they can resist stigma in their communities and develop positive living and productive lives (Besser, 2010). In support of the above, Hampanda (2012) echoes that women's empowerment is a crucial component for promoting PMTCT in SSA yet it is under-emphasised. Hence the need for studies like this one aimed at unearthing and formulating strategies that can be implemented in women empowerment under PMTCT programmes.

2.3.5. Theories on Social Networks and Social Support on PMTCT

Another cluster of theories utilised in studying PMTCT interventions are theories on social networks and social support which have been found useful in acquiring insight into the influence of interpersonal dimensions on HIV positive pregnant women's decision making and health-seeking behaviours. According to Ware et al. (2009), social capital and social responsibility have been linked to general adherence to ART. Social Network Theory focuses

on women's HIV status disclosure, which has been connected to significant PMTCT utilisation improvements.

According to Awiti et al. (2011), the type of relational ties between an HIV pregnant woman and her reference network plays a role in her disclosure of an HIV diagnosis. In concurrence, Glanz et.al. (2008) state that social influence is also a significant factor in determining women's health behaviours and decision-making related to their health and that social undermining may be a stumbling block towards women's PMTCT utilisation. This point was supported by Moth, et. al. (2005) who emphasise that some women could not disclose their HIV status to relatives fearing stigma and discrimination and family exclusion as purported by Msellati, (2009). Glanz et al. (2008) and Awiti et al. (2011), further highlight that positive regard and treatment from significant others make women free to disclose their HIV status to their partners and utilise PMTCT services effectively. However, evidence from a multi-site study in Burkina Faso, Kenya, Malawi and Uganda found that disclosure rates remain very low (Hardon, et.al. 2012). A study in South Africa discovered that one of the major hindrances to women's disclosure was fear of the partner's reaction if the woman tested HIV positive (Varga & Brookes, 2008) which Msellati (2009) also supported. Subsequent studies created a room for even more studies on how social networks and social support under PMTCT programmes can be utilised to make women better decision-makers in matters about their sexual reproductive health.

2.4. IMPACT OF WOMEN'S FEAR OF DISCLOSING THEIR HIV STATUS ON PMTCT PROGRAM

Women's fear of disclosing their HIV status to their husband or partners or significant others has also been cited as one of the stumbling blocks to PMTCT programmes uptake.

Disclosure of HIV status plays a role in PMTCT utilisation as some pregnant women who may test HIV positive might not disclose their status to their husbands or partners posing a challenge in their adherence to medication and its storage (Wouters et al. 2009) and also in following infant feeding recommendations (Bii et al. 2008). Other studies concur that pregnant women's failure to disclose HIV serostatus to their intimate partners due to fear is a barrier that blocks completion of PMTCT interventions (Jasseron et al. 2013; Sagay et al. 2006; Olagbuji et al. 2011). This is coupled with lack of decision-making power concerning access to resources within the family also cited as a barrier to PMTCT uptake (Perez et al. 2008; O'Gorman et al. 2010).

This means that the lack of decision-making power makes some women afraid of disclosing their positive HIV serostatus, as it is associated with the withdrawal of economic resources vital for survival by their male counterparts. In addition, Bajunirwe and Muzoora (2005) and Tchendjou et al. (2011) noted that some women refuse to have blood tests or do not collect their results fearing disapproval from their partners or intimate partner violence which has also been noted as reducing PMTCT enrolment. The fear discussed mostly emanates from cultural and societal expectations found in many African contexts which stress that a decent woman should not be found suffering from sexually transmitted diseases as it will be a sign of infidelity on her part. Some women fear to be rejected by their partners after disclosure which also leads to stigma and discrimination within the society since marriage is greatly valued in many African contexts.

This study aimed to respond to those stumbling blocks based on what the people concerned believe works best for them. Working with the community to address the highlighted stumbling blocks would empower women with information on the dangers of

failing to disclose their proper HIV serostatus to their partners and significant others. The insight will bring out the fact that such fear will not only endanger women's lives but also those of their partners and unborn children, leading to unhealthy communities.

2.5. LEVEL OF WOMEN'S RISK PERCEPTION AS BARRIER TO UPTAKE OF PMTCT SERVICES

Elimination of vertical transmission of HIV can also be understood better by looking at the factors that may hinder full participation of the concerned parties, mainly intimate partners and the surrounding community. Many studies identified a variety of factors as a hindrance to women's and men's involvement in PMTCT programmes. Level of risk perception has also been included amongst the barriers to PMTCT uptake. This means that, how much one views himself or herself at the risk of contracting HIV is significant. Concerning this, Wringe et al. (2008) noted that women in monogamous marriages mostly view themselves as at low risk of contracting HIV which is dangerous because they forget extramarital affairs which may exist. Such a perception lowers PMTCT uptake amongst women in monogamous relationships and reflects that they are disempowered because they lack full information. Lack of motivation or self-efficacy has also been found as a barrier to PMTCT uptake. This was one finding by Mepham et al. (2011) who state that some are not motivated to go for HIV testing during pregnancy fearing being questioned about their whereabouts by significant others and getting a positive result. Health status also determines whether one adheres to PMTCT demands or not. Shin et al. (2008) and Starace et al. (2002) discovered that poor mental and physical health affects health-seeking behaviours in particular. They have linked depression to lower ARV adherence. Muyingo, et. al. (2008) talks of ill-health as a factor that affects appointments where concerned individuals may be

reluctant to keep health-related appointments. One‘s risk perception level determines their level of engaging in PMTCT initiatives.

The above barriers are supported by Turan et al. (2011),; Nunn et al. (2011),; Mondo et al. (2009) and Hardon et al. (2012) who highlight low personal risk perception with poor access to testing sites, high costs, lack of confidentiality and HIV-related stigma and discrimination as barriers to HIV testing and PMTCT completion. Barriers occur at both individual and providers' level. However, those with serious impact on healthcare generally were found to occur at the health systems level (Kinuthia et al. 2011; Youngleson et al. 2010; Ekouevi et al. 2012). According to Nigeria National Population Commission, (2009), Okunlola et al. (2006) and Adegbola et al. (2009), in Nigeria the majority of the women lack access to prenatal care early in pregnancy. Less than half of pregnant women deliver in a health facility of which 2.9% of these have an established PMTCT programme.

2.6. EFFECTS OF SOCIO-CULTURAL FACTORS ON WOMEN'S UPTAKE OF PMTCT SERVICES

The socio-cultural environment has also been evaluated concerning PMTCT uptake using the ecological model; however, the evaluation was reported to be difficult because of the complexity of this ecological level. Busza (2012), notes that interventions targeting the socio-cultural context try to reform social norms and create an enabling environment. At this level, community mobilisation creates local ownership of HIV interventions by utilising theories of empowerment, social action and diffusion, which targets both men and women. Community mobilisation is characterised by several activities. These include engaging traditional leaders, organising public discussions and theatrical events, peer education, and participatory methods that involve community members and focus on social constructs like

social networks, gender relations, and behavioural norms and belief systems incorporating spirituality. Khumalo-Sakutukwa et al. (2008) conducted a cluster -randomised control trial of community mobilisation termed Project Accept in Zimbabwe, South Africa, Tanzania and Thailand. The intervention sites introduced community working groups, use of peer leaders in social networks as agents of change, outreach workers to promote VCT, community volunteers promoting testing and treatment and post-test psychosocial support with the provision of mobile testing. This resulted in a rise in testing uptake in intervention sites instead of control sites and reflected adequate levels of adherence to the uptake of ARVs in Tanzania, Thailand and Zimbabwe.

Kamla-Raj (2014) conducted a systematic literature review based on women's having the highest rate of HIV infection than males in the developing world and in Zimbabwe in particular yet men are the most promiscuous. The review aimed to examine the feminisation of HIV and AIDS and its dynamics in Zimbabwe. The results indicated this feminisation occurs because of a lack of support infrastructure to women living with HIV and AIDS, women’s poverty, inequitable gender role allocation, stigma and discrimination and state of patriarchy. The author then proposed strategies to address the problem. These included neutralising patriarchy, intensifying gender empowerment campaign in all spheres of life, adopting male circumcision and affirmative employment action with the objective of women empowerment. In the intensifying gender campaign, the author suggested increased male involvement in addressing gender inequality. Government and civil societies were encouraged to undergo a paradigm shift of policies, ideologies and practises that will address patriarchal constraints leading to women empowerment. The author recommended adopting national policies that are gender-neutral, increased affirmative action, provision of more education on HIV and AIDS without assuming that everyone has the knowledge, and

mainstreaming gender in all social institutions. Therefore, it is essential to address structural issues in attempting to support women empowerment.

Kang'ethe (2013a), notes that in Zimbabwe the proportion of women who are HIV positive is higher than that of men, hence reflecting feminisation of HIV and AIDS. He notes this is also a consequence of patriarchy (Kang'ethe, 2009). This relates to gender stereotypes because women are regarded as weak and vulnerable to diseases including HIV and AIDS. Kang'ethe and Chikono (2014), supported this by noting that patriarchy increases women's vulnerability to the virus by robbing them of their sexual independence and ability to negotiate for safe sex. This can also be linked to Gaidzanwa's (2006), view that the greatest cause of HIV transmission is heterosexual sex and that married women are at high risk as they are less able to negotiate for safe sex than unmarried women. This vulnerability is coupled with biological factors which predispose pregnant women to more risks of HIV re-infection and transmission to the unborn baby. Thus, the call for the empowerment of women in PMTCT becomes a necessity.

Chitando (2011) cited McFadden, (2003) who called HIV and AIDS a black women's disease as an illustration of how cultural expectations and norms surrounding sexual practises can be blamed for women's vulnerability particularly in Africa. Kang'ethe and Chikono (2014), notes that patriarchal societies expect married women to be sexually passive and submissive to their husbands or male partners. In support of this, Kambarami (2006), says that women lack the power to negotiate for safer sexual practices and initiate sex or refuse it when they are unwilling to engage. According to Kang'ethe (2009, 2011), social construction privileges boy children concerning choices and resources that perpetuate girl children's and women's vulnerability to HIV and AIDS infections because the girl child is socialised to be

submissive to men and often given limited educational opportunities. Henceforth, this calls for an urgent address of social and cultural expectations that are harmful to women's sexual reproductive health which can be improved only through women empowerment.

Anderson (2012) conducted a study based on the notion that women are at the epicentre of the HIV epidemic in Malawi. Hence, data were obtained from forty-four key informants' interviews in which they examined how the gendered construction of women's bodies increases their vulnerability to HIV infection. It was emphasised that the body is a private entity beyond the realms of intervention and analysis. Findings indicate that taboos surrounding the female body act as hindrances to having insight and address women's embodied experiences that place them at risk. The analysis reflects that women's embodied experiences of power heighten their risk and provide the space to challenge them. Anderson recommends that policy should adopt a bottom-up approach which addresses specific gender contexts.

Anderson (2012) cited in UNAIDS (2004), highlights that HIV prevention interventions have focused on individual behaviour change ignoring critical social, structural and environmental constraints on behaviour, including gender. Concerning this, some HIV campaigns target 'higher risk' groups mainly mobile populations, sex workers and young people undermining the fact that even married women are at high risk of HIV infection (Craddock, 2006; UNAIDS, 2008). According to UN (2004), women occupy different roles as mothers, wives, farmers, providers, and caregivers. Hence, once they get infected by diseases, HIV included, it negatively impacts community and society. Therefore they need to be empowered to protect their health and that of their offspring.

As for condom use, PSI (2006), notes that men have an overall control as they can purchase the condom with less stigma than women and also carry the condom and decide when to use it. Hence, women empowerment must be characterised by the promotion of female condoms; however, female condoms have several complexities of use while microbicides have not been adequately researched (Anderson, 2012). For this empowerment to be attained, women empowerment must occur holistically which is the focal point of empowerment from a Community Psychology perspective.

Anderson (2012) remarks on the surrender of the female body to male counterparts in which she cites Ngwira et al. (2001) and Tango International,(2004) who reiterate that sexual intercourse is done according to the man's terms and for his pleasure. This is usually supported by biblical verse Ephesians 5 vs 22-23 that women should submit to their husbands as Lord, as the Christ is the head of the church just like men to women. Such religious and societal beliefs increase the level of risk for women. Anderson (2012) contends that the ABCs (Abstinence, Be faithful and Consistent use of condoms), do not apply to women from this perspective as they are on the receiving end because they are also expected to have sex anytime their male partners want it regardless of their condition. Thus socially, culturally and religiously women are at a disadvantage concerning their sexual health.

Women typically lack the power to negotiate for condom use even when the husband is HIV positive or has STIs (NSO & ORC Macro 2005). This has also been raised by FHI (2004) that condom use is almost non-existent in marriage. Anderson (2012) found that couples tend to use condoms consistently when the wife is infected not when it is the other way around. According to Kaler (2003) and IPPF et al. (2006), skin-to-skin ejaculation is popularly regarded as a sign of masculinity hence the conviction that condoms deprive the

man of sexual satisfaction. Against this background, this researcher sought to find ways of promoting women empowerment so they can protect themselves from HIV infections and re-infections and protect their offspring against all odds.

According to Anderson (2012), certain rituals and practises like dry sex and female genital mutilation or circumcision that occur in Malawi and other SSA disempower women and expose them to sexual infections. Such practises are done for the sexual satisfaction of the men, not women. Another cultural habit in Malawi is that of 'wife cleansing' where a widow is led to have sex with an unknown man to please her late husband's spirit. This occurs even when the woman is pregnant, hence disturbing PMTCT uptake. According to Banda (2005) and IPPF et al. (2006), such rituals are 'private practice' beyond the realm of state intervention. Therefore for PMTCT interventions to be effective, both men and women need to be fully empowered with information on the dangers of risky sexual behaviours even those regarded as social norms.

According to UNAIDS GAP Report (2014) four key reasons lead women to lag in safeguarding themselves from HIV infection. These include gender-based violence, limited access to health care and education with systems and policies that do not address the needs of adolescents and women. This report has also emphasised that gender inequalities and gender-based violence act as deterrence for adolescent girls and young women to protect themselves from HIV infection. This can also be noted in their inability to access treatment (Idele et al. 2014). In many African societies, adolescent girls report that their first sexual experience was forced (WHO, 2005). Various studies have demonstrated that partner violence exposes girls and women to high risk of HIV infection, unplanned and unwanted pregnancies (Bashemera et al. 2013). This has been supported by a study in South Africa which documented that young

women who experienced intimate partner violence have a 50% chance of acquiring HIV more than those who did not go through such violence (van den Berg et al. 2015). According to the Demographic Health Survey 2010-2012, more than half of married adolescent girls and young women lack a decision-making power regarding their health. The UNAIDS GAP Report (2014) has indicated that valuing protection and promoting women's autonomy is central to guarantee access to comprehensive sexual reproductive health and HIV services. This means that for women to be empowered, they need to receive comprehensive sexuality education.

The UNAIDS GAP Report (2014) also notes that adolescents girls and young women lack access to comprehensive and accurate information on sexual and reproductive health reflecting this is a group of people not equipped to manage their sexual health or to reduce potential health risks. It has also been documented these young women cannot negotiate condom use, have limited access to HIV testing, modern contraception and family planning and have limited ability to adhere to HIV prevention and treatment including PMTCT. This reflects many traditional African contexts where women are found not to be in a position to control their sexual reproductive health and rights which increases their vulnerability to sexual infections. According to the London International Community of Women Living with HIV and AIDS (2008), in some contexts, women living with HIV and AIDS have been forced or feel pressured to be sterilised by health-care workers. This, at the same time denotes that HIV-positive pregnant women may choose abortion because they have been inadequately informed about their sexual and reproductive health options to preserve their children's and their own health. It cannot be overstated that women need to be empowered with comprehensive and adequate information to fight HIV and AIDS.

According to the UNAIDS GAP Report (2014), numerous studies found that increasing girls' and young women's educational achievement is significantly linked to better HIV and sexual reproductive health outcomes while lack of access to education and leaving school because of pregnancy or other reasons can jeopardise a girl's future (UNFPA, 2013). Statistics from Demographic and Health Surveys, 2010-2012 as indicated in the UNAIDS GAP Report (2014), show that more than half of adolescents and young women approached in Niger, Burkina Faso, Cote d'Ivoire, Senegal, Guinea and Cameroon did not have a say on their health care. The Gap Report (2014) indicates that in SSA, a mere 15% of young women aged 15-24 know their HIV status. Such low percentages have been caused by a lack of adequate education for young women. Because of the high dropout rate, adolescent girls and young women are less likely than their male counterparts to have access to comprehensive sexuality education which includes HIV awareness and negotiating power relationship vital to enabling young women to protect themselves.

UNICEF, (2012) indicates that in SSA approximately 80% of young women have not completed their secondary education and one in every three young women cannot read. The Joint United Nations Development Programme on HIV and AIDS, (2004), conducted a thirty-two country study which found that women with post-primary education were five times more likely than non-literate women to know about HIV while non-literate women were four times more likely to believe that it is impossible to prevent HIV. But those few who remain in school often are not exposed to quality, comprehensive sexuality education that incorporates HIV (UN Educational, Scientific and Cultural Organisation, 2013), which also limits their HIV and AIDS knowledge. The Joint United Nations Programme on HIV and AIDS (2013) has found that twenty-eight percent of young women in SSA possess knowledge of how they can protect themselves from HIV. In support of this, the Global Coalition on Women and AIDS

(2014) reiterates that schools are not productive or safe for adolescent girls to achieve their full potential in some contexts. In South Africa, Prinsloo, (2006) found that 30% of young female rape survivors were assaulted within or near their school. Thus, there is a high need for women empowerment in the wake of HIV and AIDS.

The Gap Report (2014) also alluded to the view that discriminatory social and cultural norms when converted into customary or statutory laws lead to public denial and repression of the sexuality and autonomy of young women. According to UNPFA (2013) in some developing countries, many adolescent pregnancies occur within child marriages which is legal. In 158 countries, the minimum legal age of marriage without parental consent is 18; in 146 countries there are state or customary laws that permit girls younger than 18 to marry with the consent of their parents or guardians while in 52 countries girls below the age of 15 can marry with the consent of their parents. According to Temin and Levine, (2009) adolescent girls go through a disproportionate twenty-three per cent of the global burden of diseases associated with pregnancy, HIV included. They go through such unfortunate experiences because they are somehow disadvantaged.

In a bid to reduce girls and women's vulnerability to HIV and AIDS, UNAIDS (2014) recommended that stigma, discrimination and violence based on gender must be abolished. Also, that discriminatory laws that block young women from reaching their full potential and from recognising their rights including sexual reproductive rights must be revoked to reduce HIV infections and mandatory parental or spousal consent requirements for accessing sexual and reproductive health and HIV services must be removed (The Global Coalition on Women and AIDS, 2014). According to WHO (2013), the approaches that can be utilised to reduce women's vulnerabilities to violence and HIV include empowerment of girls and women

through economic empowerment and engagement with families, the transformation of harmful cultural and social gender norms through effective school-based interventions, keeping girls in school and integration of services against gender-based violence into HIV services. For instance, addressing violence during HIV testing and counselling and promoting and implementing laws and policies related to violence against women, gender equality, and HIV.

Nankinga et al. (2016), explored the relationship between sexual empowerment and the STI status of married or cohabiting women (women in a union) aged 15 - 49 in Uganda. The central focus was on sexual empowerment, involvement in decision-making on one's health, experience of any form of sexual violence, recent condom use with most recent partner and the number of lifetime partners and partner control behaviours. The indicators of sexual empowerment included a woman's reported capability to deny sex, ability to influence her partner to use a condom and opinion regarding whether a woman is justified for denying her husband sex if he is unfaithful. Findings indicated that twenty-eight percent of women in a union had suffered from STIs in the previous year, with sexual violence and the number of lifetime partners being the strongest predictors of reporting STIs. These findings are supported in Jewkes et al. 2010; Blanc, 2001; Stephenson et al. 2008; Stephenson, Koenig & Ahmed, 2006; Dude, 2007 and Koenig et al. 2004. Unexpectedly, the likelihood of reporting STIs was higher among women who were sexually empowered. Reporting of STIs was inversely related to a woman's participation in decision-making concerning her health and positively associated with the experience of sexual violence, partner's domineering character, and numerous life partners.

According to UBOS, Macro International Inc. (2007) and UBOS, ICF International Inc. (2012), in Uganda and other parts of Sub-Saharan Africa, for example in Zambia and Rwanda, the level of new HIV infections is higher among people in marriage or cohabitation than in those not in a union. Concerning this, Garcia-Moreno et al. (2006) and Salam, Alim and Noguchi (2006), noted that gender relations and sexual behaviours are influential in sexual and reproductive health and the general well-being of individuals and communities. Pederson, Greaves and Poole (2015), further elaborated that gender inequalities have been associated with health inequalities and heightened exposure to STIs. Sexual behaviours are determined by gender relations which may also determine one's STI status. This is in line with Turmen (2003), who notes that socially constructed gender-based expectations, power relations, roles, duties and relationships between men and women put women at risk of contracting STIs. According to Sanchez et al. (2012), inequalities in gender relations frequently disadvantage women because they are usually assigned a subordinate role in sexual relations. These inequalities also affect women under PMTCT programme hence there is a need to address them before programme implementation.

Adherence to traditional gender roles related to sexual behaviour is stronger among females than males (Part et al.,2011), making it difficult for females to negotiate for safer sex in such relationships; yet, their partners might be found not using condoms outside marriage after developing trust in their extramarital partners (Marston & King, 2006). The danger comes within unions when condom use is usually resisted or dismissed as unnecessary (UBOS, ICF International Inc. 2012; Chimbiri, 2007) because in such relationships faithfulness and trust are expected, and regular sexual activity is viewed as a conjugal right especially by male partners (Ahmed et al., 2001). Henceforth if PMTCT interventions are

implemented without addressing inequalities found because of such traditional gender roles, they will not be effective.

In Uganda, it was found that women's empowerment in relation to household decision-making and attitudes towards violence was not a significant predictor of intimate partner sexual violence (Wandera et al., 2015). Also, that prevalence of HIV was higher among employed women than unemployed women (Ministry of Health, Uganda, 2012). Researchers have established that sexual and gender-based violence is linked to poor reproductive health outcomes, including STIs (Jewkes et al. 2010; Blanc, 2001; Stephenson et al. 2008; Stephen, Koenig & Ahmed, 2006; Dude, 2007) and the women who experience sexual and gender-based violence are at higher risk of contracting STIs. This has been linked to gender imbalance that usually accompanies partner abuse and increases in STIs including HIV (Pederson et.al. 2015; Turmen, 2003, Raiford, Seth & Diclemente, 2013).

Findings from Uganda by Koenig et.al. (2004), denote that young women who reported having been forced for their sexual debut were less likely to use condoms or any other form of contraception resulting in unwanted pregnancy and STI symptoms. This supports the view that coercive sex is mostly unprotected hence exposing victims to the risk of STI infection (Johnson & Hellerstedt, 2002). In a study in South Africa, a woman's experience of domestic violence was associated with her demand for condoms. It was also found that sexual control (empowerment) of women was not directly linked to condom use (Teitelman et al., 2008; Jewkes, Levin & Penn-Kekana, 2003).

Nankinga et al. (2016), support Mahmud, Shah and Becker's (2012) view that contextual interpersonal and socio-cultural factors should be considered in efforts of individual empowerment because it does not occur in a vacuum. Some studies found that

traditional and religious beliefs may interact with health advice reducing motivation to comply with PMTCT requirements. For instance, believing in traditional healers and the healing power of other spiritual forces (Roura et al. 2010; Wanyama et al. 2007; Doherty et al. 2006; Nor et al. 2009). They suspected that contextual, socio-cultural, gender-based prescriptions and expectations concerning sexual activity are likely to affect women in union. In future, to empower women in PMTCT programmes such issues must be considered for the programmes to be effective

2.7. IMPORTANCE OF MALE INVOLVEMENT IN EMPOWERING WOMEN IN RELATION TO PMTCT

This section reviewed several studies which tested the importance of male involvement in PMTCT programmes. Most of the reviewed studies pointed out that involving men is crucial in the success of women empowerment in PMTCT initiatives if their involvement was to support women not to disempower them. Men must be involved as support members, not as leaders.

Yende et al. (2017) conducted a study based on the assumption that male involvement in antenatal care improves prevention of mother-to-child transmission outcomes in SSA. The authors assessed male participation's acceptability from both male and female perspectives and potential incentives that can encourage men to attend antenatal care. A quantitative study recruited participants from pregnant women and men attending primary health care at a health centre in Johannesburg. The majority of women participants preferred partner attendance at antenatal care, and few reported partner attendances during their then pregnancy. The male participants reflected low levels of knowledge about services offered at antenatal clinics besides pregnancy monitoring. Few had attended antenatal care and mentioned some factors that may motivate them to attend; these include blood pressure screening, fatherhood

information and HIV testing. The majority of the participants from both genders indicated high acceptability of antenatal care letter invitations whose message focuses not only on HIV testing but on fatherhood and primary healthcare.

Enhanced male involvement in antenatal care and PMTCT programmes has been reported to reduce mother-to-child transmission of HIV in South Africa. However, the failure to follow up from ART programmes was prominent particularly in the postpartum period and among women newly diagnosed with HIV during pregnancy (Clouse et al., 2013; Goga et al., 2015). One of the contributing factors noted by Hodgson et al. (2014), was a failure by some women to share their HIV status to a partner or family which makes it difficult for them to attend antenatal clinics after giving birth, as pregnancy attributed to frequent clinic visit is no longer there; this also affects drug adherence. On the other end, male's social and economic roles within the family circle have been noted to place them in a position to make health-related decisions for their spouses and children hence their involvement in antenatal clinics can lead to an improvement in PMTCT outcomes (Aluisio et al., 2011; Farquhar et.al., 2004). This study targeted to promote women empowerment in PMTCT initiatives by incorporating and enlightening men on the pros of supporting their partners in PMTCT without being restrictive or imposing.

A study in Kenya found that male involvement increases adherence to maternal ART prophylaxis and infant feeding methods and reduction in risk of mother-to-child transmission of HIV (Aluisio et al. 2011). Couples testing at antenatal clinics was found to increase male involvement and support towards their pregnant partners. However, some factors have been documented as hindrances to men's attendance at antenatal care. These include a worldwide general view that maternal and infant health are women's responsibility, men feel unwelcome

at antenatal clinics because the waiting rooms will be occupied mostly by women, experienced and anticipated poor treatment of men by healthcare practitioners and long waiting times (Ditekemena et al. 2012; Kululanga et al. 2011; Nkuoh et al. 2010; Adelekan et al. 2014; Mullany, 2006). Also, most men are employed; hence they would not risk losing allowance due to absenteeism caused by attending antenatal clinics (Morfaw et al. 2013). This means that in coming up with strategies to empower women in PMTCT programmes, the developers must address these issues that negatively impact men's involvement. Sustainable women empowerment can only become meaningful with the involvement of supportive, not controlling, men.

Yende et al. (2017), found there was a high willingness among men and women to involve men in ANC attendance regardless of their HIV status which concurs with the findings of a study in Cameroon (Nkuoh et al. 2013). Yende et al. (2017), discovered that both men and women were interested in using invitation letters for male involvement in antenatal clinics and also inclusion of fatherhood information and general health screening including HIV and STIs as incentives for male attendance. A review by Bolu et al. (2007), revealed that giving men invitation letters to antenatal clinics focusing on men with HIV counselling and testing knowledge and publicising HIV couple counselling and testing are closely and positively related to improvement in PMTCT uptake.

Other studies proposed that extending clinic visiting hours to weekends, or earlier morning hours, shortening of the waiting period, attending first to women who attend antenatal clinics with their male partners and making use of some public holidays like Father’s Day may increase male attendance at antenatal clinics (Nyondo et al. 2014; Byamugisha et al. 2010). However, caution must be taken not to stigmatise unmarried women and those

attending antenatal clinics without partners (Beckham et al. 2015). Yende et al. (2017) state that women were less willing than men to support HIV testing in invitation letters perhaps because they were not comfortable to offer their partners letters inviting them for HIV testing or they feared that an invitation for HIV testing might chase the men away from antenatal clinics. One of their study's strengths was that it included men to embrace the male voice, promoting male involvement in women's attendance at antenatal clinics.

Several studies noted that men had little insight on what transpires at antenatal clinics visitations which may lead to lack of willingness to be involved in maternal care (Yende et al. 2017; Nkuoh et al. 2010; Nyondo et al. 2014; Theuring et al. 2009). A Malawian study discovered that structural amendments to make antenatal clinics male-friendly can increase male participation (Mphonda et al. 2014). A review of these studies reflects that, it is of paramount importance to involve men and hear their concerns even at a structural level when targeting women as they work hand in hand.

Wai et al. (2015) employed a cross-sectional study to investigate the factors influencing men's involvement in antenatal care in Myanmar in Asia and how it influences women's utilisation of maternal care services during pregnancy, at delivery and after birth. It was found that men were mainly involved financially during the periods and most were highly educated. Some men were also found to attend antenatal clinics with their spouses, and most of them had knowledge of antenatal care services. A general finding was that men would mainly get involved in decision-making because they were the ones who were financially strong but would not be concerned about a safe delivery place for the women or any other birth preparations which had nothing to do with their areas of influence in the family set up. In response, this study aimed to assess the level of empowerment of rural women about

decisions affecting their maternal health to assist in strategising empowerment programmes in PMTCT within the rural community.

According to findings from some studies, for instance Bolu et al. (2007), there is a positive association between HIV-positive pregnant women's adherence to PMTCT treatment and their intimate partners' knowledge level, support and involvement. A literature review by Betancourt et al. (2010) found a strong association between intimate partner communication and male's acceptance of HIV counselling, testing and HIV positive pregnant women's adherence to PMTCT treatment.

Randomised control trials (RCT) have also been used to measure methods to heighten the level of male engagement in women's treatment when pregnant, at delivery and during follow-up. Mohlala et al. (2011) randomly allocated women in South Africa to receive an invitation letter for their male partners to attend an antenatal clinic. It was found that less than half of the women were accompanied by their male counterparts in their next visit to the clinic. Mainly the men came from those who had received VCT, and few came for information only. The results were statistically significant; however, the study did not test for women's PMTCT uptake. In Uganda, Byamugisha et al. (2011) conducted a similar study with a sample of 1060 pregnant women who received invitation letters for their male partners to attend antenatal care (intervention) or disseminate basic information on pregnancy (control). Findings showed no significant difference between the two groups concerning the number of males who accompanied their partners for antenatal care visits. However, the researchers noted that both groups reflected a rise of over 10% from a baseline rate of 5% male partner attendance in antenatal care (Busza, 2012), indicating a formal invitation for antenatal care services to men carries a potential impact on male involvement. The difference between the two studies was

because in South Africa the intervention came after some information campaigns and community sensitisation tasks to promote male involvement more widely.

Male partner involvement has also been cited as a positive move toward the success of PMTCT interventions. However, Larsson et al. (2012), Peltzer et al. (2011), Falnes et al. (2011) and Farquhar et al. (2004), report that requesting women to invite their male partners for HIV testing can present a stumbling block to male involvement even though it was noted that many women wish to have their partners tested for HIV during pregnancy. This study measured interpersonal communication in rural women in an African context and the findings will be expected to contribute to improving PMTCT uptake.

Ampt et al. (2012) also studied male involvement, utilising a questionnaire and a cross-sectional method in Myanmar which is a male-dominated country in the mainland of South East Asia (Ampt et al. 2015). The study aimed to establish necessary indicators of male involvement in maternal and newborn health taking into consideration socio-demographic, knowledge, and attitude correlates of involvement. This intervention was based on findings from other research that male involvement positively affects maternal and newborn health However, because of the complexity of defining male involvement, Ampt. et al. suggest the need for further research in unearthing factors that promote and those that hinder the construct of male involvement as it relates to maternal and newborn health. The targeted sample comprised married men with one or more children. The findings reflected a positive correlation between high male involvement in maternal and newborn health and women's high level of education and men's knowledge of maternal and newborn health.

However, there was a negative relationship between the number of children a couple had and male involvement in maternal and newborn health. According to Greene et al. (2004),

Adeleye, Aldoory and Parakoyi (2011) and Mullany, Hindin and Becker, (2005), women's level of education and empowerment are essential concerning their health and that of their infants but that without the involvement of males, little will be achieved. This further informed this study regarding some variables to take into account in trying to bring women empowerment in PMTCT initiatives.

In various societies men play a critical role in making decisions about the health of their wives and children like family planning, access to health services, food quality and availability and women's workload (Davis et al. 2012; WHO, 2010; Sternberg et al. 2004), despite possessing minimal or irrelevant health knowledge (Chattopadhyay, 2012). Hence their role could pose barriers to women's capability to be themselves and to be active in their children's interests (Ampt et al. 2015). Though men are primary decision-makers, often they are excluded from health services and areas where they could be enlightened on family planning, pregnancy and childbirth (Ampt et al. 2015) in societies and culture where maternal issues are regarded as women's responsibilities. Men's absence from such maternal issues may be economic where males are forced to be away from home in search of employment to sustain the family's livelihood (Davis et al. 2012), or it could be programmatic whereby men are excluded from maternal health programmes which results in health services inaccessible to men (Byamugisha et al. 2010). Thus, men become unable and unwilling to make informed decisions about maternal and reproductive health (Davis et al. 2012).

Other studies found male involvement to be beneficial, for example in safer birth practices (Senapathy, 2011; Exner et al., . 2009; Ha, Jayasuriya & Owen, 2005; Lundgren et al., 2005; Shattuck et al., 2011; Solorzano et al., 2008; Ditekema et al., 2012; Shefner-Rogers et al., 2004; Davis et al. 2012; Varkey et al. 2004; Kunene et al. 2004; Sinha, 2008).

Male involvement can lead to improved quality of paternal and couples relationships, to a more valued and constructive role and increased familiarity with the health system (Carter & Speizer, 2005).

According to Greene et al., (2004), and Barker and Das (2004), if male's involvement is promoted without taking into cognisance the existing gender norms, it could become devastating as it may reinforce gender stereotyping and could lead to the out-casting of single women from health services. It may also reduce service uptake by women mainly in HIV prevention (Brusamento et al. 2012). Thus to reduce such setbacks, women should play a central role in programme design, implementation and evaluation (Davis et al. 2012; Barker et al. 2007). Interventions in which a positive model of masculinity is enhanced and men act as change agents are especially successful (Adeleye et al. 2011; Lundgren et al. 2005; Shattuck et al. 2011; Shefner-Rogers & Sood. 2004).

The review of these studies on male involvement in maternal care contributed to the design of the research instruments of this study and included elements on assessing the participants' views on male involvement as it is a great component in women's empowerment.

2.8. IMPORTANCE OF SOCIO-ECONOMIC FACTORS IN WOMEN EMPOWERMENT IN PMTCT

The lack of social support for HIV pregnant and breastfeeding women may also negatively affect PMTCT utilisation because it disturbs drug adherence (Ware et al. 2009; Nachega et al. 2006) and discourages them from adjusting to traditional breastfeeding and weaning procedures (Falnes, et al. 2011; Cames et al. 2010). Travelling long distances to healthcare centres may also negatively affect HIV testing, collection of results, and health-seeking behaviours (Posse et al. 2008).

PMTCT uptake may also be derailed by HIV stigma, social networks, health and religious beliefs, gender roles and policy environment. A comparative study was done in five states. Findings indicated that perceived stigma is statistically related to failure to adhere to treatment (Dlamini et al. 2009). Multiple reviews by Ware et al. (2009), Merten et al. (2010) and Selin et al. (2007), concur that anticipated stigma and fear of unfavourable health treatment services like prejudice from health staff, long queues at health centers and inadequate drug stocks, are under hindrances to treatment. In qualitative studies in Botswana and Tanzania another factor was that lack of concrete social networks reduces the willingness to adhere to HIV treatment (Nam et al. 2008; Mshana et al. 2006). These reviewed studies reflect an interaction between social and economic factors in determining women’s adherence to PMTCT programmes. Thus, in coming up with strategies to empower women under these programmes, socio-economic factors must be considered.

For Falnes et al. (2011) and Byamugisha et. al. (2010), gender roles that may determine women's socio-economic status in society also play a significant role in PMTCT involvement. The scholars reiterate that unequal distribution of power between men and women lowers the socio-economic standing of women which robs them of decision-making regarding their health, including sexual reproductive health. The same scholars point out that social norms sometimes lower male involvement in pregnancy and infant care. Other researchers point out the political environment as a barrier to PMTCT involvement; for example, poor social welfare services and health care services coupled with unstable economies and political arenas (Blas et al. 2008; Cavagnero et al. 2008).

Social inequalities between men and women have also been studied in evaluating PMTCT interventions. Cash transfers have been used in some sites to address socio-economic

inequalities and provide a social safety net by disbursing money as a reward for certain health behaviours or outcomes. In an intervention conducted by Adato et al. (2009), payments were distributed to girls who remained in school, young people found to be free from sexually transmitted diseases and to women who collected their blood test results, attend antenatal appointments or give birth in health facilities.

A Malawian study that aimed to measure the use of cash transfers on improving return visits to ANC also found supporting evidence that financial incentives increase health services (Lagarde et al. 2007). Though cash transfers have been utilised to increase skilled attendance at delivery, they have not been measured for PMTCT outcomes (Powell-Jackson et al. 2009). Cash transfers may lead to economic empowerment but may not address other social factors that lead to women's disempowerment.

Sahu et al. (2016) did a quantitative study in Uttar Pradesh State of India seeking to examine the effect of women’s autonomy and male involvement in reproductive and child health (RCH) services. The study focused on recently married women and men aged between 15 and 49 years of age. The researchers controlled for the women and their husband's socio-economic and background characteristics. The results indicated that socio-economic and demographic variables like women's age, residential area, number of living children, tribal background, women's employment status, their level of education, wealth index, household structure and exposure to mass media together with men’s age, education and employment status were statistically significant and related to women’s independence and male involvement. Only religion was singled out from these variables. Based on multivariate analysis, women’s independent decision-making and the support from their husbands had a significant effect on their use of reproductive and child health services regardless of socio-

economic and demographic variables. The researchers recommended promoting male involvement and women's independent decision-making in future reproductive and child health programmes to improve RCH service utilisation and women and children's overall health status.

Bandiera et al. (2012) used a randomised control trial utilising 4800 girls over a period of one year, to evaluate an intervention that attempted to jointly address the economic and health challenges experienced by adolescent girls in Uganda and the Empowerment and Livelihood for Adolescents (ELA) programme implemented by the NGO, BRAC. The programme provided vocational training to engage in small-scale enterprises and knowledge of health and risky behaviours. The findings reflected that the programme had a positive economic and health impact on behaviours. The intervention increased the number of girls engaging in income-generating activities mainly related to self-employment. Also, it led to an increase in self-reported routine condom use and a decrease in the probability of having a child. In addition, the number of girls reporting forced sex dropped to zero. The researchers concluded that combined interventions have a more positive effect among adolescent girls than single-pronged interventions aiming to improve labour market outcomes only through vocational training or to change risky behaviours solely through education programmes (Bandiera, et.al. 2012). Borrowing from the study, one can agree that those implementing PMTCT programmes may also promote economic-based activities for the targeted groups to increase their participation.

Albraccin et al. (2014) conducted a study in Illinois involving 218 Mexican women in which they examined if women's levels of economic, socio-cultural, interpersonal and political empowerment could be influenced by condom use. They found that sociocultural and

political empowerment was significantly correlated with condom use. It was noted that women whose husbands awarded them some degree of autonomy in how they acquit themselves and women who were young and understood English were more likely to use condoms with their husbands or partners than other women. In contrast, they noted that neither women's economic nor interpersonal empowerment in their romantic relationship influenced condom use. Therefore, it was concluded that women's general empowerment may be a critical element to safe sex, also one of the behaviours encouraged under PMTCT programmes.

In a qualitative study by McLean and Modi (2016), 15 Congolese girl researchers were trained by the UK's Department for International Development to engage in a peer-to-peer research in an exploration of the experiences, views and aspirations of adolescent girls and young women in urban Kinshasa concerning their economic and social empowerment. This participatory approach was adopted for programme developers advocating for women empowerment to get insight into these girls and young women's realities and aspirations.

Maclean and Modi's (2016) study produced several findings. First, girls' transition from childhood to adulthood was noted as a moment, not a process marked by the onset of puberty; however, for boys it was regarded as a gradual process. At this point, girls are expected to conform to religious, cultural or societal expectations to be labelled as a good girl who could be respected in society. If a girl fails to conform to the norms of society, she was regarded as a bad girl not worth marriage or any positive outcome in life. The transition also exposes girls to sexual abuse from community male figures and sometimes from family members. Second, the participants' economic lives were characterised by reliance on male family members or boyfriends for their economic needs, engaging in informal employment

like hairdressing or selling of some items and transactional sex. Some girls and young women reported that they would feel good and important when they save cash on their own after small-scale trading. However, those who reported relying on transactional sex as a survival strategy indicated that circumstances would force them to engage in that for example orphanhood or be chased away from home for failing to contribute financially to the family. Most of the economic activities these girls and young women engaged in were not as profitable. Most boys and young men were in formal employment, but one would find very few girls and young women there.

Concerning decision-making power, the girls and women highlighted that they had limited power compared to boys and young men in making decisions important in their lives. For instance, decisions about their education, when to marry and sometimes whom to marry and about sexuality were made by their parents or guardians and in some cases by fathers, brothers or any other significant male figures in the family. Some girls indicated a willingness to see a change that grants them more decision-making power in general and especially in critical domains like mobility, education, and decisions around marriage and sexuality. However, a few echoed that they support the status quo related to their decision-making power levels. Sexuality was regarded as a taboo (Maclean & Modi, 2016). These findings reflect that socio-economic factors may disempower women at a very tender age to the extent that even when they reach child-bearing age they lack the power to make health-related issues including decisions to get involved in or finish PMTCT programmes.

Kim et. al. (2008) state that women's economic vulnerability and reliance on men heighten their vulnerability to HIV and AIDS by robbing them of their capability to negotiate safer sexual practices and might also influence their decisions to engage in PMTCT

programmes. Several scholars have advocated for economic empowerment of women as a way of HIV prevention. Research evidence reflects that poverty on its own cannot be singled out as a driver to the HIV epidemic thus the relationship between the two is complicated. Instead, poverty's role is multidimensional, hence interacting with diverse factors like mobility, social and economic inequalities and social capital (Piot et al. 2007; Gillespie et al. 2007).

Kim et al. (2008) examined how socio-economic programmes like microfinance, livelihood training and efforts to safeguard women's food security and access to property have incorporated an HIV prevention focus. According to Kim et al., various calls to 'mainstream AIDS' in economic development, cross-sectoral responses have not been widely adopted by many governments, or other stakeholders, hence suggesting potential reasons for limited progress even today. The authors concluded by giving programme and policy recommendations to explore and harness linkages between economic empowerment and HIV prevention in Southern Africa. Piot, et al. (2007), assert that worldwide, poverty, gender inequalities and social marginalisation are some of the major factors hindering efforts to prevent HIV and AIDS. Research has also found that AIDS is not a disease of inequality, usually connected to social or economic transition, rather than a disease of poverty itself (Piot, et.al. 2007; Gillespie et al. 2007). Women have been found to carry the economic burden of trying to meet basic needs. Yet, they are more illiterate than men, are often denied property rights and access to credits, are usually unemployed or work in informal sectors with risky and unfavourable working conditions, increasing their vulnerability to HIV and AIDS (UNIFEM, 2000; Rao Gupta, 2002). This creates an opportunity for women empowerment to improve their health conditions.

A systematic review in SSA discovered that possession of formal education reduces vulnerability to HIV especially among young women and it helps in granting them the ability to negotiate for safer sex (Hargreaves et al. 2008). A study in Botswana and Swaziland found that educated women were less likely to report lack of sexual control in relationships, inconsistent condom use, and intergenerational sex (Weiser, et al. 2007). Kim et al. (2016) contend that education has increasingly become a protective factor against HIV infection. A cohort study in rural South Africa (2001-2004), found that young women from poorer households reported less use of condoms (Hargreaves et al. 2007). In Botswana and Swaziland food shortages among women were strongly associated with inconsistent use of a condom with a non-primary sex partner, transactional sex, intergenerational sexual relationship and lack of control in sexual relationships (Weiser et al. 2007). Thus, one may conclude that economic empowerment must also be considered in women empowerment within PMTCT initiatives.

Women's economic reliance on men throughout much of the developing world has meant that their personal resources including sexuality and their ability to decide on the life and health of the unborn child during pregnancy have taken on heightened economic potential (Piot. et al. 2007). According to Gillespie et al. (2007) and Rao Gupta et al. (2000), social norms in various SSA contexts allow and promote men to engage in sex with multiple partners, with much younger partners and to dominate sexual decision-making. A study by Greig (2003) in Gaborone, Botswana, found that women's negotiating power and economic independence determined their level of condom use hence Greig suggests that besides providing education, increased access to income-generating opportunities and negotiating skills may assist in women empowerment to guard themselves against HIV infection through greater condom use.

Anderson (2012) also highlights that economically women occupy levels lower than men as they do not have equal access to resources and get low paying jobs which may also be a risk factor in HIV infection. She states that men are 'decision- makers' while women are 'decision-takers' whose bodies are under men's guardianship. Men have been called controllers of women's sexual reproductive health as they decide family planning methods and when to have children and when to take medication. In relation to this, other scholars remark women are controlled to this level because most have low levels of education compared to men and are socially conditioned to do what their husbands want (Munthali, et.al. 2004; Lwanda, 2005; Mbweza, et.al 2008; McElmurry, 2008). This reflects how women may be disempowered by lack of, or low levels of education which negatively affects how they make decisions about their health.

Gerritzen (2012) conducted a longitudinal study with over 1200 married women in rural Malawi from 1998-2008 to assess strategies that may improve women's bargaining power in HIV prevention. The study adopted a multidimensional approach and discovered that condom use and communication among sexual partners are essential strategies for HIV prevention. The research concentrated on different dimensions of women's empowerment, namely personal and interpersonal empowerment. Under personal empowerment, the focus was on one's income and knowledge of other local languages, which were found crucial in HIV prevention. Under interpersonal empowerment, emphasis was on awareness of social status, and exit options from marriage, an important determinant of preventive measures. Gerritzen suggests that greater emphasis should be placed on women empowerment for meaningful and effective combating of HIV and AIDS, particularly in developing nations. The higher a woman's income level, the higher her negotiating power for safer sexual behaviours and the more likely she can risk the survival of her relationship than risk her life

and vice versa. The author also noted that women empowerment differs in regions within the same country; hence there is a need to take cognisance of regional differences when designing empowerment programmes. Gerritzen continues that condom use is the best strategy towards HIV prevention from a public health perspectives, but from a sociocultural perspective it is not, hence it calls for a change of perceptions and attitudes. As a result, this study was conducted in different regions of Zimbabwe because people in different regions go through different experiences; thus, their empowerment might come from different dimensions.

Data from Botswana reflected that condom use among sexually active women is positively associated with women's economic independence and negotiating power (Greig & Koopman, 2003). In their analysis of the determinants of HIV-related spousal communication among participants of the Malawi Ideational Change Project, Zulu and Chepngeno (2003) found that women with greater programme exposure and informal social contacts are more likely to talk with their spouse about HIV risk. Hence spousal communication on HIV and sexuality issues in general becomes a necessary component in women empowerment.

Rodrigo and Rajapakse (2010) reviewed literature to examine the link between financial status and HIV and its implications for women specifically. They also examined how poverty and wealth may be linked to HIV infection. Wealth put both men and women at risk, but poverty puts women at a notable disadvantage. The authors remark that higher rates of infected women have led to the feminisation of HIV and AIDS and that factors that make women vulnerable to HIV and AIDS can be biological or non-biological. In Malawi, women were reported to be at high risk of HIV infection because of poverty, resulting in a higher percentage of infected women than men (NSO & ORC Macro, 2005). Pregnancy has also been called a disadvantage to women as it can facilitate infection or lead to maternal mortality

in HIV positive women (Khanet al. 2001; Bicego et al. 2002). According to Rodrigo and Rajapakse (2010), biological factors are universal to all women but non-biological are context-specific where factors like poverty, restrictions because of subservient gender norms, gender-based violence, limited employment and educational opportunities for women place women at high risk of HIV infection.

Increase in women's wealth has also been documented by some researchers as closely linked with a high rate of HIV sero-conversion (Awusabo-Asare, 2008; Msisha et al. 2008; Johnson & Way 2006; Barnighausen et al. 2007; Tanzania Commission for AIDS, 2005) as it facilitates paid sex, drug use, extramarital relationships, less conformity or non-conformity to sexual norms and deviation from traditional values. Mishra et al. (2007) have supported this in their national surveys of eight SSA countries as have Johnson and Way (2006) in their demographic survey data in Kenya in 2003 and Barnighausen et al., (2007) in a large-scale longitudinal data series in South Africa. However, these studies focused on family household income or equipment that may not be very appropriate in determining one's level of wealth or empowerment level.

Numerous studies have supported the view that poverty put women at higher risk of HIV infection as it forces them to engage in unsafe sexual behaviours (Ibrahim et al. 2008; Ghosh & Kalipeni, 2005; Mbirimtengerenji, 2007; Lima & de Viana, 2009; Robinson & Seiber, 2008; Silveria, Santos & Victoria 2008; Tladi, 2006; Versteeg & Murray, 2008; Wenzel et al. 2007; Langen, 2005; Sa & Larsen, 2008; Rowley et al. 2008; Adimora et al. 2006; Dunkle et al. 2004; Hargreaves et al. 2002; Gavin et al. 2006; Weiser,et al. 2007; Oyefara, 2007; Bachmann & Booysen et al. 2006; Riley et al. 2007). Most of these studies were done in SSA with a few from outside Africa and other developed states. Poverty creates

a base for other factors that increase women's vulnerability, for example, limited employment and educational opportunities, intimate partner violence or communal violence, and harmful gender norms.

Maclean and Modi (2016) in their study compared their participants from urban Kinshasa and Sharma's, (2008) participants from rural India and they noted that the two groups were different. Thus, in trying to promote empowerment of different people there is a need to contextualise empowerment. This supports Sharma's (2008) recommendation that interventions of this nature must conceptualise empowerment to understand what empowerment means to particular women within specific contexts, thereby influencing the development of empowerment programmes. Brouder and Sweetman (2015) found that urban Kinshasa girls and young women have increased access to services, markets and economic opportunities though mostly they work for low pay, poor and insecure conditions which may expose them to high risk including gender-based violence different from rural Indian women studied by Sharma, hence different conceptualisations of empowerment. According to Maclean and Modi (2016), DFID's vision for La Pe'pinie're was that economic empowerment can be the starting point for improving the situation for adolescent girls and young women in Congo. This is supported by Kabeer's (1999) view that economic empowerment underpins women's broader social and political empowerment as individuals and as a collective marginalised group. She notes that women's ideas, aims and aspirations will not be considered without economic empowerment; however, money does not address all the requirements for full women empowerment and there is need for women's awareness to improve their lives, education, training and support from other significant women.

For Maclean and Modi (2016), women's empowerment programmes which have narrowly focused on increasing women's income generation have been criticised because if interventions do not offer women a voice and agency and redress structural inequalities they experience, any efforts to advance women economically will not lead to empowerment because they will lack control over assets. Golla et al. (2011) pinpointed that empowerment will only be possible and sustainable where change occurs at multiple levels within the individual (capability, knowledge, self-esteem); in communities and institutions (involving changing norms and behaviour); in available resources and economic opportunities and in the broader political and legal arena. Also, Lutrell et al. (2009) emphasise the inter-relationship, and sometimes the inter-dependence of various forms of empowerment which are economic, social, political and psychological. This points to empowerment addressing all facets of an individual's life.

2.9. THE ROLE OF PEER COUNSELLING ON WOMEN'S PMTCT SERVICES UPTAKE

The promotion of peer counselling has been recommended by researchers to be used as a strategy to subdue isolation feelings and provide support and help to pregnant women. According to Busza (2012), peer counselling is more acceptable among people living with HIV as they will be getting advice from individuals who have gone through the same experience. Baek et al. (2007) did a quasi-experimental study that used peer counsellors. The results showed lowered depression, heightened HIV status disclosure and improved coping strategies, clinic attendance and breastfeeding among the experimental group; however, there was no difference in the treatment uptake.

According to findings from one of the systematic reviews of peer counselling on infant feeding outcomes, community-based peer counsellors' inclusion led to improved breastfeeding initiation, duration, and exclusivity (Chapman et al. 2010). In support of this, a randomised control trial of peer counsellors promoting exclusive breastfeeding in Bangladesh by Haider et al. (2000) found a higher percentage in exclusive breastfeeding in the intervention than the control group. Tylleskar et al. (2011), replicated this study in three countries in SSA (Uganda, Burkina Faso and South Africa). The same success was noted, but in South Africa, there was a challenge of participants' mistrust towards the peer counsellors.

A six-year descriptive qualitative study by McCreary et al. (2014) reached out to 18 experienced peer group leaders who had engaged a multisession HIV prevention peer group intervention in rural Malawi. The study described the participants' emotions toward how being a peer group leader affected their lives. Three major themes were identified. First, the leaders experienced personal changes in their knowledge, attitudes or HIV prevention behaviours. Second, they became competent in interacting with family, neighbours and friends and church mates, community members in discussing HIV prevention issues. Three, their position improved their self-efficacy to engage others in sensitive HIV prevention issues, developed a self-identity as agents of change and earned the trust from their communities as advisors on HIV and AIDS. These three themes combined create the meta-theme of psychological empowerment. The peer group leaders became empowered as change agents to prevent HIV prevention, which affected the community even beyond the intervention period, thus having the potential to increase the long-term effectiveness and cost-effectiveness of peer group interventions. The empowerment of these leaders had the potential to empower the community consistently with information as they now had local people easily available in leading them on HIV prevention.

Other studies found there are cultural barriers to HIV prevention which include stigmatisation of HIV, gender inequality and norms that hinder open discussion of sexual reproductive issues particularly with young people, and between partners (Benotsch et al. 2004; Chimbiri, 2007; Kathewera-Banda, 2005; Lindgren, Rankin, & Rankin, 2005; Muula & Mfutso-Bengo, 2004). However, these could be overcome through peer group interventions. Integrative reviews and meta-analyses show the effectiveness of peer group interventions in overcoming barriers and obtaining HIV-risk reducing behavior change across many countries and target groups (Albarracin et al. 2005; Albarracin, Albarracin & Durantini, 2008; Medley, Kennedy, O'Reilly, & Sweat, 2009; Muula & Mfutso-Bengo, 2004).

According to McCleary et al. (2013), peer group interventions promote Bandura's 1982 social-cognitive learning theory, which states that increasing self-efficacy or confidence promotes behavioural change. McCleary et al. reiterate that the peer group intervention explicitly builds self-efficacy, which impacts self-understanding and confirms that it is plausible that peer group leaders also experience empowerment through their participation. Therefore peer groups may also be useful in women empowerment targeting to increase their PMTCT involvement.

Peer groups were also found useful in interventions studies. For example, CARE in partnership with the International Center for Research on Women (ICRW) engaged in grounded analysis to ascertain how their HIV prevention programmes and advocacy activities impact women's vulnerability to HIV (Scott, 2012). This was done through multi-country comparative studies from June 2007 to December 2008 in Africa, Asia and Latin America where they explored the relationship between women's empowerment and vulnerability to HIV. The studies considered CARE's programme interventions that used solidarity groups

and peer education, and assumed that if these strategies would foster collective agency to support women's empowerment, it increased women's ability to protect themselves from HIV related risks. The researchers utilised interviews, focus groups and semi-structured questionnaires with over 1800 women to explore women's conceptualisations of empowerment and associations between empowerment measures such as agency and decision-making and HIV risk reduction behaviours like condom use and HIV knowledge.

In Bangladesh, the researchers focused on CARE's interventions with sex workers, which began in 1955. They explored the dynamics of power, women's empowerment and violence in the context of sex work. In Burundi, they focused on CARE's programming which addresses gender-based violence and social fragmentation through economic empowerment and community sensitisation; hence the study explored how reconstructing support systems shapes women's ability to negotiate sexual decision-making. In Cambodia, where democratic institutions were just emerging and where there was high mobility, gender inequity and stigma around HIV and AIDS, HIV prevention and women's empowerment programmes were crucial. CARE's programmes focused on reducing HIV risk and developing leadership skills among sex workers through peer education activities, referral systems and alternative livelihoods skills training.

Therefore, the study explored how sex workers define empowerment and whether or how vulnerabilities to HIV changed with participation in the project. In India, the researchers focused on CARE's programmes with sex workers. It utilised best practices for using women's empowerment as a tool to fight HIV and AIDS among marginalised populations. They explored sex workers' definitions of empowerment, how the type of clients and partners affect their sexual behaviours and also if there is a link between association to solidarity

groups and sexual behaviours and practices. In Lesotho, CARE was concerned with how women risk their lives through transactional sex hence the study assessed how peer education has led to lowered HIV risk for female garment factory workers. In Peru, CARE was promoting the national implementation of HIV prevention efforts for sex workers to narrow the gap between men and women's infection rates, hence the study focused on analysing various programmes targeting to empower sex workers and reduce HIV risk.

The interventions discovered : women regarded themselves as more than just housewives, sex workers, and so on, and but as women with multiple roles; women's definitions of empowerment reflect their desire to defend their rights as citizens and fit into mainstream society, traditional gender norms and family roles. They wish to be respected and supported in intimate relationships and that being a part of a solidarity group leads to greater access to health and HIV and AIDS services, positive self-esteem and self-efficacy, greater knowledge of rights and a greater sense of social acceptance. However, even though women felt supported in groups, others still kept their HIV status a secret from their partners and family. Women in solidarity groups reported higher rates of condom use than their peers not in solidarity groups but the figures were low. Condom use was practiced with clients but not with intimate partners or husbands as non-use was regarded as cementing these relationships.

Thus, Scott (2012) recommended that for an HIV prevention programme to be comprehensive and have a more profound impact, there is need to create solidarity groups as bases for women to make safe choices and safeguard their dignity. Programmes were also discouraged from categorising women overlooking a vast array of other factors which define them. For example, classifying a woman as a prostitute may overlook the fact that the woman is also a mother, worker and intimate partner. Technical strategies should consider the web of

values, incentives, structures and power relations that influence women's decision-making power concerning her sexual behaviour. Male involvement in solidarity groups was also recommended for couples to make sexual decisions that are safe and establish trust and love.

Several studies were conducted in Zimbabwe, South Africa and Ethiopia on the importance of peer counselling or support in PMTCT. These studies focused on support groups that used mentor mothers who were HIV positive mothers and had gone through PMTCT programmes and successfully managed to raise their children (Shroufi et al. 2013; Mundell et al. 2012; Viadro et al. 2008). These women were recruited to empower other HIV positive pregnant women by instilling hope in them, sharing information, and accepting their condition. From such studies, it was gleaned that women living with HIV could also obtain their empowerment by getting support from other women who have gone through the same experiences. Thus, such support helps foster some key psychological processes in HIV pregnant women or nursing mothers. They include identification, modelling, acceptance, and empowerment, crucial in making PMTCT programmes successful.

2.10. KNOWLEDGE GAP

The reviewed studies provided a rich source of information and highlighted gaps that this study desired to fill. First, there is participant bias where most of the studies focused only on girls and young women aged 15-49; this study focused on those aged between 15 and 60 years of age, which included girls, boys, men and women. The motivation for these inclusions and to go beyond the age of 49 was to capture most people who could contribute towards the success of PMTCT. Most of the reviewed studies concentrated either on males or females but mainly the latter. This, study thus included both genders because women's meaningful

empowerment requires the backup of men. Still, this should be done with caution not to facilitate male domination.

Also, most of the reviewed studies adopted either a quantitative or qualitative approach, but mostly they employed the former. In contrast, this study employed a mixed-method approach to ensure complementary findings. The significant gap in the literature, however, is the lack of utilisation of a holistic empowerment approach which caters for empowerment at individual, family, community, societal, political and cultural level. Most of the reviewed studies found it difficult to look at empowerment and PMTCT alone without separating it from other HIV interventions in general. They unearthed the barriers to PMTCT uptake, talk of gender inequalities concerning PMTCT uptake but underemphasised the crucial role that can be played by empowering women in PMTCT initiatives, the major objective of this study.

2.11. CHAPTER SUMMARY

This chapter reviewed the studies and interventions conducted in SSA, Asia and a few European countries. Most of the studies attempted to explore factors that hinder full participation of women in PMTCT. Among the common factors that block such participation include gender inequalities, cultural constrains, non-involvement of male partners, unfavourable family relationships, fear of disclosing HIV status, lack of social support, long travelling distance from health centres and unconducive health centres and personnel. Other reviewed studies tested constructs of several models and theories in addressing PMTCT challenges. Such models include the social-ecological model, health belief model, information motivation behaviour model, models based on social networks and social support and the theory of planned behaviour. Generally, most of the reviewed studies recommended

male involvement in antenatal care; autonomy in HIV status disclosure, ending stigma and discrimination, spousal communication in HIV and sexual reproductive health issues, promotion of condom use, economic empowerment of women, adoption of an ecological analysis in PMTCT interventions and psychological empowerment of concerned individuals. The following chapter will detail the theoretical framework that guided this study.

CHAPTER 3
OVERVIEW OF EMPOWERMENT THEORY AND OTHER RELATED PERSPECTIVES

3.0. CHAPTER OVERVIEW

Strategies to address HIV and AIDS for long have focused on the biomedical aspects of the infection and prevention. Statistically, at a global level, more women are infected because of biological reasons and socio-cultural norms (Harrison et al. 2015). Constructions of gender inequalities between men and women in Africa have exposed women to HIV and AIDS infection expressed by women's economic and social reliance on their partners or other male figures. Despite politically appropriate agendas in many African states taking women's gender needs into account concerning HIV and AIDS, an empowerment-based approach is still often neglected in practice. Such a background led this study to be mainly guided by the Empowerment Theory from a community psychological perspective with the backup of Bronfenbrenner's Ecological Model, Theory of Learned Helplessness and Strength-Based Perspective. The following sections reviewed books and articles with some which are outdated. Such have been included because they mainly laid the foundation for the field of Community Psychology.

3.1. OVERVIEW OF COMMUNITY PSYCHOLOGY

This study was mainly guided by principles and values from Community Psychology. Therefore it becomes necessary to briefly conceptualise Community Psychology showing how its historical background influences research and practice. According to Nelson and Prilleltensky (2010), Community Psychology mainly focuses on the relationship between social systems and individual well-being in the community context. This field is broad, which creates strong connections to disciplines like sociology, social work, public health, cultural

psychology, hence its adoption in this study of a public health issue. Community Psychology is a paradigm shift within the field of psychology with its emphasis on using the seeking mode instead of the waiting mode of Traditional Psychology.

In this new paradigm, psychologists move out of their workplaces and get into the communities where behaviour occurs naturally (Zirima & Chimunhu, 2020). Community Psychology is an emerging field within Psychology that is a proactive approach to addressing community problems and evaluates how community issues impact individuals' health and wellness (Fox, Prilleltensky & Austin, 2009). It has continued to grow and has been embraced by many, especially in Africa, where Psychology had for the most part been elitist and a rubber stamp for existing inequalities (Zirima & Chimunhu, 2020). The field advocates for community participation where people become active contributors to their own communities. It also centres on the prevention of problems, health and wellness promotion.

Community Psychology’s approach to human problems is based on its history. The events that led to its emergence mainly occurred in South Africa and the United States of America (USA). According to Naidoo, Shabalala and Bawa (2003), the emergence of Community Psychology in South Africa and the USA follow the same pattern. There was social upheaval in both countries characterised by the 1960s Civil Rights Movement in the USA and the socio-political conflict and opposition to apartheid during the 1960-1990 period in South Africa. In both countries, psychology was regarded as a service for the elite unavailable for the poor and helped in maintaining an oppressive status quo (Zirima & Chimunhu, 2020). Hence its emergence came in to address the needs of the disadvantaged groups of people and to bring empowerment. In Zimbabwe, it took time to be regarded as an independent subfield of psychology. According to Chireshe (2005), Community Psychology

took time to be officially incorporated into regulations that govern psychological practices in Zimbabwe. Various professionals had offered community psychological services from different disciplines. This can be traced back to 1971 though it was not given the specific label it holds now (Zirima & Chimunhu, 2020). The field became a specialised area of study in 2011. Hence it is still growing.

From such a historical background, Community Psychology as a field adopted ecological perspective, empowerment, prevention, and a psychological sense of community as its core values (Naidoo, Shabalala & Bawa, 2003). Besides these, Gumani et al. (2017) talk of respect for human diversity, social justice, risk prevention and health promotion. One of its fundamental models utilised in this study is the social ecological model that emphasises the importance of the interaction between the individual and the systems surrounding them. According to Naidoo et al. (2013), the model moves beyond focusing on the individual to consider community interaction. Therefore this researcher was inspired by these values and models in trying to unearth and formulate the strategies that can be adopted in promoting the empowerment of the disadvantaged rural women of Zimbabwe under the PMTCT programme.

3.2. CONCEPTUALISATION OF EMPOWERMENT

Empowerment suggests a unique approach for developing interventions and establishing social change. It highlights that many social problems occur due to unfair distribution and access to resources (Rappaport, & Seidman, 2000). According to Cowen (1990) cited in Zimmerman (2000), an empowerment approach does not just focus on improving negative aspects of a situation but also searches for the positive, promoting wellness instead of only fixing problems, identifying strengths instead of classifying risk

factors and searching for environmental influences instead of blaming victims. Thus this theory is of paramount importance in PMTCT implementation, especially when focusing on women because some risk their own lives and that of their babies due to lack of power in many spheres.

The diversity of the conceptualisation of empowerment means that the support for its processes does not have a recognised niche in any one academic field. Although there are long-established models of empowerment theory within Community Psychology, psychologists are yet to apply them to investigate women's empowerment in health promotion at a global level. According to Richey, (2003), there is a need for a specific empowerment framework to specify what empowerment is with the motive of avoiding a situation where women would be inserted into development programmes. The question then is on why there is no accurate conceptualisation and investigation of the processes surrounding women's empowerment in a global context.

Empowerment is a double-edged sword because it is both a value orientation for working in the community and a theoretical model for comprehending the process and the outcomes of efforts to exert control and influence over decisions that affect one's life, organisational functioning and the quality of community life (Zimmerman, 2000). The popularity and ambiguity of the term empowerment expose it to misuse and unclear definitions, creating a greater need for assessment in its application in different contexts. Within the field of psychology, it has been conceptualised as a sense of personal control and freedom in which individuals gain agency and mastery over issues of concern to them and are supported by access to and control over resources (Rappaport, 1987; Zimmerman, 1990; 1995). Empowerment theory also explicitly links subjective well-being with larger social and

political contexts and integrates a critical understanding of the socio-political environment (Perkins & Zimmerman, 1995; Zimmerman, 1995 as cited in Christens, Speer & Andrew, 2011).

International development literature has defined empowerment as the expansion of freedom of choice and action to shape one's life. However, it is often recognised that for many marginalised groups, that freedom is severely curtailed by lack of opportunity determined by structural inequities (Mosedale, 2005; Narayan, 2005). Kabeer (1999) as cited in Tandon (2016), views empowerment as a process of transformation in which those individuals denied the ability to make strategic choices in life gain such ability. According to Rappaport (1987), empowerment is the mechanism by which people, organisations and communities acquire mastery over their personal affairs. Maton's (2008) definition states that empowerment is a group-based participatory, developmental process through which marginalised or oppressed individuals and groups gain greater control over their lives and surroundings, acquire valued resources and fundamental rights and achieve important life goals and reduced societal marginalisation. The general view here is that empowerment is the acquisition of personal control which can become effective when one gains access to resources. In this context, such resources must affect one's physical and mental health.

The vast literature on community development has focused on community empowerment in defining the concept of empowerment. It is highly uncommon for community development to focus on empowerment at the psychological level. Brofrenbrenner's 1977 human ecological perspective has been utilised in theorising the concept of psychological empowerment. This perspective positions human development within nested levels of analysis, namely psychological, organisational and community, and it

has been effective for empirical studies of empowerment as it emphasises specificity (Christens, 2012). However, psychological empowerment should not be mistaken for essential distinctions between ecological levels of analysis. This means that while empowerment may show different observable characteristics at an individual level, psychological empowerment does not occur independently of empowering processes at other analysis levels. Therefore the term 'psychological empowerment' can be defined as the psychological aspects of processes through which people acquire greater control over their lives, take a proactive approach in their communities and develop critical understandings of their socio-political environments (Zimmerman, 1995, in Rappaport & Seidman, 2000). It includes one's skills and motivations to make social, cultural and political change, the knowledge to do so, and the interpersonal relations and behavioural actions that can contribute to changes that impact women's lives. Christens (2012) views psychological empowerment as the increasing cognitive, emotional, behavioural and relational capacities that individuals gain as they participate in empowering community settings to change social and political system which influence women's development.

Individual capacities noted in psychological empowerment include critical insights into social and political systems and self-perceptions of competence and control in the socio-political domain. Many studies have sought to assess self-perception of control in the socio-political domain theorised as pointers of the affective component of psychological empowerment (Peterson, 2006). Measures of the cognitive component of psychological empowerment have strived to examine the participants' depth of understanding of social power and its use in local community systems (Christens, Peterson & Speer, 2011). However, psychological empowerment is theoretically linked to organisational and community-level empowerment processes, and this makes it portray different facets across different

communities (Zimmerman, 1995, in Rappaport & Seidman, 2000). Hence, context plays a central role in the conceptualisation and measurement of psychological empowerment. More knowledge is required to understand which elements of empowerment are contextually or culturally specific and go beyond context.

Psychological empowerment accompanied by higher levels of community participation and psychological sense of community have protective effects on psychological well-being (Christen, Peterson & Speer, 2011; Speer, 2000; Christens & Peters, 2012). The benefit of psychological empowerment is that it promotes collective action against environmental stressors, which prove difficult to change or avoided by individual effort. Therefore, it indicates positive and protective developmental processes at the community level concurrently beneficial to the individual participants in those processes. Psychological empowerment can be viewed as both a relevant process and an outcome variable for vulnerable groups of people, for example women and children. It can be endorsed through collaborative efforts and action to encourage local change and challenge the status quo and resist unwanted change.

The empowerment theory stipulates both a value orientation for practice and a conceptual framework for having an in-depth know-how of community and organisational processes and outcomes (Rappaport, 1987, in Rappaport & Seidman, 2012). The theorisation of empowerment portrays this concept can be understood and applied at different levels namely psychological empowerment, organisational empowerment and community empowerment. Many scholars emphasise that processes and outcomes at these different levels of analysis are interdependent (Christens, 2012). This means that empowerment processes are moulded due to the actions between individuals and their contexts. The mutual dependence

between psychological and community empowerment denotes that identification and evaluation of empowerment processes should comprise "the study of the changing relations among psychological and environmental aspects of holistic unities" (Altman & Rogoff, 1987,p.9 in Rappaport & Seidman, 2012). Paradoxically studies of psychological empowerment neglect community-level processes. On the other hand, community development initiatives concerned with community-level empowerment have been seen to neglect psychological processes and outcomes among individuals affected by community development projects (Goldsworthy, 2002).

Empowerment can be analysed at three levels namely individual, organisational and community. Israel et al. (1994) in Kasmel (2011), differentiates among these three levels. They highlighted that whereas psychological empowerment focuses on individuals gaining mastery over their lives, organizational empowerment centres on collective capacities. Community empowerment focuses on the social environments where empowerment occurs. These different levels make empowerment organisations conceptualised differently in health promotion work. However, the levels are interrelated in empowered communities as, there are empowered organisations whose level of empowerment relies on their members' empowerment level (Robinson & Elliot, 2000; Smith et al. 2001). Some scholars have noted that though the three levels are interdependent, the goals of each may differ, and this may hinder practice (Laverack & Wallerstein, 2001, in Kasmel, 2011).

Individual psychological empowerment has been conceptualised in Zimmerman (1995, 1999, in Rappaport & Seidman, 2000) and Kasmel (2011). They proposed this concept operates through intrapersonal, interactional and behavioural components. The intrapersonal component focuses on how individuals perceive themselves, and it comprises concepts such

as perceived control, self-efficacy, motivations to control and perceived competence. The interactional component assesses how people comprehend and link to their social environment. This component's characteristics address one’s potential to develop a critical understanding of the forces that mould their environment and insight of the resources needed and methods to access those resources to yield social change. Management skills, problem-solving skills, and critical awareness are characteristics of interactional components of psychological empowerment. Last, the behavioural component of psychological empowerment is packaged with actions that address needs in a specific context. Individual transformation eventually becomes a bridge to community connectedness and social change.

According to Peterson and Zimmermann (2004), organisational empowerment points to the organisational efforts that produce psychological empowerment among members and organisational effectiveness necessary for goal achievement. It endeavours to bring out the organisation’s ability to implement its skills and resources to meet its goals and mission and fulfil its stakeholders’ expectations. Kasmel (2011) defines organisational empowerment as the potential of an organisation to establish an empowering and democratic partnership with a community, through enhancing the community’s capacity to note and address its priority health concerns. Laverack and Wallerstein (2001) in Spencer (2014), define it as organisational domains that portray an honest way to define and measure empowerment construct as a process.

Community empowerment may be interpreted as a process or outcome depending on one’s understanding of the concept. Those who regard it as an outcome understand it as an interplay between individual and community transformation with a long time-frame concerning the social and political change (Raebun 1994 in Kasmel 2011). Examples of such

outcomes may include a change in government policy or legislation favouring individuals or groups who participated in bringing that change; pluralism in the community; or presence of coalitions in the community and accessible community resources. Kasmel (2011), added that one could measure social cohesion, social trust, reciprocity, networks and community involvement as forms of outcomes.

The outcomes that can be witnessed at an individual level of empowerment may include feelings of increased self-efficacy or confidence, motivation and willingness to be involved in community problem-solving which evolved from collective action (Kasmel, 2011). Henceforth in health promotion interventions, individual empowerment dimensions, and social capital dimensions must be potential outcome characteristics. Kasmel further states that though community-related individual empowerment indicators are relatively credibly associated to the community health promotion intervention, the same cannot be applied to social capital indicators. As such, attribution is argumentable. Laverack and Wallerstein (2001), proposed that community empowerment outcomes are more confusing as they specifically apply to specific contexts, settings and time but not to others.

Some scholars have defined empowerment as a process. According to UNDP (1995 as cited in Kasmel,2011), as a process, empowerment increases the competence of individuals, groups, organisations and communities to examine their environment, identify problems, needs, issues and opportunities, engage in strategy formulation, design a plan of action, assemble and utilise resources effectively to implement the plan of action and make use of feedback to learn lessons. Empowerment as a process may also be defined as capacity-building, competence and skills development and critical awareness in community issues. Laverack (2006), notes that community empowerment as a process is best regarded as a

progressive continuum of more organised and broad-based forms of social and collective action. Kasmel (2011), also notes that the continuum is dynamic with the steps feeding on each other. If one step is acquired, the progression moves on to the following point, thus each step is viewed as an outcome and after its achievement the process towards next goals proceeds. Programmes themselves can and should be perceived to increase community empowerment.

An empowerment agenda is concerned with developing individuals and group capabilities and awareness about the social and cultural spaces in which they exist and that mould their everyday interactions and community relations. In this sense, empowerment is not restricted to individual psychological dynamics but incorporates social and political processes (Rappaport, 1994 in Sonn and Quayle, 2014). According to Nelson and Prilleltensky (2010), the focus here will be on the transformative or second-order change: changing the systems and their assumptions. This conceptualisation of empowerment emphasises actual power increases both materially and symbolically hence avoiding the cognitivist and decontextualised focus on an individual's sense of or views of empowerment. Its emphasis on the social structural factors also makes the personal political instead of making the political personal which leads to the act of blaming the victim (Riger, 1993 in Sonn & Quayle, 2014). Cornish, (2006) points out that determining a person or group's level of empowerment or disempowerment requires specification of the domain of activity in which a person or group has the power to act because the powers and disempowerments that people go through and enact are multiple and contradictory.

Sonn and Quayle (2014) point out that participation, conscientisation and social change are also vital for empowerment. A community psychology view emphasises that

participation is a key mechanism for empowerment. It can foster democratic decision-making processes to subvert traditional power relationships and support community engagement (Kagan et al. 2011; Nelson & Prilleltensky, 2010). Concerning this, other scholars highlighted that through participation individuals and communities can identify social and cultural resources that can be mobilised for social identity construction and community making (Campbell & Jovchelovitch, 2000; Sonn et al., 2002; Montero, 2009;). Nelson and Prilleltensky (2010) stress that while it is vital to recognise the benefits of participation and to promote participation as a key value of community psychology, it is also essential to focus on the symbolic and material power relations that shape and constrain opportunities for and experiences of participation.

Christens, Hanlin and Speers (2007) also drew attention to the importance of getting the 'social organism thinking' when social change occurs through transforming the social imagination. These authors viewed cultural beliefs, ideology and shared understandings as pivotal in shaping the views that individuals hold about the systems and societies of which they are a part. However, they also noted that although individuals within systems are the bearers of social imagination, they are not totally responsible for the views they hold or for changing them. A social imagination accentuates that the potential to facilitate social transformation is constrained by social power, especially the capacity to shape ideology (Christens, Hanlin, & Speers, 2007). According to Sonn and Quayle (2014), the argument is that social imagination is of central importance to systems change which can come through a dialogical view of the individual and system. Sonn and Quayle affirm that transformative change is always achievable by creating opportunity for participation in processes of shared meaning-making, where cultural beliefs, ideology and shared understandings can be made noticeable, deconstructed and reconstructed meaning spaces for conscientisation.

According to Kasmel (2011), effective health interventions need empowerment-related processes and outcomes throughout multiple analysis levels. He further regards empowerment as a construct common in many disciplines and arenas, for example community development, psychology, education, economics, studies of social movements, and organisations. Thus, it becomes challenging to come up with a clear definition. Zimmerman (1984), in Kasmel (2011) has stated that declaring a single definition of empowerment may try to achieve it systematically and contradict the very concept of empowerment. However it is paramount to operationalise empowerment in health promotion. Rappaport (1984), cited in Kasmel, (2011), states that empowerment is a concept that connects individual strengths and competencies, natural helping systems, and proactive behaviours to social policy and social change. Also, it is simple to define empowerment by its absence but difficult to define it in action as it adopts different forms in different people and contexts. Czuba (1999) quoted in Kasmel (2011), proposes three components of empowerment definition, which are essential to any understanding of it as a concept: that empowerment is multi-dimensional, social, and a process. Its multi-dimensionality comes in the sense it cuts across sociological, psychological, economic and various other dimensions. Empowerment is regarded as a social process because it occurs in connection to others, and it is a process along the continuum. These aspects remain constant even though some other aspects of empowerment vary according to specific contexts and individuals concerned (Kasmel 2011). The understanding of empowerment is also fathomed differently among perspectives and context.

3.2.1 Historical Background of Women Empowerment

The initiatives for empowering women have a traceable record, and they were linked mainly to development purposes. Different approaches were implemented to empower women. In the 1970s, the Welfare Approach (WA) was dominant. This viewed women as

vulnerable, destined to be mothers and wives only. Its purpose was to include women in development as better mothers regarded as their most crucial role and it focused on women's basic needs related to their reproductive roles such as food, malnutrition and family planning. According to Pillai et al. (2009), in developing countries this approach has often been utilised as a process of tokenism or hand-out very cautious of avoiding meddling with societal norms and customs that have seldom been flexible towards women. This emphasis on women's reproductive role consequently constituted the perception of women as passive receivers of aid thus, the approach failed to change the position of women which led to the emergence of other approaches.

The Welfare Approach was succeeded by the Women in Development (WID) approach which emphasised issues of equity, anti-poverty and efficiency. The equity strategy emphasised reducing inequalities between men and women, thus regarding women as active participants in development (Valimaa, 2004). An anti-poverty strategy aimed at reducing income inequalities between men and women as poverty was viewed as a stumbling block to including women in development. The efficiency strategy focused on ensuring more efficiency and effectiveness in development through women's economic contribution. It was implemented during the industrialisation period; thus women were also included as part of the workforce. This approach shifted from the focus on women to development and it aimed at changing men's attitudes and ideologies so women could be fully incorporated into development as active agents. However, the assumption was that women were already active participants, which led to a lack of consideration of women's positions and relations in society in project implementation. Thus, once again, the position and relations of women in society were not addressed by this approach.

In the 1980s, the Gender and Development Approach (GAD) was developed, and this shifted focus from focusing on women to gender relations across time and space. GAD emerged from Third World women. According to Parpart (2000) in Buckley (2007), this approach considers power as it relates to gender and strategies for empowering women challenging the status quo. The difference between WID and GAD is evident in how GAD emphasises the distinction between practical gender needs and strategic gender needs (Moser, 1993). Women's practical gender needs are recognised between men and women and they refer to what women need to fulfil their roles and tasks, such as healthcare, food, access to childcare services, and others. Strategic gender needs connotes what women require to endure their subordination. These can only be met through sufficient policies to minimise inequalities, improve women's status, and promote equity. In that view, according to Richey (1994; 2000), empowerment can be achieved through challenging the status quo and the pre-existing notions of power relations.

3.2.2 The Process of Empowerment

Empowerment as a construct is formulated by different components which differ depending on the orientation of diverse scholars. This section will highlight the different constitutes of empowerment.

According to Kasmel (2011), the principle of empowerment as a concept is power that occurs at various levels. This helps to understand the term and its relationship to a community organisation. He further expounds that power is experienced at an individual level. It denotes one's ability to make decisions at the organisation level where it comprises shared leadership and joint decision-making. Czuba (1999) as cited by Kasmel (2011), notes that empowerment depends on power dynamics and expansion. Therefore empowerment becomes a procedure that cultivates power in individuals to apply in different facets of their lives on issues they

regard as important to them. A general historical view of power from Weber (1964) cited in Kasmel (2011), is the ability to make others do what one wants even against their will. However, in implementing empowerment, the recipients are the ones to determine what they want and what they are comfortable to do without coercion which points to community participation, one principle of Community Psychology. Kasmel (2011) points out that the second requirement of empowerment is to have the power to expand. The power that expands does not have a zero-sum conception which refers to a situation where power is vested in a selected few unwilling to share it. Instead it advocates for shared power in different interactions. Shared power may be called relational power, generative power, integrative power or simply, power. All these terms denote that gaining power should strengthen the power of others rather than diminish it such as with domination power.

Woodall et al. (2010) remark that, individual empowerment and community empowerment are distinguished; however, the concepts are highly interconnected because the latter builds from the former. Individual empowerment is also termed psychological empowerment. It possesses several attributes aimed at bringing out individual capacity, and these include establishing people's confidence or self-worth, boosting their esteem, developing their coping mechanisms or enriching their skills for them to make health-related choices. Psychological empowerment essentially refers to people's feelings and the actual sense of control over their lives which directly affects enhancing an individual's mental and physical health (Koelen & Lindstrom, 2005). Though this empowerment is vital for people to gain control over their lives, it is limited. It neglects the broader environmental influences on people's health, for instance, poverty and unemployment. Thus, the broader meaning of empowerment is not just restricted to individuals attaining skills for themselves, but it is also

about communities overcoming structural barriers and bringing change through collaboration, participation and collective action (Wallerstein, 2006).

Wallerstein (1992) in Woodall (2010), comments that community empowerment refers to a social-action process that enhances people's participation, organisations and communities towards the goals of increased individual and community control, political efficacy, improved quality of life and social justice. Focusing on community empowerment means concentrating on power relations and intervention strategies which eventually focus on challenging social injustice through political and social processes (Wallerstein, 2006). The main objective here is to allow people to control the decisions that influence their lives and health. Community empowerment may be regarded as both a process and an outcome; however, it is mostly regarded as a process in a continuum (Woodall, 2010). As a process, it can be viewed as a series of actions which progressively lead to more organised community and social action (Laverack, 2004).

Embraced in community empowerment is participation, regarded as an essential feature of the process. Participation gives individuals an opportunity to achieve their health goals by sharing ideas with similar others facing the same problem (Woodall, 2010). According to Laverack (2005), as individuals participate, they are likely to experience some degree of control as they are better able to define and analyse their concerns collectively and find joint solutions to act on their issues. Wallerstein (2006) reiterates that participation creates the backbone of empowerment strategies; however Woodall (2010) claims that participation on its own does not guarantee empowerment as it can often be manipulative and passive instead of being genuinely engaging and empowering.

As a process, empowerment yields empowerment outcomes as its results. These could be the redistribution of resources to rectify health inequalities or a change of policy in the interest of community groups that have collaborated to bring about that change (Woodall, 2010). Empowerment cannot be imposed on people; the concerned individuals should bring their own empowerment as they understand their own situation better than everyone else. Health practitioners and other professionals come in as collaborators and facilitators, not experts thus promoting the change of terms to enhance their relationships with the people in need. These professionals may create a situation where empowerment may be more likely, through facilitation and support. However, community empowerment can only be fully realised when groups of people gain their momentum, acquire skills and advocate for their change (Wallerstein, 2006).

Empowerment is a key concept in both Community Psychology and international development (Kabeer, 2005; Rappaport, 1987). In these disciplines, it is central to enhancing well-being and improving human lives (Zimmerman, 1995; Sen, 1999). The question then is what needs to be encompassed for empowerment to become effective in different disciplines. Across disciplines, it is widely agreed that empowerment processes encompass material resources and inequities in the environment, the individual's strength and a sense of personal control and the enhancement of well-being (Cattaneo & Chapman, 2010; Zimmerman, 1995). However, explanations of such differ from one discipline to another. A variety of literature has suggested that empowerment is a process whereby multiple components influence each other; however, much empirical research does not identify the multiple components or links (Cattaneo & Chapman 2010; Kabeer, 1999; Zimmerman, 1995). This study thus endeavoured to establish the relationships between the different components of empowerment.

According to Kabeer (1999), there are three interrelated components of empowerment: resources, agency, and achievements, which are critical in people's understanding of empowerment. Resources may be construed as material or social and are considered the medium through which agency or the ability to exercise choice is carried out. Achievements refer to agency outcomes. This approach is set apart from a singular focus on agency and highlights the profound importance of social context in empowerment processes. Other views emphasise strategic gender needs and practical gender needs as components of successful empowerment of women. Women's reproductive and sexual rights cannot be achieved by making women control their fertility alone. According to Batliwala (1994), it is of paramount importance to explain that efforts that address practical gender needs will also affect the possibility of changes in women's strategic gender needs. Approaches to women's reproductive health often overlook the importance of linking this with more fundamental questions related to women's status connected to strategic gender needs, for example discrimination against girls and women in access to food and healthcare, male dominance in sexual relations, women's lack of control over their sexuality, the gender division of labour that renders women little more than burden-bearers in many cultures or denial by many societies of women's rights to determine the number of children they want. Therefore, in this light, improving women's physical health issues does not necessarily mean empowerment will be guaranteed. According to Sciortino and Rosalia (1998), tackling underlying barriers to gender equality in all social spheres will grant women more power over their reproductive rights, act effectively to fulfil their needs and attain a high standard of health and development.

In psychology, early conceptualisations and investigations of empowerment focused primarily on individual psychological components such as perceptions of personal control giving limited attention to context and social structures (Perkins, 1995; Riger, 1993). Grabe

(2011) extends the investigation of empowerment out of the individual psychological realm by identifying various components of empowerment and specifying relationships among them, so it enables the formulation of a measurement model.

The components identified by Grabe (2011), include resources, ideology and agency. He stresses that structural power in which individuals have more control over resources than subordinates is one of the significant contributors to social inequalities. Institutionalised inequities in distributing resources contribute to power imbalances and gender-based norms that create an environment that legitimises and perpetuates women's subordinate status (Connell, 1987; Glick & Fiske, 1999). Research has demonstrated links between property ownership and women's negotiating power within the marital relationship, financial decision-making and receipt of physical and sexual violence in West Bengal, Nepal and Nicaragua (Grabe, 2010b; ICRW, 2006; Pandey, 2010). Such studies put forth a framework for investigating land ownership as a potential source related to women's well-being. According to FAO (2004), though in various states, women's property rights have improved but there are deeply entrenched social barriers which still prohibit women from taking advantage of opportunities to effectively exercise their right to own property (Narayan, 2005). Ideology refers to a cultural ideology that is, social rules, norms and values, that govern gender roles and play a critical role in how they are sustained (Glick & Fiske, 1999). Due to cultural ideologies surrounding gender, women's lack of access to institutional resources is a central locus of disempowerment not true for other disadvantaged groups (Malhotra & Schuler, 2005).

According to Social Dominance Theory, ideologies are functional and promote or maintain group inequality (Pratto et al., 1994). Thus, women's empowerment is likely to

involve an awareness of the socio-political environment that can lead to an emergence of new beliefs about the right to exercise capabilities and take advantage of opportunities in one's community. According to Grabe (2011), a combination of land ownership, organisational participation and more progressive ideology will relate to a greater sense of women' s agency, another component of empowerment processes. It is defined as the people's capacity to define their own goals and take purposeful action, a function of both individual and structural opportunities (Bandura, 2006; Kabeer, 1999; Sen, 1999). Therefore a combination of the three components is believed to constitute the empowerment process.

Rappaport (1984) stresses that empowerment occurs at diverse levels. The concept of empowerment is regarded as a process or mechanism by which people, organisations and communities attain control over their lives. The focus of many definitions of empowerment is efforts to exert control. The crucial components of the construct are participation, meaning collective participation with others to achieve goals, efforts to gain access to resources and some critical understanding of the socio-political environment (Zimmerman, 2000).

Community Psychology emphasises understanding empowerment beyond the individual level. However, it is of paramount importance to integrate levels of analysis and how they relate to each other to understand empowerment in its entirety (Zimmerman, 1990). The psychological argument behind this is that external conditions are necessary for empowerment, but material resources alone do not inevitably lead to empowering process if people do not have internal feelings of competence (Diener and Biswas-Diener, 2005). Rowlands (1998), coined the terms collective empowerment, personal empowerment and empowerment within close relationships which stresses that the empowerment process needs to take place simultaneously on all three levels, leading to women perceiving themselves as

able and entitled to decide. Therefore the empowerment process must be all-encompassing in terms of the necessary components that need to be included to be effective.

Critics have been laid however on the issue of overemphasising the agency component in empowerment processes. First, several reviews in international development literature have discovered that the majority of the research had used a narrow and limited range of indicators of empowerment by routinely assessing household decision-making as the primary indicator of women's empowerment because it reflects agency (Hill, 2003; Malhotra & Schuler, 2005). That women's decisions fall in the areas of household consumption and decisions related to child health, evidence that women play a role in deciding based on pre-existing gender roles says little about their ability to define their own goals and take purposeful action (Kabeer, 1999). More so, lack of contextual analysis does not allow an understanding that defines how agency is arrived at or, alternatively, what outcomes agency may influence. Many argue that together with individual agency, there must be an analysis of gender relations in understanding women's empowerment (Grabe, 2010). Gender relations are how power relationships between women and men are constructed and maintained (Malhotra & Schuler, 2005; Riger, 1993). According to Grabe (2010), a few studies paid attention to proxies, such as comparative education and income levels (Hill, 2003). Indirect measures of women's marital power overlook the psychological elements in nature or that index how power operates in the relationship (Greig & Kapman, 2003). Adding to this, the absence of a dyadic assessment leaves questions surrounding how gender ideology and power relations in the home may relate to women's agency. A comprehensive model of empowerment would explain women's ability to act with agency and how women's belief surrounding their capacity to exert control over their lives relates to their well-being.

Rappaport (1986) emphasises that the language of empowerment can lead to raised awareness. However, to grasp the concept of empowerment the first step to consider is to examine the concepts of power and powerlessness (Moscovitch & Drover, 1981 as cited by Lord & Hutchison, 1993). According to the Cornell Empowerment Group (1989), power is the capability of some individuals and organisations to produce intended foreseen and unforeseen effects on others. The critical sources of power include personality, property or wealth and influential organisations (Galbraith, 1983).

Rowlands' (1995) concept of empowerment is strongly linked to that of power. He stresses two perceptions of changing existing power relations, namely the zero-sum versus that of the plus-sum game. The distinction between the two is vital in terms of 'gains' and 'losses' when power relations change. Power is divided between the two as one part must gain whilst another must lose. In the plus-sum game, both parts of the 'game' gain on the changing power relations whilst in the zero-sum game, one gains and the other loses (Rowlands, 1995). This means that if men or politicians view women empowerment as a zero-sum game, they become threatened because of the potential loss of power to them. Hence, they will be bound to show resistance if women compete with men for power or challenge the patriarchal family relations of power, rights and the privileges of men within the family setup. Perceptions of gender within the plus-sum game are greatly affected by the constructivist ontology. Social and cultural beliefs are not static but created and acknowledged through human interaction. That roles of men and women are biologically determined ceases to be an issue; instead, the definitions of male and female is an on-going social process determined within each community (Rowlands; 1998). Such a perception of gender and of roles of both men and women as social and cultural constructions mitigates any assumption of automatic male privilege. It makes it possible to change the lower status of women.

Men's views about women empowerment are two-fold as it also depends on the social status of the concerned men and their orientation towards women in power. According to Batliwala (1994), poor men are not threatened by women empowerment as their opposites because they are as powerless as women. They support women empowerment as this can change their economic standing and bring the much-needed resources to their families. This view suites when one considers empowerment in development issues. Regarding this, women's empowerment will also lead to gains for men as they too by some means are oppressed by gender systems. Gender stereotypes may impede and restrict men's development potential. Therefore if men could go past gender stereotypes and express or discover their 'feminine' sides, it could lead to an increase in their well-being. In turn, women would be equal partners able to share 'male' work and responsibilities. In turn, men would become psychologically free from the 'oppressor role' which may have serious implications for them, and they may discover new ways of living.

If women empowerment is to be effective with the participation of men, then power relations between men and women should not be perceived as a zero-sum game in which empowerment of women will lead to a decrease in the power of men. This constitutes a significant obstacle to women's empowerment and unfortunately this is mostly the case in many societies. Rather, empowerment must be understood in relation to the plus-sum game and increase the overall power that exists in society rather than as empowerment against men. Women empowerment is viewed as an on-going process without a final goal and is affected by numerous power relations. It should not be initiated by family and community but should stem from women themselves. Therefore empowerment for women cannot be generated by someone for women. The only way is to capacitate women to claim empowerment

themselves. This is in line with Community Psychology principles of social action, community participation and that of empowerment.

Foulcalt operates with a power model constituted by multiple power relations so "power is considered to circulate and be exercised rather than possessed" (Mosedale, 2003, p. 7). Such a perception of power is in line with empowerment analyses as these require identification of those power relations constraining women's choice-making. Thus, more attention is to be paid to power relations perceived as nature-given yet are in no small measure social constructions. For instance, sometimes women are disempowered due to internalised oppression while some men exercise excess power on women because of internalised control. The two, if maintained, support inequality between men and women but can be mitigated through awareness and consciousness processes as women become aware of learning of their own interests and how these are related to those of others (Rowlands, 1995). This, therefore, asks for the empowerment of women to change such unequal distribution of power.

For Kabeer (1999), to change existing power relations and achieve social justice, there is a need to value agency which encompasses the ability to make choices. Power relations change over time and on different levels and are difficult to capture. This perspective of empowerment describes how power relations change and is within the feministic frame used to describe the equity objective that women should be able to make important life choices without being forced to choose according to norms, partners, family or any other deterministic factors. According to Rowlands (1995), empowerment is more than participation in decision-making. It also includes the process that leads people to perceive themselves as being able and entitled to decide. This is expressed by his concept of 'power within' that emphasises the

importance of women achieving self-esteem and self-confidence. These factors are crucial in achieving power.

Empowerment has been conceptualised as an iterative process whereby connections between components are likely to be reciprocal; however, evidence also suggests that there are pathways to empowerment, and changes in resources and agency that may lead to positive outcomes (Cattaneo & Chapman, 2010; Kabeer, 1999). Psychological evidence also notes that individuals' beliefs in their abilities to exercise control over events that affect their lives are related to human achievements and well-being outcomes, particularly to one's experience of self-worth and depression (Bandura, 1989). Grabe (2011) suggests that women's perceived autonomy and competence may be related to lower levels of coercion or intimidation from an intimate partner reflecting a healthier psychosocial environment. Within psychology, empowerment theory identifies subjective well-being as a fundamental part of empowerment (Zimmerman, 1990). Other arguments are that well-being indicators rather than more traditional outcome measures, for example, education or income levels (Hills, 2003; Malik & Lindahl, 1998), are critical to assess as components of empowerment.

Because subjective well-being heightens individual's probability of acting, a certain level of well-being is necessary to pursue a range of options. For example, employment that may have been previously denied to women. However, a woman may also be empowered but chooses not to participate in the domains typically assessed as empowerment outcomes such as politics and employment. According to Grabe (2011), subjective well-being, which is the level of self-esteem, depression, and psychological violence, are the primary components of the empowerment process. According to him, without the adoption of an empowerment view that recognises the importance of psychological variables, development efforts can fail even

though adequate material resources or opportunities have been provided. The control over resources that systematically privilege certain societal members over others may be an integral part of the process of empowerment (Grabe, 2011). While it may be possible that resources serve as catalysts for empowerment, empowering women requires a contextualised understanding of power in different dimensions. Resources may provide the material conditions through which inequalities are produced, but cultural ideology plays a critical way in how they are sustained (Glick & Fiske, 1999; Grabe, 2011).

Grabe's (2011) findings indicate that women with progressive gender ideology reported having greater relationship power and received less partner control. Thus, there is a possibility that women with greater awareness of their socio-political environments and who hold beliefs about their rights to exercise their capabilities exert more significant influence in their intimate relationships. Hence, higher levels of interpersonal agency are related to women's greater individual agency due to autonomy and internal feelings of competence. Therefore linking Grabe and Malhotra and Schuler's (2005) findings, there is a suggestion that it may be most useful to think about resources as enabling factors that may be critical catalysts in the empowerment process rather than an end in themselves. The design of empowerment programmes, therefore, should be based on the potential for transformative change and on outcomes that suggest women's more remarkable abilities to act on the structures of power that constrain their lives and not on unfruitful concepts in favour of a neoliberal globalised economy.

Different scholars bring out the different understandings of the empowerment process through how they define the concepts. Batliwala's (1994) definition of empowerment differs from that of Rowland (1998) and Kabeer, (1995), because she talks of it as an expression of

women's ability to control material assets, intellectual resources and ideology. According to Batliwala (1994) as cited in Mosedale (2003), empowerment can be achieved by making women aware of both their condition and their position. But Kabeer (1995) criticises women empowerment, which is directed towards power over resources, institutions, and decision-making. She states that power consists of controlling discussions, discourses, and agendas. Advocates for a feminist approach emphasise the transformative potential of power 'from within' so power is rooted in self-understanding that can inspire women to recognise and challenge gender inequality in the home and the community. She focuses on collective participatory action, which is the power to work with others (Parpart, 2000).

Empowerment is an important initiative; however, it is not always easy to empower vulnerable populations, in this case, women. According to Batliwala (1994), it may often be difficult to empower those women who are the most marginalised and poor though it is the aim of empowerment approaches. This is due to many resources needed to reach this group, and that poor marginalised and generally marginalised women do not have the strength and excess of energy needed to participate, for instance, in health programmes or even consider their reproductive choices and rights (Parpart, 2002). Thus, empowerment of women whose practical gender needs are already fulfilled and who to a greater extent are positioned to challenge unequal power relations and fulfil their strategic gender needs may eventually decrease gender inequality at societal level thus benefitting the marginalised and poor. However, this can be criticised from Rowlands' (1995) view that others cannot bring empowerment forward. This is also linked to Community Psychology's perception, which also emphasises that empowerment must come from the disadvantaged people themselves through their full participation and involvement.

The success of empowerment movement comes from changing people's perceptions about those forces that undermine the disadvantaged groups. According to Rowlands (1995), empowerment is not a matter of changing men's perception of women, but of changing women's perception of themselves. Marginalised women may have internalised oppression whilst men may have internalised control; thus, such mind-sets need to be changed for empowerment endeavours' to prosper. Women may achieve practical gender needs, but different life circumstances may be obstacles in achieving their strategic gender needs. Therefore, empowerment initiatives need to be initiated on both local and national levels if women are to change existing power relations with men. For instance, women empowerment needs political initiatives to provide for women's basic needs, such as access to health care services free of discrimination. However, such top-down approaches are not sufficient if inequality expressed by factors such as women's inability to make choices are not eliminated. Hence, the focus must be on addressing both practical and strategic gender needs if equality between men and women is to be achieved.

In examining HIV-positive women's empowerment process necessary for participation in PMTCT programmes, the assumption is that power structures within society may constrain women's choice-making. Only by perceiving these power structures and the resulting gender relations from a plus-sum game perspective can the existing gender inequalities be understood and restructured. Empowerment should be viewed as both a process and an end.

3.3. STRENGTH PERSPECTIVE

The theory of empowerment works hand in hand with the strengths-based perspective as the two cannot be separated in practice. According to Rankin (2007), empowerment is the

practice approach embedded in the strengths perspective. It consists of various techniques used by professionals to stimulate strengths within the client and their environment. A strengths-based approach is a philosophy for working with individuals, families, groups, organisations and communities (O'Neil, 2005), which is an ecological perspective that recognises the importance of people's environments and the multiple contexts that influence their lives (Saint-Jacques, Turcotte & Pouliot, 2009). This perspective recognises individuals' resilience and focuses on the potentials, strengths, interests, abilities, knowledge, and capacities of individuals, rather than their limits (Grant & Cadell, 2009). In this way, a strengths-based approach is seen to differ from traditional deficit models (Scerra, 2011). The strengths-based perspective comes in as a reaction to the problem-based approach utilised by many professionals whereby they would view clients as people with problems because of some weaknesses within them. This perspective views clients as partners with positives within them, which can be utilised in ameliorating their problems. These problems will be regarded as challenges to be overcome. . In this study, the strength perspective was meant to assist professionals engaging in PMTCT programmes to value their clients as people with strengths which can empower them.

According to Hammond and Zimmerman (2010), the inadequacies of the problem-focused interventions have motivated service providers to create a coordinated sequence of positive experiences and provide fundamental developmental anchor and opportunities. In reforming the traditional approach that was problem-oriented and risk-focused, a strengths-based approach endeavours to acknowledge the availability of strengths and capabilities in people who can positively transform their lives. However, there is usually a discrepancy between adopting a strengths-based approach and putting it into practise. A variety of helping organisations and individuals claim to be working from such a strengths-based perspective.

In reality the underlying set of values, principles and philosophy of a strengths-based practice will not materialise (Hammond & Zimmerman, 2010). In many PMTCT initiatives in Zimbabwe, women's strengths and capabilities seem not be considered.

In the past, human service agencies have focused on efforts to understand the biological or psychological and environmental risk factors that alleviate the chances of developing or maintaining at-risk behaviour and the potential implications for prevention (Hammond & Zimmerman, 2010). Interventions based on the deficit, problems or pathologies of individuals tend to direct the focus of helping organisations towards a single view of the individual. This has led to the conclusion that interventions, even prevention programmes, must focus on risk reduction by assisting those in need to develop more effective coping strategies or alignment with prescribed support resources.

The strengths-based approach is based on six key principles highlighted by Saint-Jacques et al. (2009) as cited in Scerra, (2011). The first principle is that every individual, family, group and community possess strengths rather than pathology; thus, there is a need to unveil those in times of facing challenges. The second is that the community is a reservoir of resources that must empower the concerned individuals. Third, interventions are based on the concerned individual's determination. The fourth is that collaboration is central with the practitioner-client relationship as primary and essential, however, in Community Psychology the term 'client' is not used. Thus, the relationship is regarded as that of partners. The other principles are that outreach should be utilised as a preferred mode of intervention and all individuals have the inherent capacity to learn, grow and change. In this study, adopting these principles reflects valuing rural women which can encourage them not to risk their lives and that of their children and partners.

Besides the principles highlighted above, Rapp, Saleebey and Sullivan (2008), came up with six standards for judging what constitutes a strengths-based approach. The first standard is that strengths-based practise is goal-oriented, thus, the affected people must set the goals they wish to achieve. Second, there is strength assessment so the focus should not be on the problem or the deficit but on what the people possess within themselves to address the existing difficulty or condition. The third standard refers to the resources within the environment because every environment has useful resources that the affected people can utilise. Thus, helpers must assist the concerned people in identifying and linking them to such resources.

There must be utilisation of explicit methods to identify the client's and the environmental strengths for goal attainment. These methods will be context-specific. Another standard is that the relationship should be hope-inducing. The strengths-based approach thus aims to instil hope in the concerned individuals by strengthening relationships with people, communities and culture. Last, there is a meaningful choice resulting from a collaborative stance between the concerned people and the practitioners. The people become the experts of their own lives, and the practitioner's role will be to increase and explain choices and encourage people to make their own decisions and informed choices.

The strengths-based perspective employs several approaches in its implementation. Approaches differ in how they conceptualise the problem at hand. For instance, most traditional change–focused interventions maintain the belief that an individual needs help because they have a problem that distinguishes them from others without the problem (Hammond & Zimmerman, 2010). Using the terminology 'having a problem ', suggests that the problem is inherent in an individual and expresses an important fact about that person.

The assumption that certain individuals have problems within themselves leads to trained helpers with a developed language for care providers to bring out a picture of the problematic areas of concern (Benson, Leffert, Scales & Blyth, 1998). This emphasis on deficits or what a person lacks leads to a cycle centred on what needs to be repaired based on prescribed resources or assumed solutions. This approach denies and limits those individuals facing the problem the chance to explore the strengths and capacities they might have in exploring, participating, taking control and learning (Heramn-Stahl & Petersen, 1996).

Thus, there is a need to empower the affected people by capitalising on their strengths by addressing them. In this study, the focus was on women's strengths in trying to prevent transmission of HIV to their children. Therefore, the belief that the problem is the problem; the person is not the problem is crucial from a strengths perspective. From this view, one would be trying to externalise the problem separating it from the person, hence giving the individuals a responsibility to tackle their own problem. Often people are crippled by structural, cultural, social, political and economic forces thus considering and exploring the broader context in which experiences take place enables an individual better to fathom the determinants of the problem, and it helps to address debilitating blame (McCaskey, 2008).

The strengths-based approach does not deny that people face challenges and problems and that these issues require to be considered with a more holistic approach (Hammond & Zimmermann, 2010). However, prioritising the problem and focusing on what is lacking, for instance, among rural women, creates a dependency on the helping professions with lowered positive expectations and blocked opportunities for transformation. This then leads to a process of disempowerment which is shown through labelling thus limiting options, lack of recognition of the concerned individual’s unique capabilities and strength, lowered self-

efficacy, not valuing diversity, prescribed programming as opposed to women-focused approach, focusing on the negatives to explain difficulties and an incredible way of reflecting cause and effect (Hammond & Zimmerman, 2010).

Some researchers have criticised strengths-based approaches, stating that they are not new or different from many other traditional approaches (McMillen, Morris & Sherraden, 2004) and that they are not based on evidence of efficacy (Staudt, Howard & Drake, 2001). Indeed, as interest has grown in this perspective, members of different disciplines try more positive approaches and use different words to describe it. For example, in mental health, there is a strong focus on recovery and positive psychology which is an inherently strengths-based perspective (Petersen & Seligman, 2004). In community development, the term 'asset-based' is used to describe communities as areas of potential rather than areas of lack (Kretzmann & McKnight, 1993). Prevention practitioners use words such as resilience to describe an individual's ability to function well and achieve goals despite overbearing stresses or challenges. For practitioners, these differences in terminology can often lead to confusion and misunderstanding; however, the basic assumptions remain the same for all.

3.4. ECOLOGICAL MODEL

Linked to the two perspectives discussed above is Bronfenbrenner's 1979 Ecological Model, which stresses that an individual's functioning is affected by the systems around them: the environment. This is linked to Kurt Lewin's equation which states that behaviour is a function of the person and the environment. In Community Psychology, this model is used with Kelly's Ecological framework, which looks at how individuals and settings are interrelated. Thus, to change behaviour, there is a need to change both the perception and the abilities of individuals and the environment's characteristics. Hence in this study, where the

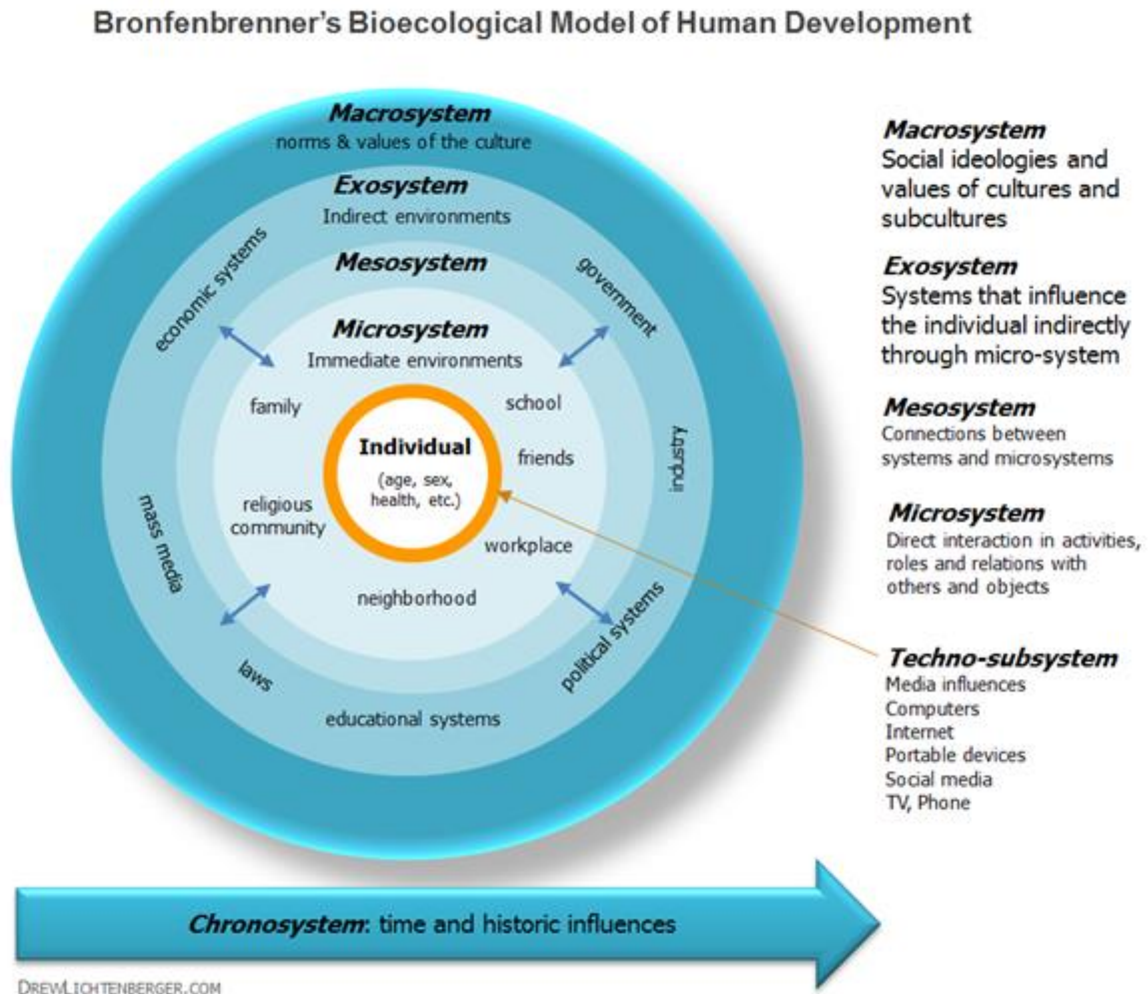
researcher, based on previous research, had the notion that socio-cultural factors hinder rural women's full participation in PMTCT programmes, the ecological model was utilised to create a platform for suggesting strategies that can be employed in making the environment of rural women conducive for full participation in PMTCT programmes.

According to Naidoo, Shabalala and Bawa (2002) in Nicholas (2003), in Community Psychology, human behaviour is viewed from an ecological perspective which upholds that all behaviours are performed in a context or setting. Therefore, it becomes paramount to understand the interrelatedness between an individual and their environment, specifically the person-environment fit. In this sense, the person and the systems surrounding the individual can be understood only if they are analysed as part of a multi-level, multi-structured, multi-determined social context (Bronfenbrenner, 1979; Rappaport, 1977). According to Reiff (1968) as cited by Naidoo, Shabalala & Bawa (2002), six levels of analysis include the individual, family, group, organisation, community and society. Naidoo, Shabalala and Bawa indicate that in adopting the ecological approach, the objectives of community psychologists are to differentiate between the different systems found within the ecological environment of the targeted population; to have insight on how the transactions between the individual or particular community and their social environments affect their development; and identify how individuals or communities are influencing their social environment and also to contemplate the future impact of individuals on their social environments.

Bronfenbrenner (1979) developed the theory of ecology of human development where he portrays that the ecological system components include the microsystem, the mesosystem, the exosystem, and the macrosystem. These systems are believed to be nested in each other, mutually influencing one another, impacting the individual's behaviour and development,

and are reciprocally influenced by the individual (Naidoo, Shabalala & Bawa, 2002). Therefore, when dealing with women from different cultural settings, one needs to know the systems surrounding them. Scileppi et al. (2000) asserts that understanding someone within their context gives a more holistic approach to behaviour, leading to a better understanding of both normal and abnormal or pathological activity by focusing on the setting. It also eliminates stigma and discrimination and labelling people negatively. Scileppi et al. emphasise that the ecological approach promotes a generation of multiple interventions at all levels to minimise problems in living and to establish an improved person-environment fit. The systems conceptualised by Bronfenbrenner (1979) are graphically shown in the following diagram:

Figure 3.1. Bronfenbrenner's Ecological Model



Adapted from hic.png

Accessed 23/05/2017 from

http://drewlichtenberger.com/wpcontent/uploads/2014/01/Bronfenbrenners-Bioecological

In connection to Kurt Lewin's ecological equation, community psychologists believe that to change behaviour it is vital to modify both the views and capabilities of people concerning the characteristics of the environment (Naidoo, Shabalala & Bawa, 2002). For instance, if there is a need to involve women fully in preventing mother-to-child transmission of HIV initiatives, three types of concerns should be addressed. First, they must be empowered

with knowledge on the meaning of such initiatives and how they can deal with stigma and any other challenges they may encounter. Second, it is important to change their conviction about being pregnant whilst HIV positive thus instilling hope in them. Issues here include self-esteem, individual empowerment, assertiveness, and contending with others' undesirable reactions. Last, contextual factors such as awareness programmes on PMTCT must be implemented to be better equipped and supportive to such women. This synergy of interventions at different levels augment the desired outcome.

In Community Psychology, Bronfenbrenner's concepts are utilised with community psychologist, James Kelly's ecological analogy. Kelly's framework differed from that of Bronfenbrenner because he did not focus much on how diverse levels of the environment may affect the individuals but on having an insight on how communities function. He proposed four principles that govern people in settings namely, adaptation, succession, cycling of resources and interdependence (Kelly, 1966; Trickett, Kelly & Todd, 1972). Adaptation means individuals' behaviour is acclimatised to the demands of the surrounding context in which they adapt to the restrictions, constraints and quality of the environment, while the environment adapts to its members (Kloos et al. 2012;, Capponi, 1991). Succession comprises a long-term time perspective and draws attention to the historical context of a problem and the urge for planning for a preferred future. This principle is based on the fact that every setting has a past that formed existing structures, norms, attitudes and policies, thus any intervention in such a setting must appreciate this history and an understanding of why systems exist in the forms they do (Watzlawick, Weakland & Fisch, 1974).

The cycling of resources focuses on the identification, development and allocation of resources within systems. A resource perspective emphasises a focus on strengths of

individuals, groups and institutions found in the setting and interventions are more likely to become effective if they build on such existing strengths, rather than introduce novel external mechanisms for change (Zimmerman, 2000). Resources may be personal, for instance, individual talents, strengths or specialties, or social, such as shared norms, beliefs or values, resting places, library and other qualities of the environment. This principle suggests that the community can be a valuable resource to women involved in PMTCT initiatives. The last principle, interdependence, asserts that the different parts of an ecosystem are interconnected and that changes in any one part will have ripple effects on other parts of the system (Zimmerman, 2000). Thus any intervention needs to anticipate its impact across the entire setting and be ready for unintended consequences. For instance, in this study, the parts may include women, the family, the community, religious affiliation groups and nation amongst many others. The ecological approach, therefore, draws attention to the three interdependent levels of analysis namely personal (micro), relational (meso), and collective (macro) which are all interconnected with each smaller level nested within the larger levels. The crucial implication of the principle of interdependence is attending to unintended side effects of a system change.

The ecological approach is very valuable in providing a systemic and holistic perspective for acknowledging human experience and behaviour. It has led to developing a variety of ways of understanding and assessing human environments. However, Kloos et al. (2012) assert that community psychology has been focusing on micro and meso levels to the neglect of macro-level structures and interventions. Inattention to the macro level of analysis is not a limitation of the ecological perspective, but a gap in the extent to which community psychologists have focused on larger social structures. Another limitation of this perspective and the systems perspective is that in their emphasis on circular causality and

interdependence, they do not consider or highlight power differences within ecosystems. For instance, women's disempowerment can be understood in terms of an ecological perspective with multiple layers of influence; however, it is also important to recognise that some players have more power than others in any ecosystem and those individuals who abuse power must be accountable for their actions. Disempowered women are not architects of their own abuse; thus, there is a need to complement the ecological metaphor with the concept of power (Trickett, 1994). This study managed to do this.

3.5. THEORY OF LEARNED HELPLESSNESS

The theory of learned helplessness that Maier and Seligman coined in 1976, was also used in this study to bring out the plight of rural women concerning HIV and AIDS. Maier and Seligman proposed this theory in their study with trapped animals that could not take simple actions to save themselves from electrical shocks. This also applies to humans. According to Rowlands (1998), women experience what is termed 'internalised oppression' whereby they believe that socio-cultural factors dictate everything to them regarding their reproductive health even at the expense of their lives. Some women believe they cannot change their situation; thus, they perish because of such misconceptions.

3.6. PHILOSOPHICAL UNDERPINNINGS OF THE RESEARCH DESIGN

This section looks at the philosophical foundations of the study's research design and focuses on the research paradigms that influenced the selection of the methodology and research methods utilised.

In this study, the paradigm played a crucial role in providing structure and direction of how the research was undertaken and how the results were interpreted. The study utilised a mixture of the interpretivist and positivist paradigms with the former having its origins in

sociology. The latter originated in the natural sciences. The interpretivist paradigm assumes that people are social performers within their environment; this promotes the idea that subjective thought and ideas are valid and led the researcher to explore the subjective views of the community and other professionals on PMTCT programmes. But the positivist paradigm assumes there is an objective reality out there which should be sought and proven. To this end, the researcher utilised a survey where objective views were sought and where effort was put to establish the relationship between variables, for instance, the relationship between age and rural women's willingness to participate in PMTCT initiatives. This study adopted a pragmatic paradigm whose proponents argue that it is not possible to access the truth about the real world by depending solely on a single scientific method. They advocated for a mixed method also utilised in this study.

The two paradigms combined in this study reflected the epistemological, ontological and methodological assumptions of the study. The pragmatic paradigm adopted a relational epistemology in which the researcher relied on scientific objectivity through questionnaires and subjective reality by acquiring participants' views on PMTCT using focus group discussions and interviews which could create a base for programme improvement. The study adopted a non-singular reality ontology that incorporated the objectivity of the positivist paradigm and the subjectivity of the interpretivist paradigm in giving a balanced understanding of ways that may be utilised in encouraging rural women to participate in PMTCT programmes. The researcher took into cognisance cultural, intercultural, and moral issues that could arise in conducting research and secured participants' goodwill. Thus, she adopted value-laden axiology in which she adhered to several ethical considerations explored in the methodology chapter.

3.6. CHAPTER SUMMARY

This chapter reviewed the theories and models which created the backbone of the study. The empowerment theory was the major one backed up by the strength perspective, ecological model, and learned helplessness theory. A close analysis of these theories and models reveal that they are interrelated. When people, in this case, women develop learned helplessness, there is a need to empower them by utilising their strengths. This should be done considering all the systems around them as they impact an individual's behaviour. Chapter Four describes the methodology.

CHAPTER 4
METHODOLOGY

4.0. CHAPTER OVERVIEW

This chapter details the research methodology utilised in illustrating how the strengths and weaknesses of the research design and research instruments were fused to benefit the study. The research questions and hypotheses informed the methodology adopted. Also, described are research instruments justifying their choice and how they contributed to the richness of the findings obtained. The researcher ensured that the research methodology was robust to minimise errors in data collection and analysis. For this reason, triangulation of research instruments was done, which included the use of questionnaires, interviews and focus group discussions. Data collection procedure and data presentation and analysis procedures, were also expounded, along with the trustworthiness, reliability and validity. The final section elaborates on the ethical considerations in making this study academically recognised.

4.1. RESEARCH SETTING

Figure 4.1. Map of Zimbabwe

The map above (Fig. 4.1) shows the physical demarcations of the study: four districts from three provinces highlighted in red. These four districts comprised different cultural groups, and most were far from the local clinics. This was done to ensure that they would fit into the inclusion criteria for the study. The districts included Masvingo Rural, predominantly occupied by the Karanga people, Chiredzi mainly occupied by the Shangaane, Umzingwane, predominantly occupied by the Ndebele, and Mutare mainly occupied by the Manyika. This selection endeavoured to capture the major cultural groups in Zimbabwe.

4.2. TARGET POPULATION

The target population was an estimated 3 000 Zimbabwean rural people from three cultural contexts, 100 community gatekeepers and 500 professionals from PMTCT-implementing organisations and local health centres. The statistics for the targeted rural people and community gatekeepers were drawn from the databases kept by local authorities that were unpublished. Those for the professionals were also based on the respective organisations' employee databases. The researcher targeted people who resided permanently in the chosen rural areas. Most of the Zimbabwean rural people are literate, unemployed, self-employed, and peasant farmers with the minority being illiterate. Most of the literate population have attained O' Level education which is secondary level education. Such people also have different convictions: some are traditionalists, others Christians which are two broad religions with diverse sub-groups within them.

The largest cultural group is Shona with sub-cultures, the second largest being the Ndebele; the Shangaane and other minority groups follow. According to the National Encyclopaedia, the Shona constitute about 82 % of the population of which the Korekore predominate in the northern side of the country; the Zezuru are in the centre around Harare, the Karanga are found in the south, the Ndau and Manyika in the east; the Kalanga are in the west. The Rozvi are spread throughout the country. People of the Ndebele origin (around 14%), who mainly migrated from the south occupy areas around Bulawayo and Gwanda. The minority (around 11 %) comprises the Tonga who mainly reside near Lake Kariba and the Sotho, Venda and Hlengwe mostly found on the southern border. The researcher, targeted groups of people who reflect the greatest part of multicultural Zimbabwe.

PMTCT-implementing organisations are usually Non-Governmental Organisations (NGOs), who work hand-in-hand with health professionals from the Ministry of Health and Child Care (MoHCC), found in local clinics which may be state-owned or church-owned. Thus the researcher targeted professionals from such organisations as they constitute some of the key informants who work closely with the rural people in PMTCT initiatives. These professionals do not just get access to the community without the permission of community gatekeepers who include traditional chiefs, councillors, village heads and kraal heads. Therefore, community gatekeepers were also targeted as the researcher assumed that they possess useful knowledge concerning the PMTCT implementers in their area and the PMTCT activities conducted in their areas. Their good relationship with the targeted participants also made them very relevant for the study.

4.3. SAMPLE SIZE

The researcher drew the following composition of the sample from the population highlighted above. The sample comprised 200 rural men and women aged between 15 and 60 years, plus 20 professionals and 20 community gatekeepers. The 200 rural men and women were randomly selected (elaborated upon later in the chapter). They comprised 98 women and 102 men. This sample was recruited through door-to-door visits hence due to the spacious nature of rural homesteads, the researcher could not attain a bigger sample than this. The professionals comprised ten midwives because they are the health professionals who are mostly involved in direct interaction and communication with pregnant women during PMTCT service process; the other ten came from implementing organisations which included National AIDS Council (NAC), Zimbabwe Community Health Intervention Research Project (ZiCHIRe), Elizabeth Glaser Paediatric AIDS Foundation in Zimbabwe (EGPAF – Zimbabwe), Médecins Sans Frontières in Zimbabwe (MSF–Zimbabwe) and Family AIDS

Caring Trust (FACT). Community gatekeepers included chiefs, councillors, village heads and headmen. The sample for qualitative data might not have represented the whole nation; however, it was beneficial for this study in providing a reflection of PMTCT services within the chosen communities. These sample sizes were advantageous because they permitted for optimum involvement and maximum elicitation of responses for each participant. The following are the inclusion and exclusion criteria for this study:

Inclusion criteria

- Men and women between the ages of 15 and 60 years. The men were randomly selected, and they were included in this study which primarily targeted women because they are also directly involved in PMTCT, a reproductive health issue. Empowerment of women without male inclusion would be equal to failure; however, the women would be the leading figures.
- Men and women who permanently resided in rural areas.
- Professionals who work in or with rural communities comprising midwives, social services officers from different organisations.
- Hard-to-reach communities which are remote rural communities which are not easily accessible due to poor road networks.

Exclusion Criteria

- Men and women within the 15 to 60 age group who did not permanently reside in targeted communities but were just visitors who could be identified by asking them their state of residence (that is, was it permanent or temporary) before including them in the study.

- School children within 15-19 age group were excluded even some who were under the PMTCT programme. They were excluded because the researcher did not want to disturb their school schedules.
- Doctors and other nurses not involved fully in midwifery.

4.4. SAMPLING PROCEDURE

This study was a mixed-method research with both qualitative and quantitative sampling methods. Multiple sampling strategies were adopted to ensure statistical significance and rigour depending on the data and nature of the specific population.

The researcher randomly selected four districts considering that each district was supposed to have its unique cultural background different from the others. In selecting the sample for the quantitative research component, the researcher employed a probability sampling technique, namely proportional stratified random sampling. Probability sampling gives all population elements an equal chance of being selected; this also strengthens the representativeness of the sample. The researcher chose this method because she needed an equal number of men and women per site and per age group. Specifically, the researcher selected twenty-five women and twenty-five men per site and three women and three men per age group. Basically the sample was divided into nine age groups: 15-19; 20-24; 25-29; 30-34; 36-39; 40-44; 45-49; 50-54, and 55-60. Therefore all the respondents for the questionnaire had an equal chance of participating in the study. It also helped in the analysis of data whereby the researcher aimed to test the relationship between age and participation in PMTCT initiatives and that between gender and participation.

The researcher employed two non-probability sampling techniques, namely quota sampling and purposive sampling. Usually non-probability sampling methods involve

judgment and select participants due to their easy accessibility. Quota sampling was used in sampling the rural women and men for focus group discussions because the targeted number was twelve women and twelve men for each of the focus group. Participants were drawn from those who had engaged in the survey. Specifically, the researcher used uncontrolled quota sampling because the selection was done at the participants' convenience. The second non-probability sampling method was purposive sampling which was utilised in selecting professionals and community gatekeepers whom the researcher assumed to be key informants or proximal agents in PMTCT issues in the community. They participated in the semi-structured interviews in all the districts. Both quota sampling and purposive sampling depend on the participants' convenience; this was appropriate for the study as some targeted people could not be reached because of other commitments or reluctance to contribute to the discussion on sensitive issues such as HIV and AIDS.

4.5. RESEARCH DESIGN

The research design was grounded in pragmatism and considered practical consequences or experiences of the world as vital elements of meaning and truth (Johnson & Omwuegbuzie, 2004). A mixed-method design gives a multi-dimensional approach in addressing the research problem by focusing on its diverse aspects or by tackling the same research problem from different perspective to give a more complex, comprehensive and accurate understanding and perspective. In this study, the qualitative approach is holistic and its fundamental aim is to understand social life and the meanings that people attach to it. The quantitative approach, on the other hand, focuses on specific questions or hypotheses and targets to describe reality objectively by measuring specific variables quantified through empirical methods (Delport, 2005). Thus because this study adopted interpretivist and positivist paradigms, it included two research approaches.

Data were sought from people of different ages and cultural background. Though the participants had some of the noted different aspects, they all shared the same social background: rural setting and most within child-bearing ages. Quantitative measures do not capture the subjective, often intangible nature of human existence; therefore, the qualitative approach, which tends to be open-ended, individualistic, and process-oriented, covered that gap. In this way, the study utilising focus group discussions and semi-structured interviews which provided detailed information about the different contexts accessed and emphasised the voices of participants, while quantitative methods in the form of questionnaires assisted in testing the empowerment theory through examining the relationship between different variables like age, culture, educational level and full involvement in PMTCT initiatives. Quantitative methods facilitated the possibility of replicating the study in other areas and generalising findings to the rest of the population and facilitating comparison of the different cultural groups in the study. They also provided insight into the breadth of the participants' understanding of PMTCT issues. Generally, the integration of these research methods helped in maximising their strengths and minimising their weaknesses.

4.6. DATA COLLECTION INSTRUMENTS

Data were collected through questionnaires, focus group discussions and semi-structured interviews. All the research instruments for the study were constructed by the researcher for data collection.

4.6.1. Questionnaires

The questionnaire was used for the targeted group to solicit quantitative data, thus testing the hypotheses. It was administered to rural men and women between the ages of 15-60 years of age. A semi-structured questionnaire with closed-ended questions and a 5 Likert-scale of agree, strongly agree, neutral, disagree, and strongly disagree was used. The Likert-

scale, was utilised to make it easy to quantify the data, and the questionnaire made it easy to employ descriptive statistics.

This instrument had four sections. The first asked about biographical data which had variables like age, marital status, the highest level of education attained and cultural background. These variables would be helpful to discover if they influenced participation in PMTCT programmes. The second section asked questions attempting to measure participants' level of knowledge of PMTCT programmes which could indicate the extent to which they had been empowered with PMTCT information. The responses from the third and fourth sections were measured using a 5-Likert Scale. The third section asked questions about the influence of cultural practices and beliefs on women's participation in PMTCT programmes. The aim was to ascertain if these factors have a disempowering effect on rural women's involvement in PMTCT programmes. The final section proposed strategies that may be utilised in women empowerment under PMTCT programmes. This was done with an endeavour to give the participants a platform to air what they wish to see being implemented under programming in PMTCT. The questionnaire was translated into the vernacular language of every cultural group. It was completed in the presence of the researcher and research assistants who could help in cases of ambiguity.

4.6.2. Focus Group Discussions

Focus group discussions were conducted with small groups of twelve people, and at each site, two discussions were held. One group comprised men only; the other comprised women only, to ensure that all participants could air their views and perceptions. Each discussion was conducted for about 30 to 60 minutes. The researcher developed a focus group discussion guide which provided basic questions to facilitate the debate. The questions focused on the general understanding of PMTCT issues amongst participants, the level of

involvement of both men and women, the hindrances to their participation, and the strategies they thought would empower rural women to participate fully in the PMTCT programme. The aim was to obtain a glimpse of the participants' realities which may help clarify participants' views on willingness to participate in community interventions.

4.6.3. Semi-Structured Interviews

Semi-structured interviews were conducted with two groups of people, namely professionals and community gatekeepers. The researcher developed two sets of the interview guides (Annexures 5 and 6) for the two groups. These questions were also structured in such a way that they did not lead or intimidate the participants and served to guide the discussions. The interviews with the professionals aimed to discover the degree of influence of cultural beliefs and practices on rural women's empowerment in PMTCT programmes and discover how much PMTCT implementing organisations are trying to collaborate with communities in empowering women. The interviews conducted with community gate keepers were utilised to unearth the extent to which communities are supportive of PMTCT programmes and get their views on how empowerment strategies in PMTCT initiatives can best be used in their contexts. Semi-structured interviews were chosen as they give room for further clarification or explanation of some misunderstood questions. They also demand objectivity from the researcher to ensure authenticity of the research findings.

4.6.4. Translation of Research Instruments

The research instruments that is the questionnaire, the interview guides for the focus group discussions and the semi-structured interviews were developed in English by the researcher. The instruments were to be used amongst people whose native language was not English; therefore, the researcher translated the instruments into the chosen communities' vernacular languages. These languages included Shona, Ndebele and Shangaane. The

decision to use vernacular languages implied that the inclusion criteria also had to incorporate the participants' preferred language. Using English implied that the researcher and her assistants would have a cumbersome job of translating the questionnaire of almost all the participants during data collection. Hence, it was efficacious to do the translation before data collection and considerate to give participants a questionnaire in their language. The English versions of the instruments were translated into Shona, Ndebele and Shangaane using the back-to-back translation procedure.

Three independent translators were assigned to translate the English version into any of the three vernacular languages mentioned above. The translated versions were then given to a group of community members in the target population to measure their degrees of congruence or equivalence to the measure's English version. Feedback from the community members was incorporated into the versions translated into local languages. Eventually, the translated versions were given to three sets of external translators to translate back into English. This was done to iron out the differences between the original and back-translated versions of the instruments.

Back-to-back translation has its strengths which include that it helps researchers who may not be familiar with the target language to scrutinise both versions of the source language as a way of evaluating the translation. Also, the involvement of community members in the translation is a welcomed strength as it supports valuing diversity in the community and appreciating the strengths of community members and promoting citizen participation from the onset. Its major weakness is that the evaluation is done in the source language only; however, independent translators in this study helped to compensate for this.

4.7. DATA COLLECTION PROCEDURE

In qualitative research, the primary research tool is the researcher; in quantitative research, the principal tools are the designed research instruments which have been tested. A researcher should strive to adhere to the data collection procedure as planned as this helps in data analysis and the trustworthiness and reliability and validity of the data.

4.7.1. Entry into the Community and Accessing of Participants

The first step in data collection was to get permission to enter the community. This was not an easy task. It is difficult to penetrate the rural communities as an unauthorised entry may be regarded as politically motivated. Thus, the researcher made sure that she acknowledged and respected community gatekeepers. The researcher sought entry into the community by writing an application to the Ministry of Local Government and Public Works. It took a month for her to be granted permission and when permission was given, she was asked to sign a declaration of secrecy. From there, permission was sought from the Provincial Administrator's office for every site entered; the process took around three to four weeks for permission to be granted. After obtaining provincial permission, the researcher had to get permission from the District Administrator's office for each site. Permission was then sought from the chief's office for every site again. Finally, before accessing participants, the researcher had to get permission from the village head for each village involved. The researcher reached out to four villages per site. The process was almost similar for accessing professionals whereby the researchers got permission from their head offices, provincial offices, and district offices. After obtaining permission to enter the community, the next task was to recruit participants. To lessen the burden, the researcher requested one of the community members to help recruit participants adhering to the inclusion criteria.

4.7.2. Data Collection Using the Questionnaire

Participants for the survey were recruited with the help of the village heads who identified the households with participants who meet the inclusion criteria. Thereafter, the researcher and her research assistants would move from one household to another, seeking qualified participants. Before participation, the researcher introduced herself and her team and explained their mission. Those who would show a willingness to participate were then made to sign consent forms before filling in the questionnaires. For confidentiality and anonymity, no names were required on the questionnaire. The questionnaires were completed in the presence of the research team so those who had challenges in completing the forms could be assisted, and to ensure it was the participants, not someone else, who completed the questionnaire. For those who were illiterate, interviews based on the questionnaire were done and the researcher or her assistants filled in the questionnaire. The researcher's roles, therefore, were to seek consent from participants, distribute questionnaires, clarify ambiguous questions, help those who are illiterate, and collect completed ones. To lessen the burden, the researcher employed three research assistants who helped execute the elaborated roles above. At the end, the participants were given a small token of appreciation for their time, this included a pen and $200 (Zimbabwean Dollars).

4.7.3. Data Collection Using Focus Group Discussions

For the focus group discussions, participants were selected with the help of community gatekeepers over and above those who were selected participants in the survey. The participants chose a convenient venue they could reach and where they could express themselves freely. The researcher organised transport to ferry participants from their home areas to the chosen venue. Focus group discussions were conducted during the most convenient times for the participants. Two groups were drawn from each cultural group. The

first comprised only women, and the second was only men. The researcher targeted twelve participants per site; however for unforeseen reasons, some groups at some sites ended up with a minimum of nine participants. Single-gender groups gave participants room to express themselves freely because in some cultures, women are not given a platform to open up in the presence of men. The one for females was facilitated by the researcher with a female moderator also taking down notes. The one for males was facilitated by a male research assistant and a male moderator.

The facilitators started the sessions by introducing themselves and the moderator. The roles of the note taker included making notes about issues being discussed, noting non-verbal communication and coordinating audio-recording. After the introductions, consent was sought with permission to use a digital recorder for capturing the discussion. The facilitator asked the participants to use pseudonyms of their own choice, to promote anonymity, written on name tags visible to everyone else for identification. In some areas where the facilitators were not familiar with the local language, translators were recruited.

The discussions started from the general to the specifics guided by a focus group guide (Annexure 4), which comprised ten questions. The discussions were between one to two hours; usually, those that required the help of the translators were longer. Some discussions took longer owing to talkativeness of participants. Issues of discussion included knowledge, attitudes and behaviours associated with PMTCT and the proposed ways of improving rural women's participation in PMTCT initiatives. Biscuits and juice were served to the participants during the discussions. At the end of the discussion, the facilitators portrayed gratitude towards the participants' involvement.

4.7.4. Data Collection Using Semi-Structured Interviews

Face- to face semi-structured interviews were conducted with the professionals and community gatekeepers. Twenty professionals and twenty community gatekeepers were involved in these interviews. Five interviews with community gatekeepers and five with professionals were conducted per site. Interviews with community gatekeepers were conducted during the week that focus group discussions were conducted then interviews with professionals ran for a week per site. There was no need for follow up interviews. The researcher and her assistants were interviewers, and they used audio-recorders to capture information and note-taking.

The interview guides (Annexures 5 and 6), consisted of open-ended questions for the two groups and the interviews took approximately thirty to forty-five minutes. The participants' talkativeness mainly determined the duration of the interviews. The interviews for the professionals were conducted at their workplaces after making an appointment with them. Those for the community gatekeepers were conducted at their places of residence at their most convenient time. Before conducting the interviews, the researcher and her assistants unpacked the study's objectives and sought consent for both willingness to participate and for accepting audio recording of the interviews.

Most of the community gatekeepers interviewed were men with only two females. This is because traditionally, men are the ones supposed to occupy positions of influence in the community hence this portrayed male dominance. The women in these influential positions occupied them because of the government's efforts to include women in leadership to empower women in national administration.

In trying to perform these duties efficiently, the researcher and her assistants had to develop skills for listening and interpreting information to ensure accurate recording of the phenomena under study. Consistent with Kelly's (2006b) cautions, the researcher and her assistants did not disturb the participants' natural context by entering carefully and interacting in an open and empathic manner.

Questions were asked in sequence, from the general to the specifics. When the interview ended, participants were assured of the researcher's availability if they needed any additional information and were also encouraged to write down any additional views they wanted to share. To complement the recorded information, the interviewers made field notes soon after the interview to capture any nonverbal cues or additional information acquired during the interview. Transcription was done soon after.

4.7.5. The Use of Field Notes and Records

Field notes and record-keeping were essential during focus group discussions. The research assistants took notes to alleviate the facilitator's (the researcher or the other research assistant) task. However, the facilitator also made field notes soon after the focus group discussion sessions.

Field notes for semi-structured interviews were done by the interviewer (the researcher or the research assistants) to avoid having a separate note-taker as this could have affected some participants' openness to the interviewer. In taking down notes, the researcher and her research assistants tried to adhere to the two practical rules for compiling field notes alluded to by De Vos et al. (2011) and Silverman, (2010) which include recording what they see and what they hear and expanding field notes beyond immediate observations. In taking field notes for focus group discussions, the researcher and the research assistants borrowed ideas

from De Vos et al. (2011), who emphasise the inclusion of the following in note-taking: seating arrangements; participants' order of speaking which aid in voice recognition; nonverbal cues such as eye contact, posture; gestures among group members; striking themes and highlighting the conversation as much as possible. The field notes complemented the audio-recorded data.

4.8. DATA PRESENTATION AND ANALYSIS PROCEDURE

The researcher employed a mixed method approach where she used both qualitative and qualitative research methods. Due to this, the data was analysed separately because of its different nature. However at the end, the complementary nature of the data was established. According to Polit and Beck (2010), the aim of data analysis regardless of the type of data or underlying research tradition, is to organise, provide structure and elicit meaning from data. The following sections will highlight how the data were presented and analysed.

4.8.1. Quantitative Data Analysis and Presentation

Data analysis was done using a software package (SPSS version 20.0) which also facilitated the presentation of data through tables, pie charts and graphs.

Quantitative data analysis occurs in stages. Stage 1 refers to data preparation which aims at converting raw data into something meaningful and readable. It comprises four steps: The first is data validation where the objective will be to verify if the data collection was done as per the pre-set standards without bias. This step has four sub-steps, namely confirming non-fraud practice, where the researcher had to confirm that the targeted respondents were contacted. The second step is screening, which asks for a verification of respondents' selection as per the research criteria. Particularly for this study, the researcher was present during the selection phase to confirm adherence to the criteria. The third step is procedure, where one

should check whether the data collection procedure was duly followed. The researcher and her research assistants met before data collection, discussed the procedure and agreed on how it would be followed. The researcher also monitored this during the fieldwork to ensure that it was being followed. The final step is completeness which asks for a confirmation of completion of all questions. After collecting the questionnaire, the researcher and her team would check if all questions were completed with the respondents still present The second step is data editing, where there is a check for errors like missing data, skipped questions or incorrectly filled spaces. This was done soon after receiving the completed questionnaire, and, where errors were noted the respondents were asked to correct them. If errors were identified without the presence of the respondents, the erred questionnaires were discarded if there were too many errors or if the error distorted the rest of the responses. The third step is data coding which refers to grouping and assigning values to responses from the survey. In this study, the researcher coded variables like age, gender, cultural background, education level, and marital status using different colour highlighters. The researcher categorised age into different age groups and colour coded them in preparation for analysis.

There are two common data analysis methods for quantitative data: descriptive statistics and inferential statistics. This study used both. Descriptive statistics or analysis is the first level of analysis which helps researchers summarise data and find patterns. The standard descriptive statistics include mean, median, mode, percentage, frequency and range; this study used percentage and frequency. These statistics provide absolute numbers but do not explain the rationale or reasoning behind such numbers; they are most useful when the research is limited to the sample when there is no generalisation to the target population. Descriptive analysis is also called univariate as it concentrates on one variable of analysis. To

compensate for the limitations of descriptive statistics, the researcher also utilised inferential statistics or analysis.

Inferential statistics are used to generalise results and make predictions about the entire population, such as correlation, regression, and variance analysis. The choice of these depends on research objectives. These statistics are complex analyses that reflect the relationship between multiple variables rather than a single one and may be referred to as bivariate analysis (when limited to two variables) or multivariate analysis (when there are over two variables). The researcher engaged in a bivariate analysis to establish correlations as follows: between gender and women's participation in PMTCT initiatives, culture and rural women's participation in PMTCT initiatives, age and rural men and women's involvement in PMTCT initiatives, highest level of formal education attained and women's participation in PMTCT initiatives, and rural men and women's levels of PMTCT knowledge and awareness and their involvement in PMTCT programmes. The chi-square test of independence that tests categorical data was used to establish relationships.

4.8.2. Qualitative Data Analysis

Thematic data analysis was used in analysing data from focus group discussions and interviews. The researcher followed the general steps found in qualitative data analysis. The first step is to familiarise oneself with the data through transcribing and reading the transcription. Audio recorded interviews were transcribed verbatim by the researcher and her research assistants within 48 hours of interviewing. The research team exchanged the transcriptions they had made and read them alongside the recorded sessions and notes taken during and immediately after the sessions to ensure representativeness and give room for amendments as necessary. An independent analyst further analysed all the transcripts. The report was compared with initial results for data analysis to ensure the credibility of the data.

This was followed by revisiting research objectives to match the research questions to collected data. The third step involved developing a coding or indexing framework to identify broad ideas, concepts, behaviours or phrases and assign codes to them. For this study, during the transcripts' careful reading, the research team highlighted key issues using colour coding. Initial codes were inductive as they were based on the participants' responses. The research team ensured that the coding framework had explicit boundaries, was not interchangeable or redundant, was limited in scope and focused explicitly on analysis. The fourth stage included identifying patterns and connections and themes, looking for the most common response to questions, identifying data or patterns that can answer research questions and finding areas that can be explored further. At this stage, the researcher utilised thematic analysis explained below.

According to Braun and Clarke (2006) one advantage of thematic analysis is its theoretical independence that can either be inductive or theory-driven. Despite this flexibility, the researcher followed systematic and rigorous guidelines to gain meaningful and useful results. Braun and Clarke stress that researchers should embrace this flexibility and ensure that the procedures of thematic analysis are theoretically and methodologically sound. In this study, analysis of the data was based on both the theory of empowerment and the experiences and general views of participants related to their willingness to participate in community-based PMTCT interventions. The researcher also adopted a semantic approach which emphasises extracting themes and categorising them according to explicit or surface meanings of data as alluded to by Braun and Clarke. Application of thematic analysis in this study gave room for qualitative data targeting to uncover the salient themes in the texts at different levels. Various steps were involved to ensure transparency in the data analysis procedure as described below.

A -six-step process was adopted to analyse data using thematic network analysis as proposed by Attride-Stirling (2001). The following table gives a synopsis of these steps categorised into three broad stages.

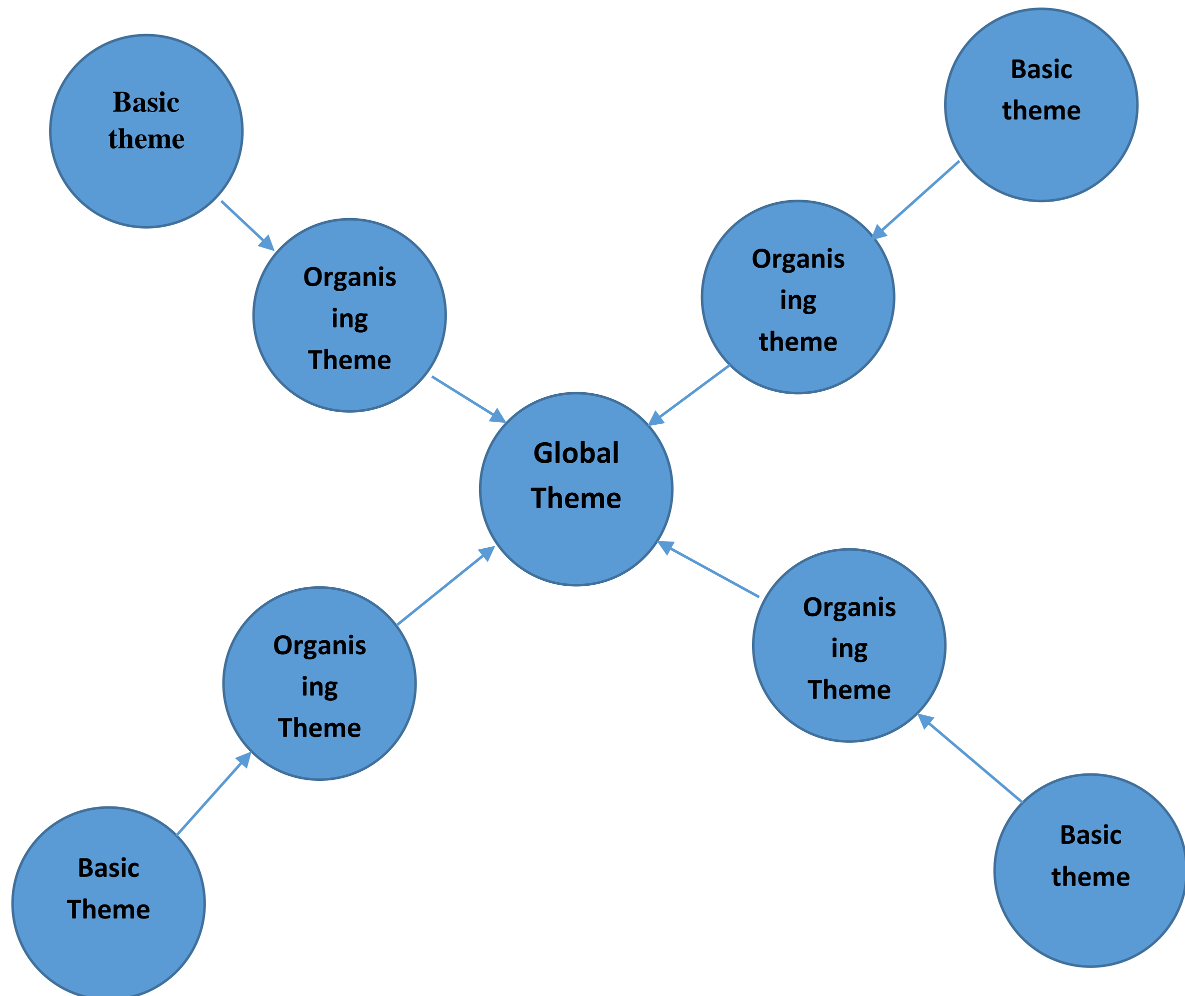
Table 4.1. Attride-Stirling's stages of thematic analysis

ANALYSIS STAGE A: REDUCTION OR BREAKDOWN OF TEXT
Step 1: Code Material (a) Devise a coding framework (b) Dissect text into text segments using this coding **Step 2: Identify Themes** (a) Abstract themes from coded text segments (b) Refine themes **Step 3: Construct Thematic Networks** (a) Arrange themes (b) Select basic themes (c) Rearrange into organising themes (d) Deduce global themes (e) Illustrate as thematic networks (f) Verify and refine the networks
ANALYSIS STAGE B: EXPLORATION OF TEXT **Step 4: Describe and explore thematic networks** (a) Describe the network (b) Explore the network **Step 5: Summarise Thematic Networks**
ANALYSIS STAGE C: INTEGRATION OF THE EXPLORATION **Step 6: Interpret Patterns**

According to Thithi (2014), thematic network analysis gives the reader web-like representations, as an organising principle, to demarcate the procedures used in moving from data to interpretation. The procedure systematically extracts themes from basic themes which are the lowest order premises found in the text to organising themes which are categories of basic themes put together to summarise more abstract principles to global themes which are super-ordinate themes encapsulating the principal metaphors in the text (Attride-Stirling, 2001).

In line with Attride-Stirling's systematic analysis procedures, the researcher started developing basic themes and moved towards a global theme. In a way, the analysis was moving from the general to the specific. After establishing the basic themes, they were then classified according to the fundamental descriptions told. These classifications became the organising themes which eventually helped to establish the global themes. The following schematic diagram represents the organisation of the themes:

Figure 4.2. Thematic Organisation



After abstraction of themes, the researcher refined them further into specific ones that were discrete yet broad enough to condense a set of ideas in several text segments as recommended in Attride-Stirling, (2001). The next step was to construct thematic networks; this involved organising the themes into similar, coherent groupings that created the foundation of the networks. These groupings formed the basic themes then grouped into

clusters based on shared issues leading to the emergence of organising themes. Rearranging basic themes into organising themes helped the researcher identify and label the underlying issues. A synopsis of the underlying claim, argument or assumptions of the organising themes was produced, and it formed the global theme of the network. Themes were then illustrated in a web-like presentation, as noted in Figure 4.2. This was crucial to ensure that the themes reflected the data, and the data supported the themes.

The next step explored and described the thematic networks which asked for a deeper meaning and a deeper level of abstraction. The researcher had to return to the original text and interpret it using the established networks to achieve this. These networks became a tool to anchor the interpretations. The fifth step involved summarising the thematic networks through the key themes that emerged in describing networks and identifying the underlying patterns of the text. In time, the researcher interpreted patterns. This involved collating the deductions in the networks' summaries and the theory to explore the themes and patterns that emerged from the texts. This was the final step of the analysis in which the researcher endeavoured to address the research questions taking into cognisance the assumptions of the empowerment theory that guided this study.

4.9. VALIDITY, RELIABILITY AND TRUSTWORTHINESS OF THE STUDY

Whether they are qualitative or quantitative, all studies need to be evaluated to ascertain the integrity and robustness of the research. However, each research approach employs distinct evaluation criteria to ensure the rigour of the investigation. Under quantitative research, validity and reliability are utilised to ensure the study's trustworthiness. Qualitative researchers consider credibility, dependability, transferability and conformability as the criteria for ensuring trustworthiness (Schwandt, Lincoln, & Guba, 2007). In this study

the researcher employed both qualitative and quantitative means of ensuring trustworthiness of the study since it adopted a mixed-method approach. The following section will look in detail at these ways of ensuring study trustworthiness.

4.9.1. Reliability

In this study, the researcher endeavoured to ensure the reliability of the questionnaire items through a pilot study and by using SPSS to measure internal consistency reliability. The questionnaire was tested for consistency among the Zezuru people, one of the sub-groups found in the Shona community. The researcher ran the Cronbach's alpha test using the reliability command in SPSS, and the alpha fell on 0.8, which is acceptable, and it reflected that the instrument items reliably measure the same latent variable.

4.9.2. Validity

The pilot study helped the researcher determine whether the test items covered the whole domain that the research questions and objectives wanted to cover. Ambiguous test items were removed from the measuring instruments. This study utilised three types of validity to assess the questionnaire's validity, including structural validity, face validity and content validity. Face validity is the most straightforward validity which refers to how much a research instrument looks valid and seems to measure what it intends to measure. In this study, participants in the pilot study, PMTCT experts and other academics helped ascertain face validity. Structural validity was also ensured by piloting the questionnaire. To ensure content validity, the researcher consulted her supervisor and other academics for their input and critique before finalising the questionnaire. For external validity, this study's findings will be generalised only to populations with similar cultural values and norms and live in societies similar to the targeted population.

4.9.3. Study Trustworthiness

Study trustworthiness refers to how qualitative researchers ensure that credibility, transferability, dependability and confirmability are evident in their studies. The researcher ascertained those four aspects were acquired in this study. First, the researcher and her assistants did their utmost to engage with the participants and relied on peer debriefers. Second, the researcher assessed the findings to check if they could be transferred to a different population. Third, for dependability, the researcher consistently monitored the research design by keeping an audit trail. Last, to acquire confirmability, the researcher maintained objectivity from data collection to data analysis and interpretation. All these steps gained study trustworthiness and authenticity and they will be explained in these paragraphs.

4.9.3.1. Credibility

Credibility may be regarded as the establishment of authentic research results related to the trustworthiness of findings in a qualitative study. It comes as an alternative to internal validity. To ensure this study's credibility, the researcher utilised a number of strategies that include prolonged engagement, persistent observation, triangulation, member checks, peer debriefing and structural coherence. The strategies have been detailed below:

Prolonged Engagement

This is the entry point into qualitative research. During this study, the researcher and her assistants involved themselves in the data collection. They wholly engaged the participants, showing an appreciation of their culture and language as the instruments were designed using vernacular language. The researcher’s full involvement allowed her to have an in-depth understanding of the people under study, detect misinformation and distortions, and ensure saturation of information. The prolonged engagement was also crucial for building

rapport and trust between the research team and participants, leading to obtaining rich, accurate information. The researcher and her team allocated themselves adequate time and resources to be in the field with sufficient time for data collection to ensure this. Reciprocally, the collection of accurate, useful and rich information on knowledge and involvement in PMTCT programmes was facilitated. This was useful in the establishment of study credibility. All this was done to enhance the nuance of prolonged engagement.

Persistent Observation

The researcher was in constant touch with her participants within their context. This helped in clarifying or discussing further issues about the research area of interest even after the main activities like focus group discussions and interviews were completed. To ensure this aspect was met, the research process was supervised and discussed continuously with the supervisor.

Triangulation

In this study the researcher made use of methodological triangulation, investigator triangulation and data triangulation. Methodological triangulation refers to using various methods for investigating the phenomenon of interest and searching for converging evidence from different sources. In this study, the researcher employed interviews, focus group discussions, questionnaires, notes and reviewing secondary data. Using these various sources helped in verifying the findings obtained from one source to another.

Data triangulation denotes the utilisation of several data sources in a study. In this study, the researcher worked with participants from diverse backgrounds that were differentiated based on culture, educational background and marital status to unearth the forces and different views that influence their involvement or non-involvement in PMTCT initiatives. As a backup, the

literature reviewed provided information on related studies conducted by other researchers on the same phenomenon. Investigator triangulation refers to using different researchers to draw focus on a researcher's previously unidentified researcher effects on the study's context. To ensure this, the researcher discussed her findings with her supervisor, research assistants, independent data analysts and colleagues to obtain feedback on her interpretations.

The researcher also made use of field notes to synthesise and understand the obtained data. They comprised observational notes, methodological notes, theoretical notes and personal notes. The research team recorded as objectively as possible observation notes which objectively described the context, events, behaviour and conversations with information relating to time, place, activity and dialogue. The notes were recorded whilst they were still fresh in the researcher and her assistants' minds to describe what transpired where, when and how. The researcher used methodological notes to provide instructions or reminders to herself on how subsequent data collection and observations were conducted and how some actions were undertaken. Polit and Beck (2012) also refer to theoretical notes as records that document the researcher's thoughts about making sense of what is going on. To attain this, the researcher endeavoured to understand what was going on whilst in the field through long time involvement with the participants and constant observation of the context. This was crucial for subsequent analysis. Last, the researcher employed personal notes that refer to comments about the researcher's own feelings in the field. These notes were utilised to give a picture of the researcher's reactions, reflections and experiences during the interviews and focus group discussions which provided insight into the experiences under study.

The triangulation process enabled the researcher to differentiate between relevant and irrelevant data. The fusion of the research methods assisted in enhancing diversity, enriching understanding and accomplishing specific goals.

Member Checking

Member checking enables participants to confirm whether the initial findings and interpretations follow their views and experiences as they relate them to the researcher. This process can be done during data collection or after data have been collected and analysed. During this study, this process was done amidst interviews and focus group discussions. The researcher and her assistants restated, summarised, paraphrased, and clarified the information received from the participants to ensure factual correctness.

Peer debriefing

The researcher discussed her methodology and findings with co-workers at the Women's University in Africa, colleagues at UNISA and with her supervisor as a way of ensuring study credibility.

Structural Coherence

The researcher took it upon herself to familiarise herself with the participants to create coherence. In coming up with the study report, the entire document's introduction and conclusions were closely connected to show coherence. The study was focused, paying particular attention to key questions, purpose and problem statement. Coherency of the document was also maintained by smoothly bringing out the transitions between paragraphs and sections. In addition, consistent formatting assisted in maintaining document coherency.

4.9.3.2. Transferability

According to Vos et al. (2011), the study's usefulness in other settings may be strengthened by utilising multiple cases, multiple informants or more than one data gathering technique. Some techniques that may be used for ensuring that data are transferable include rich or dense descriptions and purposive sampling. To achieve this, the researcher utilised triangulation, where she employed interviews, FGDs and field notes whose findings were compared with similar studies carried out nationally and internationally. Transferability was enhanced in this study by ensuring these aspects:

Dense description

The researcher endeavoured to provide sufficient descriptive data and analysis processes. The researcher extensively described the research findings backed up by direct quotations from community members and key informants, which included community gatekeepers and professionals involved in PMTCT programmes.

Sampling of Participants

To ensure credibility, the researcher carefully and diligently sampled the participants for qualitative research. Those who participated in FGDs were selected using quota sampling based on their gender to ensure that gender differences were catered for, which reduced bias in generalising the findings. Key informant interviewees were selected using purposive sampling, and these possessed different characteristics. All the participants gave room for more in-depth exploration and description of experiences regarding rural women's participation in PMTCT programmes.

4.9.3.2. Dependability

The researcher assured dependability by collecting, recording, transcribing and translating information accurately. The following aspects helped in enhancing dependability:

Dense description of the research methodology

The researcher gave a comprehensive description of the research design and methodology by describing the research design and its implementation reflecting the execution of planned strategies. Adequate information was provided for other researchers who might use the same methodology to confirm the conclusions.

Audit strategies or trail

The researcher kept all the data collection documents safely as evidence that the research was conducted. Systematic documentation of various methods used for collected and interpreted data about the phenomenon of interest was done to converge on an accurate representation of reality. Taking De Vos etal.'s (2011) ideas, the researcher used a logical research process well documented to provide a refined understanding of the research setting.

Code-recode Procedure

The researcher and her team immersed themselves in the qualitative data obtained and engaged in a code-recode procedure and step-by-step replication research method. This helped in coming up with themes that were labelled and categorised according to the level of analysis. Identifying themes and coding were so blended that the codes were never regarded as final and unchanging.

Triangulation

The study employed interviews, FGDs and field notes amongst a diverse pool of participants, including community members, community gatekeepers and professionals to converge on the truth.

Peer Examination

The researcher got assistance from a colleague who specialises in qualitative research for auditing. The enquiry auditor followed the processes and procedures utilised by the researcher in the study and determined they were acceptable ensuring dependability.

4.9.3.3. Confirmability

Confirmability is the alternative to objectivity or neutrality of data emphasised in quantitative research. This concept ensures that measures are taken to ascertain as far as possible that the study's findings result from the participants' actual experiences and ideas rather than the characteristics and preferences of the researcher (Shenton, 2004). Confirmability, therefore gives assurance that the data support the findings, consensus and recommendations. There is an internal agreement between the researcher's interpretation and the actual evidence. The researcher endeavoured to remain objective by internalising the findings of other studies in the field and giving a voice to the data rather than trying to force it into preconceived categories. To ensure this, the researcher maintained an open mind about other themes that emerged from the interviews without being restricted by the categories identified in the literature review. The researcher also shared results with stakeholders, research assistants and other academic experts to verify her findings. Confirmability was also supported through reflexivity and detailed description of the research methodology to permit the integrity of research results to be evaluated. It was also maintained through an audit trail

through meticulous storage of all records about the study for continuous reference. The researcher was guided by these aspects of confirmability:

Triangulation

The participants' views on rural women's participation in PMTCT initiatives were explored and described in a natural setting. The data were linked to their original sources which were only the community people, community leadership, and professionals working under the PMTCT programme.

Peer Examination

To verify the authenticity of the data, an independent researcher's scrutiny of the data was required. In that regard, the views and interpretations of the researcher, research assistant and peers working as a team were triangulated. An independent researcher analysed chosen transcripts and compared the coding of emerging categories and subcategories with those of the research team. The differences were discussed and resolved. In line with Polit and Beck's (2012) views, the findings portrayed the participants' experiences rather than the researchers' biases, motivations, and perspectives.

Reflexivity

The researcher appraised the project by evaluating the effectiveness of the inquiry process. The researcher took time and energy to analyse and document the data. She also scrutinised herself and perpetually asked questions about how previous experiences, values, background and prejudices moulded the research methods, analysis and interpretation. A reflective diary was kept throughout the fieldwork process.

Audit Trail

The researcher created an audit trail by gathering of data via interviews, FGDs and field notes helped by her research team. External reviewers thoroughly examined the data to establish the trustworthiness of the data and the meanings attached to them. The audit was complicated however this supported Polit and Beck's, (2012) view that it serves as a tool for persuading other researchers that qualitative findings were worthy of confidence. As evidence of research findings, the researcher stored all the collected data in a secure place with coding decisions.

The researcher endeavoured to use all the above criteria to ensure that the research was trustworthy and credible and that similar findings would be obtained if a similar study was carried out. However, this does not mean that the above criteria are not prone to distortions because all research is not immune from bias.

4.10. ETHICAL CONSIDERATIONS

Social researchers work with humans which makes their participants vulnerable. When there is contact and interaction between the researcher and people they are studying, the former should be guided by the specific governing boards' ethical principles. Ethical clearance for this study was sought and granted by the Ethics Committee of the Department of Psychology at the University of South Africa in 2015. Henceforth this doctoral study was conducted in accordance with the ethical guiding principles stipulated by the University of South Africa as well as the ethical code of conduct recommended for social research.

4.10.1. Access to Participants

As the study was undertaken in rural communities, the researcher had to first present the official identification from the institution of study to the authorities to acquire permission

to get to the people and to avoid being suspected of politically mobilising the community. The first undertaking was to get permission from Ministry of Local Government and Public Works' head office. After obtaining permission from the head office, the researcher had to also get permission from the Provincial Office followed by District Office. When these offices guaranteed permission, the researcher took the documents to the community gatekeepers starting from the chief, councillor to the village head. Accessing women for research in a rural community sometimes poses a challenge, especially when dealing with women’s sexual reproductive health and rights coupled with women empowerment. Men may take it as a step to challenge them. Thus, to handle such an ethical dilemma, the researcher visited the community gatekeepers first and informed them about the study’s objectives and asked for their permission to access such women. Besides getting permission from the gatekeepers, the researcher sought permission from the household heads before accessing the targeted people. In many contexts, men were the household heads, thus informing them helped in clearing out any suspicions. The researcher had to set aside a day per each community to seek permission to access the participants. The same protocol was followed even for professionals whereby access was granted from their respective head offices.

4.10.2. Informed Consent and Voluntary Participation

The researcher ensured that the participants gave informed consent. This was done through disclosing to the participants the scope and objectives of the study, its duration, the methodology and any possible psychological harm they might be exposed to. The participants were also informed that focus group discussions and interviews would be audio-recorded for transcribing and data analysis. They were also informed that the study’s findings would be published and that the report would be available to them upon request. Thus participants were expected to agree to be involved after being informed. They were also granted the right to

withdraw during the study with no adverse consequences. Participants' consent as given by putting their signatures on written informed consent translated in the vernacular for the rural community. Those who could not read and write the consent forms were read out to them by the researcher or research assistants then they would then put their thumbprint as a symbol for their signatures. Participants below the age of eighteen had to sign assent forms attached as Annexure 2 and also their parents, spouses or legal guardians had to give written consent. No one was forced to participate in this study. This can be verified by the informed consent form (Annexure 1).

4.10.3. Privacy, Confidentiality and Anonymity

The ethical principles relating to privacy, confidentiality and anonymity were upheld. Privacy points to personal privacy and confidentiality, which implies handling information in a confidential manner (Strydom, 2005). The researcher treated all information as private and confidential and she safeguarded the participants' identity. Privacy and confidentiality were ensured by storing the responses in a safe place and avoiding sharing the findings with any other person without the knowledge and participants' consent. The participants were informed of shared confidentiality between the researcher, the supervisor and the university team. Anonymity was maintained by numbering questionnaires without using the participants' names; hence there was no identifying personal information on the questionnaire which ensured that the information obtained remained not only anonymous but private and confidential. During focus group discussions pseudonyms were also used to protect the identities of participants and to maintain anonymity. No pictures were taken to maintain the privacy of the participants as well. These principles were highlighted to the participants initially and it helped them to express themselves.

4.10.4. Respect for Human Dignity

Consistent with the principle of Community Psychology of valuing diversity, the researcher endeavoured to understand the cultural values, belief systems and practices of the participants and showed respect and value towards them. The researcher collected data from some participants whose cultural practices and language differed totally from hers. To avoid conflict or disgruntlement from the participants, the researcher and her team put effort into learning some of the basic cultural practices or language like their way of greeting before commencing data collection. In such contexts, the researcher also utilised local translators who facilitated interaction between the participants and the researcher, which made communication easy and comfortable. All this was done as a way of trying to understand behaviour within its cultural context.

4.10.5. Minimising Risk to Participants

Participants were assured there were no obvious anticipated risks in participating in this study. The researcher ensured that the participants were not exposed to either psychological or physical harm. Issues regarding HIV and AIDS, if not handled well, may cause psychological harm through discomfort or embarrassment. The data collectors were trained to conduct and administer the questionnaires and focus group discussions honestly and respectfully. The researcher also safeguarded the participants by ensuring they were contacted at the places where they were comfortable. Those who participated in focus group discussions were asked beforehand if they were comfortable with their group members. They were also granted the right to leave the group anytime they felt uncomfortable without any negative consequences. The researcher closely monitored the participants during focus group discussions for any signs of distress or discomfort. Similarly, the research assistants were reminded about their right to safety and to withdraw from any situation in which they felt

threatened or uncomfortable during the data collection process with no adverse consequences. The researcher recruited a Clinical Psychologist on standby to attend to those who experienced severe emotional distress; however fortunately, no such cases occurred. At the end of the sessions, the researcher provided debriefing to the participants to clear out any grey areas and attend to their questions.

4.10.6. Right to Know

The researcher disclosed everything about the study to the participants and clarified they had the right to know anything that seemed unclear to them. Through debriefing, the researcher ensured that the participants got to know the outcome of their participation. The final copy of the whole thesis would be available to the community leaders upon request so that anyone who participated can have access to the study's findings.

4.10.7. Beneficence

This principle requires that the researcher attempts to maximise the benefits of the research for participants. One of the apparent benefits was that rural women who participated in this study benefitted by getting an opportunity to discuss issues relating to their sexual reproductive health in such a male-dominated society. All participants and stakeholders were also informed about the various benefits they would derive from the study. The research assistants gained the experience, acquired knowledge and practise that could benefit them in future work. For the community, the anticipated benefit would be that communities would increase their willingness to participate in PMTCT interventions leading to healthy communities and reduced maternal death through the shared views. The researcher also benefited by getting first-hand information and experience in contacting the community, working with them for a noble cause.

4.10.8. Scientific Honesty

Scientific honesty refers to the truthful practices commonly accepted within the scientific community to conduct and write research reports. In avoiding plagiarism, all sources and references used in the study were acknowledged. The research process and its subsequent findings were undertaken without the manipulation of data and information received from the participants during data collection and data analysis phases. Contributions received from specific individuals and which contributed to the successful completion of this study were duly acknowledged. The researcher maintained scientific honesty throughout the study by ensuring proper cross-referencing and listing all references at the end of the study report. The American Psychological Association (APA) referencing style was adhered to in compiling a report for this study. All the strategies and measures utilised by the researcher enhanced this study's trustworthiness and served to ensure its scientific integrity and credibility.

4.11. CHAPTER SUMMARY

This chapter encapsulates everything that was adhered to in shaping the methodology of the study. It also brought out the targeted population, sample and how it was selected, data collection procedure, research instruments, data presentation and analysis and the ethical considerations. The following chapter will present the procedure taken in conducting the pilot study and its findings.

CHAPTER 5
PILOT STUDY

5.0. CHAPTER OVERVIEW

This chapter will present the procedure followed in conducting the pilot study and the amendments made based on the findings. It will also highlight how such a procedure and findings helped gather data for the thesis. The pilot study was the first step of the practical application of the empowerment theory from a Community Psychology perspective in addressing the prevention of mother-to-child transmission of HIV and was conducted in April 2018. A brief discussion of the findings was done as these directly influenced the research itself.

5.1. OVERVIEW OF THE PILOT STUDY

The researcher conducted a pilot study after gaining a clear vision of the research topic and questions, the research methods and techniques to be implemented, and the outlook of the research schedule. The pilot study aimed to test the research techniques and methods that the researcher envisioned to determine their practicability. The research methods and instruments like the questionnaire, interview and focus group discussion guides were tested. The researcher constructed a closed-ended questionnaire with rural residents of the selected rural areas and facilitated focus group discussions with some participants who completed the questionnaires. In-depth interviews were also conducted with community gatekeepers like chiefs, village heads and councillors. Various other interviews were also conducted with professionals from various organisations involved in PMTCT within the selected districts. The pilot study was regarded as both a feasibility study and a pre-test of research instruments.

5.2. IMPORTANCE OF A PILOT STUDY

According to Blaxter et al. (1996) as cited in Calitz, (2009), a researcher may be disillusioned that pilot studies are unnecessary because of their exposure to research. However, they noted that each research is unique. Things may come out in the least expected way. This attempts to point out that to avoid wasting time and resources, a researcher must conduct a pilot study to confirm the research instruments' validity and reliability and the feasibility of the study itself.

Calitz (2009) quotes the three values of a pilot study laid out by Welman and Kruger, (1999), which also were the values of this pilot study. According to the mentioned authors, a pilot study is required to detect possible flaws in measurement procedures, including instructions, time limits, and operationalisation of independent variables. The value of a pilot study was apparent in this study. The researcher tested the questionnaire, interview guides and focus group guides. The practical application of these was piloted, and the researcher also noted the time to be allowed for each measurement. Also the pilot study identified unclear or ambiguous items in the research instruments, an essential value because the research instruments were self-developed and translated into the vernacular. Thus, there was a great need to ascertain that the instruments measure what they purport to measure. The pilot study also helped analyse the participants' non-verbal behaviour which may offer important information about any embarrassment or discomfort experienced concerning the content or wording of items in a research instrument. In this study, research instruments' questions were regarded as taboo in some cultural groups; thus, some participants especially women were embarrassed and uncomfortable responding to them.

The Nursing Standard (2002) highlights the advantages of pilot studies. It states that the advantages include that it can give advance warning about where the main research project can fail, where research protocols might not be followed, can identify practical problems regarding the research procedure and indicates whether proposed methods or instruments are inappropriate or too intricate. The advantages highlighted above were very relevant to this study. The pilot study helped the researcher detect practical problems, sessions and methods used, highlighted in the following sections.

The researcher's main goal was to determine the applicability of the empowerment theory in PMTCT programmes to improve the participation of rural women from different cultural backgrounds. Hence, the pilot study was used as a yardstick to determine the proposed methods and instruments' appropriateness. It also helped in giving warning where particular types of techniques were bound to fail. For example, the researcher noted that a focus group consisting of men and women was not effective as the two gendered groups could not freely discuss the issues at hand. Therefore, this pilot study was valuable in testing both research instruments' feasibility and the research process itself.

5.3. THE GOAL OF THE PILOT STUDY

Generally the goal of a pilot study is strongly connected to the aim of the leading research project to which it is attached. It is to offer information that can lead to the success of the study. Calitz (2009) cited De Vos (2002), Blaxter, Hughes and Tight (1996), and Van Teijlingen and Hundley, (2002), who stressed that researchers must pilot first before conducting the leading research as it saves time, effort and resources which may be lost if research fails due to unforeseen attributes. The goals of the pilot study, thus, were twofold. First, it aimed to identify all the practical measures that had the potential for distorting the

success of the research. Second, it endeavoured to resolve all practicalities related to research instruments and the applicability of these instruments to the expected outcomes of the study. These sections lay out the procedure followed in conducting the pilot study.

5.4. INTERVENTION APPLIED TO THE PILOT STUDY

According to Barnes (2016), five crucial steps should be followed when conducting a pilot study. First, there is determining where one has to decide on the data collection tools to be used, the settings and the sampling and participants. Second, there is assessment, where the researcher has to evaluate the methodology and assess the study's feasibility. Third, there is adjustment, where the researcher changes, replaces, deletes or refines items of the research tools based on the study's findings. Fourth, there is revisiting, which simply focuses on the reassessment of research tools after the adjustment. Finally, there is reflection, where the researchers assess their professional behaviour to ascertain if one was observing and adhering to the ethical standards required when working with participants, there is also the assessment of some personal qualities of either researcher or participants which might affect the outcome of the study and the study context which considers the social and cultural contexts in which the study was done.

In relation to these steps, the researcher also highlighted the outcome of the pilot study in line with the final intervention. The outcomes were divided into two categories specifically practical considerations and assessment of research instruments. These categories had to speak to the goal of the pilot study. Among the practical considerations were the procedure taken to select participants, the language used in gathering information, keeping the sessions active and time limit for each session.

5.4.1. Step 1: Determining Phase

5.4.1.1. Setting and Location

The pilot study was done in a rural setting in Dema District in Mashonaland East Province in Zimbabwe, amongst people from the Shona culture, specifically the Zezuru subgroup. Shona is a multicultural group; therefore, the Zezuru people were not involved in the main study. Instead, other sub-cultures from the Shonas participated. The professionals involved included those from the National AIDS Council, midwives from nearby clinics, and non-governmental organisations known as ZICHIRE. All these professionals were working within that rural community.

5.4.1.2. Selection and training of research assistants

To prepare for the pre-test, the researcher had to select research assistants. The selection criteria considered one's level of education pegged at possession of a first degree or Master's degree in social sciences and experience in social research. The researcher selected three research assistants (two males and a female). The three had to go through a one-day - workshop where they were given an overview of the research and practised using the research instruments. This workshop helped in wording questions which were not very clear through the discussion between the researcher and the research assistants. It also laid the groundwork for the team to familiarise themselves with the digital audio-recorders.

5.4.1.3 Selection of participants for the pilot study

The researcher's criteria for the pilot study were similar to the criteria employed for the full-scale research. Inclusion criteria considered that these variables which included age, gender, cultural group, permanence residence in the rural areas and maintaining an ethical approach to the group members were taken into cognisance. Regarding age, the researcher selected men and women aged from 15 years to 60 years. In most studies on HIV and AIDS,

the focal age range is from 15 years to 49 years. However, the researcher noted that people aged 50-60 may play a crucial role in encouraging young and middle-aged people to participate in PMTCT initiatives in the rural area.

However, age was not a selection criterion for community gatekeepers and professionals. In selecting participants for the questionnaires and focus group discussions, the researcher ensured an equal number of women and men. Once again this did not apply for selecting professionals and community gatekeepers, primarily because males occupy most positions of influence in rural communities. The pilot study selected participants from a particular cultural group, Shona, as cultural background was a variable of interest in determining how to empower rural women in their participation in PMTCT programmes. Specifically, the Zezuru subculture was selected but they were not part of the main study. The participants were selected from people who permanently resided in the rural areas, not people who had just visited. This criterion did not apply for professionals expected to be working with the rural folks but not necessarily residing in rural areas. Last, the participants were supposed to maintain dignity and respect towards each other during the study, particularly during focus group discussions.

Some who were excluded from the study fell within the age range of 15 to19 years but were still at school. This was done to avoid disturbing children's studies, and also, most questions did not apply to them. Women and men who had just visited the rural areas were also excluded from the study because the study targeted those deeply rooted in rural living. Some criteria were added to the final selection criteria based on the pilot study outcomes, which were highlighted in the previous chapter. The sample for the pilot study comprised 50 men and women from rural areas, four community gatekeepers and six professionals.

5.4.1.4. Duration of the Pilot Study

The initial plan for conducting the study was such that the researcher would gather data within a month per site, and this was also supposed to apply to the pilot study. The time was planned in such a way that one week was reserved for distribution and completion of questionnaires, one week was for focus group discussions with community members and interviews with community gatekeepers and the other two weeks were for interviews with professionals due to the spacious nature of the organisations. After conducting the pilot study, it was noted that with the help of research assistants, the time for interviews with professionals could also be reduced to one week. Hence the final allocation of time was one week reserved for questionnaire distribution and completion, one week for focus group discussions with community members and interviews with community gatekeepers.

Focus group discussions were allocated one hour each and interviews were allocated forty-five minutes to one hour each. The focus group discussions were reduced from three to two after conducting the pilot study as the third group which comprised both men and women reflected restricted contributions from female participants as some were shy to express themselves because of gender differences and also because traditionally men are expected to lead discussions with minimal interference from women. As for the interviews with community gatekeepers, the researcher finalised four semi-structured interviews per site: the researcher conducted one, and the research assistants conducted one each. The interviews with professionals were allocated a week and could run for forty-five minutes to an hour. Finally, the whole period for data collection for the main study was allocated three weeks per site. However, there was room for adjustment because every site had its unique challenges that could affect the time allocation.

5.4.1.5. Critical Issues in Accessing Participants

The process of selecting participants was not such an easy task. These paragraphs below explain measures taken or observed in accessing participants:

Observing Protocol

The researcher noticed that it was not possible to do the mini-study without observing the protocol. Therefore permission to get entry into the community was sought from national, provincial, district and local community levels. The pilot study helped the researcher to realise that one cannot just get into the community without the approval of gatekeepers from the highest level to the lowest. This was done to ensure the protection of the citizens and the nation's political arena.

Initial Entry into the Community

The first entry point into the community was to meet the chief and other community gatekeepers. This was done on a single day. However, these could only be met with the Minister of Local Government, Provincial Administrator and District Administrator's approval. The principal objective of meeting these community gatekeepers was to unpack the study's objectives and discuss how their area was selected. This served to remove any misconceptions associated with the study considering that participants would gather at one place for focus group discussions, which could have been mistaken for a political gathering. It was also done to make it easy for the researcher to get participants for the study. The researcher adopted this approach even in the selection of participants for the main study.

Time for Conducting the Study

The pilot study was done at the time that was most convenient for the participants. Where this pre-test was done, the researcher sometimes had to shift days of engaging participants due to their busy schedules. People in the rural communities struggle with punctuality issues. For instance, the researcher arrived early at the venue for focus group discussions but had to wait for nearly an hour for the participants to avail themselves.

Recruitment of Participants

In recruiting participants for the focus group discussions, the researcher noted that it would be easy to convene all the selected participants at one place. The researcher also noticed that it was easier to get a locally based person to recruit the participants for these focus group discussions. Therefore, the researcher requested permission to conduct the focus group discussions at the chief's place and requested one of the chief's aids to recruit participants based on the laid-out criteria. This minimised the task. However, for the professionals, the researcher visited their offices and conducted the interviews there. The same applied when distributing questionnaires. The researcher and her team moved from house to house within the selected villages and requested villagers who met the inclusion criteria to fill in the questionnaires and collected them as soon as they were completed.

5.4.1.6. Introduction of the Programme

In meeting the community members, the researcher had to follow the traditional way accepted in each area in introducing the programme. Thus, the researcher had to meet the traditional leaders first and inform them fully about the study before meeting the community people. After that, the traditional leaders would take the researcher and her colleagues to meet the people where the traditional protocol of greeting was followed. The leader then would

hand over to the researcher who had to unpack all details about the study for the participants. Then the researcher had to go through the consent form (Annexure 1), with the community members to gain informed consent; the data gathering would start afterwards. All these procedures were speaking to the main study; that for each site, the researcher was to take into cognisance the unique traditional way of meeting the people and introducing the programme.

5.4.2. Step 2 and 3: Feasibility Check and Reassessment of Research Instruments

5.4.2.1 Data Collection Tools

The researcher had to decide on the research instruments to be used, and these comprised a closed-ended questionnaire, focus group discussion guide and semi-structured interview guides. Data were collected using the vernacular language, and in this case, Shona was used as it is the primary language in the selected area. The research tools were translated from English to Shona by professional and accredited translators. The process by which translation was done was back-translation to recheck the translation's accuracy and improve its trustworthiness. The following sections will highlight the issues that arose from using the research tools and how they were addressed.

5.4.2.2. Assessment of the Research Instruments

The questionnaire had four sections. The first was on biographical data; the second was on the knowledge of PMTCT; the third on the influence of socio-cultural factors on PMTCT, and the last was on the suggested empowerment strategies that may be implemented in PMTCT initiatives. Based on the pilot study, four sections were relevant with a few amendments which will be highlighted. First, there was an omission of the variable gender on the biographical data. The researcher had to correct this and added the question on gender, as this was one of the variables of interest since the researcher wanted to compare males and females' responses concerning the research questions. There were also two questions which

needed to be corrected: Item 1.7: read: '**For how long have you been living in an intimate relationship with your partner?'** This question did not apply to other participants, yet there was no option of not applicable hence the researcher had to add that option. On the same question if a participant had chosen the option 'not applicable', there was supposed to be an instruction that he or she had to skip questions 1.8 and 1.9 as they were directly linked to 1.5. Item 2.10 read: **Were you and your partner tested the last time you or she was pregnant?** The option of 'not applicable' had to be added. Generally, the researcher noted that the questionnaire needed to be filled in the researcher or research assistants' presence to clarify questions that might sound unclear to the participants.

The instruments for qualitative data were well understood and well crafted. This could also be due to the flexible nature of qualitative research which gives the researcher room to probe further, slightly change the questions or clarify questions which might not be very clear.

5.4.2.3. Language of Participants

In conducting this pilot study, the researcher considered the participants' language. As mentioned, the research instruments were translated from English to Shona, a vernacular language for participants in the selected group. The focus group discussions were also conducted in vernacular and the researcher noted that it made the participants feel valued and respected. They could also express themselves in their home language, which helped understand the research instruments. The importance of language is that it is a means through which cultural norms and values are communicated. Hence, in this pilot study, the researcher managed to note how culture may sometimes influence the participation of women in PMTCT programmes through local language. Another observation made was that, in other sites where the participants' vernacular language was unfamiliar to the researcher, like amongst the

Ndebeles and the Shangaanes, it meant that the time allocation for sessions was bound to be longer as there was a need for translation.

5.4.2.4. Participants' Tardiness

The researcher set the starting time for focus group discussions around nine o'clock in the morning to allow the participants to move from their homestead to the chief's area. However, the sessions could not start at the set time because some participants were tardy. One reason was that they were coming from afar despite the researcher getting assurance from the local leaders that all the participants lived nearby; also for some it was just in their nature not to abide by the set time. The researcher had to wait for most the participants before being able to begin. This observation made the researcher revisit the initial plan of requesting participants to walk from their places to the meeting place. To attend to this problem, the researcher provided transport for participants to be ferried from their homesteads to the meeting place for focus group discussions.

5.4.2.5. Illiterate Participants

In developing the research instruments, the researcher assumed that all the participants would be able to read and write. However, during the pilot study, it emerged that some participants were illiterate. This affected the time allocated for some sessions like giving written consent and completing the questionnaire. Thus, in preparing for the main study, the research had to allow more time for those sessions to avoid rushing the participants without fulfilling the tasks.

5.4.2.6. Handling Participants who Lack Commitment and Motivation

During the pilot study, the researcher observed that some participants were impatient, and some showed little interest. To be specific, some male participants did not regard the

study of much value to them. Some talked of being delayed to watch soccer or do other activities and viewed PMTCT issues as women's issues. To get their attention, the researcher had to explain the objectives of the study to them and highlighted that it may not benefit them directly as individuals but could do so as a community or nation. Here, the researcher had to apply the principle from Community Psychology which points to valuing or instilling a psychological sense of community in the people. The researcher had to start the focus group discussions even when other expected participants were not yet there as long as the available ones constituted a quorum. This was done to avoid inconveniencing the participants, and it was adopted even in the main study.

5.4.3. Step 4: Changes in the Initial Piloting Study Plan

The researcher had to amend her initial piloting study due to the actual circumstances on the ground. This implied that the researcher should avoid a rigid plan for the leading study. Initially, the researcher wanted to conduct the pilot study among two cultural groups: the Shona and the Ndebele. However, after conducting the pilot study amongst the Shona, it was noted that the intervention was good enough to lay the groundwork for conducting the main study amongst other cultural groups.

The other issue relates to the number of participants per focus group discussion. Initially, the researcher aimed to have focus groups which comprised twelve people each; however the researcher had to reduce the number to ten or eight because some participants were tardy while others wanted to be dismissed early as they had other activities to attend to.

Regarding focus group discussions, again the researcher initially wanted the third group to comprise six men and six women drawn from the first group of women only and the second group of men only. But on the ground, the researcher noticed that women were not

participating freely in the mixed group due to cultural and societal constraints; hence the third group had to be eliminated in the main study.

On another note, the researcher wanted to conduct all four interviews with community gatekeepers; however on the ground it was observed that it would be cumbersome for the researcher, which could have negatively affected the collected data. Hence, the other three interviews were done by the research assistants. In brief, these were some of the main changes to the initial plan of the pilot study.

5.4.4. Reflections on Challenges Experienced During the Pilot Study

Reflections mark the final stage of the pilot study. Under this stage, the researcher encountered several challenges – ethical, cultural, social and professional – which she tried to address in connection to the principles of Community Psychology. The first challenge was how the researcher could position herself in the community without influencing the participants' responses. In their warning towards researchers, Thapar-Bjorkert and Henry (2004) stress that researchers should note their location and position as these can impact the research process, affecting the end product. Concerning this, Ismail (2018) talks of putting on different 'thinking hats' as a researcher to fit well amongst the researched. De Bono (1999) invented this idea, as cited in Ismail (2018) who talked of 'Six Thinking Hats'. These 'hats' influence one's decision- making from a diverse perspective, they promote thinking outside the box and obtain a more rounded view of a situation. Different 'hats' is closely related to the principle of Community Psychology, promoting collaboration and partnership. When researchers or professionals get into a community, they have to de-role and show value towards the community members as experts because they understand their situation better than anyone else. The challenge the researcher encountered concerning this, is that the participants regarded the researcher as an expert even when she tried to be just a facilitator,

partner and collaborator. However, through much effort, the researcher fitted on different 'hats' creating a free and conducive research environment. Eventually, the researcher perceived that when studying human experiences through direct interaction with the target group, one must always be ready to put on 'different hats' under various circumstances. This helped how the researcher interacted with the participants in the main study.

The second challenge encountered was that of using technological gadgets in data collection. For instance, the researcher and her assistants, audio-recorded focus group discussions and interviews and used laptops to capture views that were coming out. They observed that, using technology created a distance between the researcher and the participants, affecting that change of relationship between professionals and ordinary people from expert-client to the facilitator-partner relationship. Some participants, especially women, were not comfortable to engage in the discussions whilst being audio-recorded possibly because of their conformist social and cultural perspective. The researcher once again had to assure the participants of the ethic of ensuring privacy and confidentiality. From this experience during the pilot study, the researcher learned the importance of establishing rapport with research participants in the first encounter, which helped to gain participants' trust in the final study.

The researcher also had a challenge of some participants who wanted to maintain the expert-client relationship, which also created a barrier between the researcher and the researched. From the participants' social perspective, researchers are knowledgeable professionals who come to communities to deliver information; hence they are supposed to be respected and listened to without questioning or airing one's views. During the pilot study, some participants could not engage in the discussions because they felt the researcher 'knows it all and has come to teach us'. To alleviate this challenge, the researcher had to wear the

'hat' of a colleague and continually motivate passive participants assuring them they were at the same level as everyone else including the researcher. This also affected the main study where the researcher and her research assistants had to even dress in a way to make the community members feel they were on the same level. Based on the pilot study, the researcher also learned the importance of emphasising the value of what the participants know when research is being conducted as this makes them open up.

The other challenge was that of male dominance in the discussions and overall study where some males even tried to give women instructions. Others wanted to make women rush by completing the questionnaire to avoid wasting their time. In the focus group discussions, which comprised men and women, it was noted that most women were not free to air their views fearing receiving disapproval from their male counterparts. This had social and cultural connotations which value men's views more than those of women. To curb this and to avoid such an experience in the main study, the researcher emphasised that every participant's views was valuable with no wrong or right answer.

Another challenge was that of researcher bias and social desirability in research. The researcher noticed there were questions in the research instruments she thought had generic answers. Some participants assumed that the researcher expected specific responses. For instance one question in the research instrument was: '**Have you ever heard of PMTCT programmes?**' The researcher assumed that everyone knew about the programme, but in reality, not everyone knew of PMTCT. Also, some participants would first confirm with other participants their responses before directing the response to the researcher. For instance, one would hear participants saying to others; 'Is my response correct?' Therefore from these encounters, the researcher gained the skill of minimising bias in research; thus, the pilot study

taught her the importance of understanding one’s own bias and assumptions before undertaking the study. Essentially, as a researcher, one has to wear the ‘researcher hat’ to maintain objectivity.

5.5. POSITIVE EXPERIENCES OF THE PILOT STUDY

The previous section focused on the challenges encountered by the researcher in conducting the pilot study. However, positive experiences were also encountered during the process. This section will explore some of those favourable experiences.

First, the researcher did not struggle with the research instruments as they proved well-constructed especially after only a few amendments to the questionnaire. As for the focus group guide and the interview guides, there were no changes as the participants could understand them reasonably well and could relate well to the study's objectives and answer the research questions.

Second, the use of local languages in constructing research instruments was greatly welcomed by the participants. They felt valued and appreciated; some participants commented positively about this to the researcher. This was in line with several principles of Community Psychology including promoting a psychological sense of community, valuing diversity and empowerment. The participants became free in expressing themselves in their vernacular language.

Third, the researcher and her research assistants were warmly welcomed by the community gatekeepers, community members and professionals. This made research very interesting as most participants reflected a full commitment to the research activities that required their involvement. Also, a warm welcome from community gatekeepers encouraged

the rest of the participants, as such figures are highly valued and respected within the community.

Last, the positive regard that the participants directed towards the research theme, PMTCT, made the research experience enjoyable. The majority of the participants reflected keen interest in the issues discussed and constituted the questionnaire items. They showed that they had a great desire to learn more about PMTCT and to get constant updates. The participants valued this as it is an area of life and death, hence they were keen to be part and parcel of those who wanted to address the negatives hindering the progress of the programme.

5.6. LESSONS LEARNED FROM THE PILOT STUDY

Because of the pilot study experiences, there were lessons learnt about the research process from both personal and professional perspectives. These points give a synopsis of the lessons learned:

In conducting a study, it is crucial to translate the research instruments and consent forms into the target group's vernacular language. This assures participants they are valued. It matches well with the principle of Community Psychology, which stresses valuing diversity. When collecting qualitative data using interviews and focus group discussions, there is a need for the researcher to maintain flexibility and be ready to probe and elaborate questions where clarification is needed. One must therefore have good probing skills to avoid deviating from the demands of the original questioning.

The researcher endeavoured to analyse the audio recording of one interview and noted that it required nearly four hours to do a thorough analysis, which led the researcher to reduce

the number of interviews from the initially planned fifty-six to thirty for the main study to facilitate in-depth qualitative analysis.

Concerning data collection using the questionnaire, in the initial plan, the researcher targeted five hundred (500) participants. However, after conducting the pilot study, there was a need to reduce the number due to the sprawl of rural settlements. Because of this, it was difficult to get one hundred participants per site because it was too costly for the researcher. Therefore, for the main study, the researcher had sixty-two participants per site from two sites and sixty-three participants per site from the other two, a target not too difficult to obtain. Thus for the final study out of four sites the researcher targeted, she contacted two hundred and fifty participants; however due to some inconveniences she only reached out to two hundred participants for quantitative data.

The pilot study also taught the researcher that when conducting focus group discussions, it was critical to monitor the discussions closely to avoid deviating from the focus group guide's demands. On another note, there was no need for a focus group of men and women because of social and cultural norms that seem to restrict women from participating freely in the presence of men. The researcher observed that the group's contributions were not well balanced, hence she had to discard a mixed-gender group. For the main study, the researcher had two focus group discussions per site adding up to eight focus group discussions for the whole study.

In recruiting participants for the focus group discussions, the researcher made use of community gatekeepers for easy access of participants; however the selection was not objective because the recruiters thought that the researcher expected to get a certain criteria

of people enlightened on PMTCT issues. From such an experience, the researcher learnt that she should work closely with the focal people to avoid bias in the selection for the final study.

As a token of appreciation for the participants' time, the participants were given pens and refreshments. The items were inexpensive but greatly appreciated so much so that the researcher was invited to come back again for further research by the participants. Therefore, this gave the researcher the confidence that she could continue to show such appreciation even in the main study.

As for the theoretical framework, the pilot study confirmed that using an Empowerment Theory from the perspective of Community Psychology was relevant for this study. Generally, the pilot study revealed to the researcher that the study's methodology was feasible for its nature. Henceforth it was adopted confidently in the main study.

5.7. IMPORTANCE OF THE PILOT STUDY IN THIS RESEARCH

A pilot study is crucial for a well-planned study design. The benefits of a pilot study are unarguably essential for both qualitative and quantitative researchers; however, this is based on a well-defined set of aims and objectives that ensure methodological rigour and scientific validity. The pilot study proved very valuable in this research owing to several amendments it offered to the final study. Its importance addressed both the practical part of the study and constructing the research instruments for the final study. The pilot study also was important to the researcher's development of research skills thus, it offered a personal gain to the researcher. The researcher also identified some loopholes in the research instruments and the procedure that could negatively impact the final study had piloting not been done. Based on the pilot study's outcome, the final study created a firm foundation that may be utilised for future research.

5.8. CHAPTER SUMMARY

The undertaking of this pilot study unpacked issues from professional, social, ethical and cultural perspectives. The perspectives had two diverse aspects: the first being the investigator's viewpoint concerned with administering research instruments and encountering participants. The second was the viewpoint of participants: how they engaged with the study design and research questions. The pilot study helped the researcher unearth as many potential challenges and problems as possible, which alleviated several potential errors or problems for the main study. Also, this preliminary study helped the researcher construct a clear road map for the research which comprised data collection instruments, methodology, data analysis and theoretical framework. It also helped the researcher fathom that it is crucial to note ethical considerations when conducting research, which includes valuing other people's culture and traditions. The researcher was further enlightened about how to achieve the study aims and objectives through using diverse 'thinking hats' during the data collection stage depending on the presenting situation. From a professional perspective, the researcher also learned the significance of checking the participants' knowledge of instruments used for data collection, for instance, focus group discussions, as some participants might not be familiar with some of them.

This study taught the researcher that when conducting qualitative research, there is a need for flexibility and reflexivity that scrutinises both oneself and the research practice. These aid in acknowledging any ethical dilemmas, such as gender bias, that might permeate the research process and become a hindrance to the acquisition of knowledge. The chapter looked at the value and application of a pilot study. The following chapter covers the presentation and analysis of data from the primary study.

CHAPTER 6
RESEARCH FINDINGS

6.0. CHAPTER OVERVIEW

This chapter focused on outlining the presentation and analysis of the findings from both quantitative and qualitative research methods. The research study utilised a mixed-method approach in which data collection was done using questionnaires, interviews and focus group discussions. The initial part of this chapter will focus on interpreting and presenting quantitative data gathered from community men and women whose ages ranged between 15 and 60. The analysis was done using SPSS version 20.0. Quantitative data analysis was initiated by outlining demographic data through descriptive statistics and then testing the relationship between variables using inferential statistics. Data came from both nominal and ordinal variables. It will be presented through tables, graphs and pie charts.

To complement the quantitative data, the researcher also gathered qualitative data, analysed and presented in this chapter through thematic analysis. Different themes were drawn from the study and extrapolated with the backup of narratives from the participants. Qualitative data were drawn from the community members through focus group discussions and from community gatekeepers and professionals through semi-structured interviews.

6.1 RESPONSE RATE AND SAMPLE SIZE FOR QUANTITATIVE DATA

Quantitative data were collected from a random sample of 200, comprising 102 men and 98 women from different rural contexts in different parts of Zimbabwe. The researcher targeted 250 people, but the remaining 20% could not be reached. The data were collected using a structured questionnaire translated for each area's vernacular language to facilitate the communication.

6.2 INTERPRETATION AND PRESENTATION OF QUANTITATIVE DATA

6.2.1 Demographic Characteristics of Respondents

Item 1.1. Age of respondents (n = 200)

Table 6.1. Age of Respondents

Age range	Frequency	Percent	Valid Percent	Cumulative Percent
15 -19	20	10.0	10.0	10.0
20 -24	24	12.0	12.0	22.0
25 -29	25	12.5	12.5	34.5
30 -34	21	10.5	10.5	45.0
35 – 39	34	17.0	17.0	62.0
40 -44	35	17.5	17.5	79.5
45 – 49	16	8.0	8.0	87.5
50 – 54	13	6.5	6.5	94.0
55 – 60	12	6.0	6.0	100.0
Total	200	100.0	100.0	

Table 6.1 above reflects that most participants were within the age ranges of 35-39 (17%) and 40–44 (17.5%), which are age ranges that contribute to the most reproductive groups. The age ranges of 20–24; 25–29 and 30–34 which comprises highly reproductive people, had 12%, 12.5%, and 10.5 % respectively. The 15–19 age range contributed 10% of the respondents, which is moderate, indicating they are also

an age group that needs to be part of PMTCT empowerment programmes. The frequencies were going down as the age ranges increased and this could be witnessed within the age ranges of 45–49 with 8%; 50–54 with 6.5% and 55–60 with 6%. This could be due to the assumption that as people grow, sexual reproductive issues become less important to them. Hence the older generation had fewer people in this study perhaps they perceived PMTCT issues to be for late adolescents, early adults and early middle adults.

Item 1.2. Gender of respondents (n = 200)

Table 6.2. Gender of Respondents

Gender	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Female	98	49.0	49.0	49.0
Male	102	51.0	51.0	100.0
Total	200	100.0	100.0	

The study reached out to 98 women constituting 49% of the whole sample and 102 men constituting 51% of the whole sample. The ratio reflects there was an almost equal representation from both genders. Men were included in this study because to bring meaningful empowerment of women there is need to get views of men also since their exclusion has been reported as a hindrance to women's full participation in PMTCT programmes. The statistics reflect this was a good sample composition as it was bound to yield balanced views on PMTCT issues from both men and women.

Item 1.3. Level of respondents' education n = (200)

Table 6.3 below portrays the levels of formal education the participants of this study attained. Very few people, specifically 13 out of 200 (6.5%), never attended formal schooling. The rest had attended formal school at different levels. The majority either attended primary school only (36 %) or proceeded to secondary education (36.5%), a scenario very common in most Zimbabwean rural areas. Only 21% attempted or completed formal education beyond the secondary level. This may be an indication that the target sample might not have been exposed to, or do not understand PMTCT issues to the same degree as those in urban areas where the majority are educated beyond secondary education. Hence, they get more information from other platforms besides clinics. In Zimbabwe, PMTCT information is mainly offered to those who visit clinics when they are pregnant. Those who do not book their pregnancies at clinics do not get information about PMTCT.

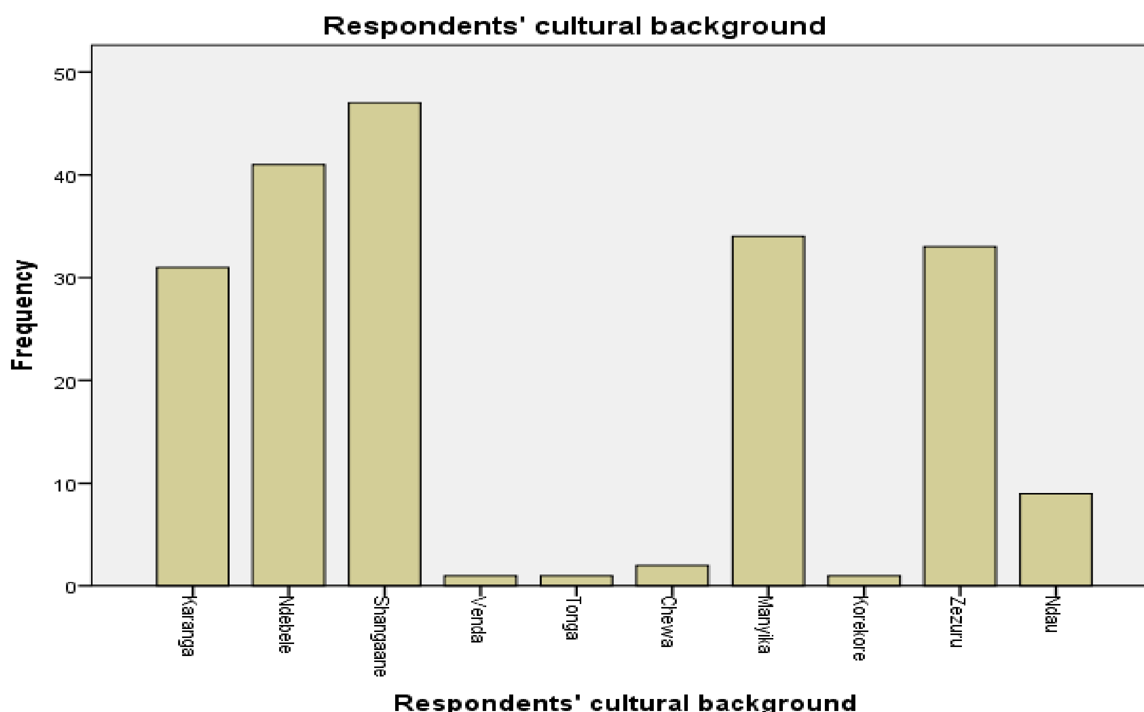
Table 6.3. Respondents' level of education

Highest level of Education	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Never attended school	13	6.5	6.5	6.5
Did not complete primary school	26	13.0	13.0	19.5
Completed primary school	46	23.0	23.0	42.5
Did not complete secondary school	28	14.0	14.0	56.5
Completed secondary school	45	22.5	22.5	79.0
Completed vocational educational	23	11.5	11.5	90.5
Did not complete college or university	10	5.0	5.0	95.5
Completed college or university	9	4.5	4.5	100.0
Total	200	100.0	100.0	

Item 1.4. Cultural backgrounds of respondents (n= 200)

From the presentation in Figure 6.1 below, one can note that the researcher reached out to the major cultural groups in Zimbabwe which helped test the influence of culture on rural people's participation in PMTCT. This variable was included so findings would inform stakeholders on whether cultural aspects should be addressed in bringing empowerment initiatives in PMTCT programmes The majority of the participants by a small margin, were Shangaane (23.5%) then Ndebele (20.5%) groups, both of which fall under the Nguni tribe and share some of their cultural practices; others were Karanga (15.5%), Manyika (17%) and Zezuru (16.5%) all sharing some cultural practices within the Shona culture. The minority came from the Ndau (4.5%), Korekore (0.5%), Chewa (1%), Tonga (0.5 %) and Venda (0.5%). These few participants became part of the sample due to migration and intermarriages, and most adapted to the culture of the major cultural group found in their contexts.

Figure 6.1. Cultural background



Item 1.5. Marital status of respondents (n = 200)

Table 6.4. Respondents' marital statutes

Marital Status	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Married	127	63.5	63.5	63.5
Widowed	17	8.5	8.5	72.0
Separated	23	11.5	11.5	83.5
Divorced	10	5.0	5.0	88.5
Single with Children	12	6.0	6.0	94.5
Single Without children	11	5.5	5.5	100.0
Total	200	100.0	100.0	

More than half of the participants (63.5%) were married, and the least 5 % were divorced. Regarding marriage, the researcher and her assistants clarified to respondents that this referred to couples who were legally and traditionally married, which excluded those who were cohabitating. Others were widowed (8.5 %), separated (11.5%), single parents (6%) and single without children (5.5%). The researcher noted that both married and not married individuals were concerned with childbearing and their roles, hence it was crucial to be knowledgeable and involved in PMTCT activities

6.2.2. Participants' Knowledge Power on PMTCT

The questionnaire had a section which tried to assess how the research participants were empowered with PMTCT knowledge. These sections are an analysis of that knowledge power based on gender. The section tried to answer the research question: '**Does the level of PMTCT knowledge and awareness of rural women and men influence their participation in PMTCT programmes?'** Each item of the questionnaire was analysed.

Item 2.1. Basic understanding of HIV transmission during pregnancy (n = 200)

Table 6.5 below shows that the participants (both men and women) knew that HIV may infect a child during pregnancy. The difference between the two genders was marginal for all the responses. This may reflect that both men and women were offered equal opportunities to gain basic knowledge about PMTCT issues.

Table 6.5 Knowledge of HIV transmission during pregnancy (n= 200)

Knowledge of HIV transmission during pregnancy			Gender of respondents		Total
			Female	Male	
	Yes	Frequency	85	91	176
		% within Gender of respondents	86.7%	89.2%	88.0%
	No	Frequency	8	5	13
		% within Gender of respondents	8.2%	4.9%	6.5%
	Don't Know	Frequency	5	6	11
		% within Gender of respondents	5.1%	5.9%	5.5%
Total		Frequency	98	102	200
		% within Gender of respondents	100.0%	100.0%	100.0%

Item 2.2. Knowledge of HIV transmission through breastfeeding (n = 200).

Table 6.6, below shows that the majority of the participants had the insight that HIV may be transmitted through breastfeeding. This comprises 71.4 % of all females and 77.5% of all males. But 17.3% of the females and 16.7% of all males refuted that breastfeeding may cause vertical transmission, which shows a marginal difference between these two genders. Amongst those who did not know, 11.2 % of all females and 5.9% of all males had no idea about the vertical transmission of HIV through breastfeeding.

Table 6.6 Knowledge of HIV transmission through breastfeeding (n = 200)

Knowledge of HIV transmission through breastfeeding			Gender of respondents		Total
			Female	Male	
	Yes	Frequency	70	79	149
		% within Gender of respondents	71.4%	77.5%	74.5%
	No	Frequency	17	17	34
		% within Gender of respondents	17.3%	16.7%	17.0%
	Don't Know	Frequency	11	6	17
		% within Gender of respondents	11.2%	5.9%	8.5%
Total		Count	98	102	200
		% within Gender of respondents	100.0%	100.0%	100.0%

Item 2.3. Knowledge of the possibility of HIV transmission during delivery (n = 200)

The presentation in Table 6.7, below indicates that the majority of the participants (69.4% of all females and 76.5% of all males) shared the same sentiment about the possibility of vertical transmission during delivery. But 14.3% of all females and 15.7% of all males refuted the possibility. There was a noticeable difference in the frequency of those who did not know (16.3% being females and 7.8% being males) indicating that rural men have a better understanding of how HIV can be transmitted from mother to child than their female counterparts.

Table 6.7. Knowledge of the possibility of HIV transmission during delivery (n = 200)

Knowledge of the possibility of HIV transmission during delivery			Gender of respondents		Total
			Female	Male	
	Yes	Frequency	68	78	146
		% within Gender of respondents	69.4%	76.5%	73.0%
	No	Frequency	14	16	30
		% within Gender of respondents	14.3%	15.7%	15.0%
	Don't Know	Frequency	16	8	24
		% within Gender of respondents	16.3%	7.8%	12.0%
Total		Frequency	98	102	200
		% within Gender of respondents	100.0%	100.0%	100.0%

Item 2.4. Knowledge of the possibility of reduction of MTCT due to ART (n = 200).

Table 6.8 below shows that the percentages of men and women who knew that there is a possibility of reducing MTCT through ART were slightly above half for both genders. A relatively noticeable percentage comprising 25.5% of females and 28.4% of males reported no possibility of reducing MTCT through ART. In addition, 19.4% of all females and 18.6% of all males had no idea of the role that ART may play in addressing MTCT of HIV. These percentages may indicate that several people in the rural communities have little knowledge of the role played by ART as a way of reducing MTCT of HIV.

Table 6.8. Knowledge of the possibility of reduction of MTCT due to ART (n = 200)

Knowledge of the possibility of reduction of MTCT due to ART.			Gender of respondents		Total
			Female	Male	
	Yes	Frequency	54	54	108
		% within Gender of respondents	55.1%	52.9%	54.0%
	No	Frequency	25	29	54
		% within Gender of respondents	25.5%	28.4%	27.0%
	Don't Know	Frequency	19	19	38
		% within Gender of respondents	19.4%	18.6%	19.0%
Total		Frequency	98	102	200
		% within Gender of respondents	100.0%	100.0%	100.0%

Item 2.5. Knowledge on the possibility of reduction of MTCT due to caesarean delivery (n = 200).

Table 6.9. Knowledge of the possibility of reduction of MTCT due to caesarean delivery (n = 200)

Knowledge of the possibility of reduction of MTCT due to caesarean delivery.			Gender of respondents		Total
			Female	Male	
	Yes	Count	31	41	72
		% within Gender of respondents	31.6%	40.2%	36.0%
	No	Count	34	37	71
		% within Gender of respondents	34.7%	36.3%	35.5%
	Don't Know	Count	33	24	57
		% within Gender of respondents	33.7%	23.5%	28.5%
Total		Count	98	102	200
		% within Gender of respondents	100.0%	100.0%	100.0%

From the presentation above, Table 6.9, less than half (36%) of all the participants knew there is a possibility of reducing MTCT through Caesarean delivery. The two genders differed by 8%, with more males than females subscribing to this view. But, 35.5% of all the participants refuted this view with the highest percentage coming from males (36.3%) slightly higher than for females (34.7%). The percentages of those who did not know were relatively high: 33.7% of all females and 23.5% of all males. The percentages show that a significant number of both rural men and women did not know that Caesarean delivery may help reduce MTCT with the biggest proportion coming from the female side.

Item 2.6. Knowledge on the possibility of reduction of MTCT by avoiding breastfeeding (n = 200).

Table 6.10, below reflects that more than half (60.5%) of all the participants knew that MTCT might be reduced by avoiding breastfeeding if a woman is HIV-positive. However a significant proportion either refuted the view or had no idea about it. Specifically, 25.5% of all women and 26.5% of all men refuted this view. Also, 14.3% of all women and 12.7% of all men had no idea about the link between avoiding breastfeeding and reducing MTCT. As much as those who showed knowledge about this link was more than half, it is also worrying that nearly half of all the participants (49.5%) were on the negative side.

Table 6.10 ***Knowledge of the possibility of reduction of MTCT by avoiding breastfeeding (n = 200)***

Knowledge of the possibility of reduction of MTCT by avoiding breastfeeding.			Female	Male	
	Yes	Frequency	59	62	121
		% within Gender of respondents	60.2%	60.8%	60.5%
	No	Frequency	25	27	52
		% within Gender of respondents	25.5%	26.5%	26.0%
	Don't Know	Frequency	14	13	27
		% within Gender of respondents	14.3%	12.7%	13.5%
Total		Frequency	98	102	200
		% within Gender of respondents	100.0%	100.0%	100.0%

Item 2.7. Knowledge about Prevention of Mother to Child Transmission (PMTCT) Programme (n = 200).

Table 6.11. ***Knowledge about PMTCT programme (n = 200)***

Knowledge about Prevention of Mother- to- Child Transmission (PMTCT) programme.			Gender of respondents		Total
			Female	Male	
	Yes	Frequency	78	82	160
		% within Gender of respondents	79.6%	80.4%	80.0%
	No	Frequency	9	15	24
		% within Gender of respondents	9.2%	14.7%	12.0%
	Don't Know	Frequency	11	5	16
		% within Gender of respondents	11.2%	4.9%	8.0%
Total		Frequency	98	102	200
		% within Gender of respondents	100.0%	100.0%	100.0%

Table 6.11 above, shows that the majority (79.6 % of all females and 80.4% of all males) knew about the PMTCT programme indicating that basic information about the programme had been effectively disseminated to the rural people. Almost twenty-one per cent (20.4%) of women and 20% of men had no idea about the programme, a percentage showing there is still a need to revisit the community and reintroduce or introduce the programme to the people.

Item 2.8. Knowledge of the availability of PMTCT services at local clinic (n = 200).

The presentation, Table 6.12 below, portrays a significant number of participants (76% females and 73% males) who acknowledged that PMTCT services were available at their local clinics. But, 10.2% of females and 10.8% of males indicated that the services were not there whilst 12.2% of females and 17.6% of males had no idea about whether the services were there or not. Most males fell on the negative side which maybe an indication of their partial involvement in PMTCT issues.

Table 6.12. ***Knowledge of the availability of PMTCT services at local clinic (n = 200)***

Knowledge of the availability of PMTCT services at local clinic.			Gender of respondents		Total
			Female	Male	
	Yes	Frequency	76	73	149
		% within Gender of respondents	77.6%	71.6%	74.5%
	No	Frequency	10	11	21
		% within Gender of respondents	10.2%	10.8%	10.5%
	Don't Know	Frequency	12	18	30
		% within Gender of respondents	12.2%	17.6%	15.0%
Total		Frequency	98	102	200
		% within Gender of respondents	100.0%	100.0%	100.0%

Item 2.9. Awareness of the availability of HIV voluntary counselling and testing services at antenatal clinic (n = 200).

The presentation in Table 6.13 below, indicates that the majority of the participants (86 % of females and 79 % of males) knew the availability of HIV voluntary counselling and testing services at the antenatal clinics. But 5.1% of females and 9.8% of males indicated that such services were not available at the antenatal clinics. Also, 7.1% of females and 12.7% of males did not know whether the services were available or not. The differences in knowledge between the men's and women's responses were small; however, this may reflect that men are not concerned about getting tested for HIV.

Table 6.13. ***Awareness of the availability of HIV voluntary counselling and testing services at antenatal clinic (n = 200)***

Awareness of the availability of HIV voluntary counselling and testing at antenatal clinic.			Gender of respondents		Total
			Female	Male	
	Yes	Frequency	86	79	165
		% within Gender of respondents	87.8%	77.5%	82.5%
	No	Frequency	5	10	15
		% within Gender of respondents	5.1%	9.8%	7.5%
	Don't Know	Frequency	7	13	20
		% within Gender of respondents	7.1%	12.7%	10.0%
Total		Frequency	98	102	200
		% within Gender of respondents	100.0%	100.0%	100.0%

Item 2.10. Involvement in voluntary counselling and testing during one's or partner's last pregnancy (n = 200).

Table 6.14. ***Involvement in voluntary counselling and testing during one's or partner's last pregnancy (n = 200)***

Knowledge of involvement in voluntary counselling and testing during one's or partner's last pregnancy			Gender of respondents		Total
			Female	Male	
	Yes	Frequency	62	58	120
		% within Gender of respondents	63.3%	56.9%	60.0%
	No	Frequency	28	31	59
		% within Gender of respondents	28.6%	30.4%	29.5%
	Don't Know	Frequency	3	9	12
		% within Gender of respondents	3.1%	8.8%	6.0%
	Not Applicable	Frequency	5	4	9
		% within Gender of respondents	5.1%	3.9%	4.5%
Total		Frequency	98	102	200
		% within Gender of respondents	100.0%	100.0%	100.0%

A significant number of the participants as portrayed in Table 6.14 above (63.3% of females and 58% of males) had gone through voluntary counselling and testing during their own or their partner's pregnancy. But, under one-third of the participants did not go through that process. The rest either forgot or had never been or their partners had never been pregnant. The small difference in the responses might indicate that men are not involved in voluntary counselling and testing during their partners' pregnancies.

Item 2.11. Source of PMTCT knowledge for those involved in PMTCT activities (n = 200).

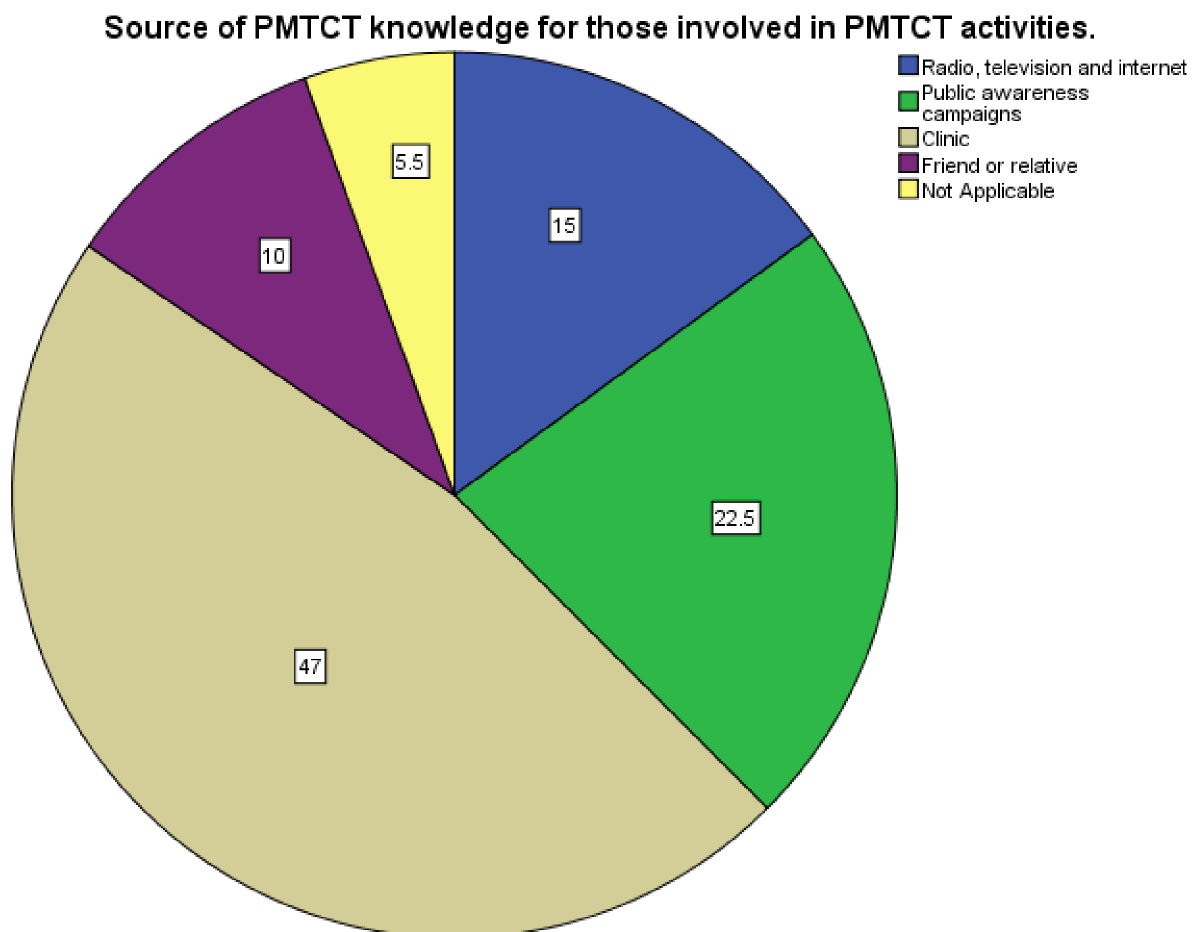


Fig. 6.2. Source of PMTCT knowledge (n = 200)

A reasonable number alluded to the clinic as their source of knowledge on PMTCT. This could be because it is mandatory for pregnant women to get tested for HIV at the clinics when they make their pregnancy bookings. Others referred to public awareness campaigns as their source of information, reflecting that service providers need to put more effort into engaging the community on PMTCT issues. Fifteen per cent mentioned the media as their source of information, which indicates there is need to expose the rural community to different types of media to access information about PMTCT. Regarding this, the responses may also reflect that PMTCT service providers are not utilising the media frequently enough to educate

the community on PMTCT. Around 10%, referred to friends and relatives as their source of PMTCT knowledge, which might show that either people do not value PMTCT issues or they are not free to share PMTCT information amongst themselves.

Item 2.12. Composite measure of participants' knowledge on PMTCT (n = 200)

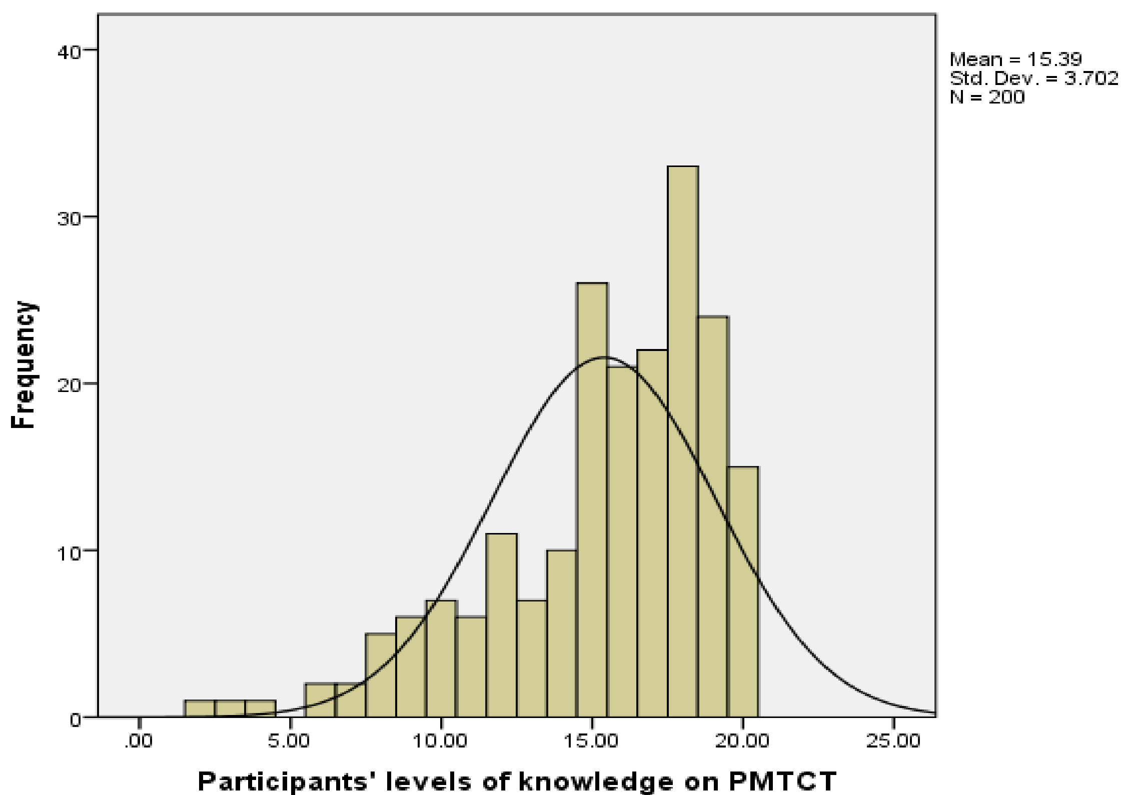


Fig. 6.3. Overall levels of Knowledge (n = 200)

The composite measure of participants' knowledge and awareness was gauged by the total of correct answers to the above ten items on knowledge and awareness. These totals ranged from 2 to 20 marks among respondents with a mean of 15.39 and standard deviation of 3.702. The histogram above (Fig 6.3) shows their distribution.

Item 2.13. Participants' levels of knowledge on PMTCT (n = 200).

Table 6.15. Categories of PMTCT knowledge and Awareness (n = 200)

Category	Score	Frequency	Per cent	Cumulative Per cent
No Knowledge	0 - 4	3	1.5	1.5
Low Knowledge Level	5 - 9	16	8.0	9.5
Moderate Knowledge Level	10 - 14	41	20.5	30.0
High Knowledge Level	15 - 20	140	70.0	100.0
Total		200	100.0	

The overall level of knowledge was calculated using scores obtained on a Likert scale with the highest possible score being 20. Based on the scores, the participants fell into four categories highlighted in Table 6.15 above. Overall, participants were knowledgeable about basic information regarding PMTCT with 70% and 20.5% falling in the high knowledge and moderate knowledge categories respectively. This may be due to the clinic's efforts in disseminating PMTCT information to the community. On the negative side, 8% possessed little knowledge, and 1.5% had no knowledge. Both of these categories with little or without knowledge need intervention.

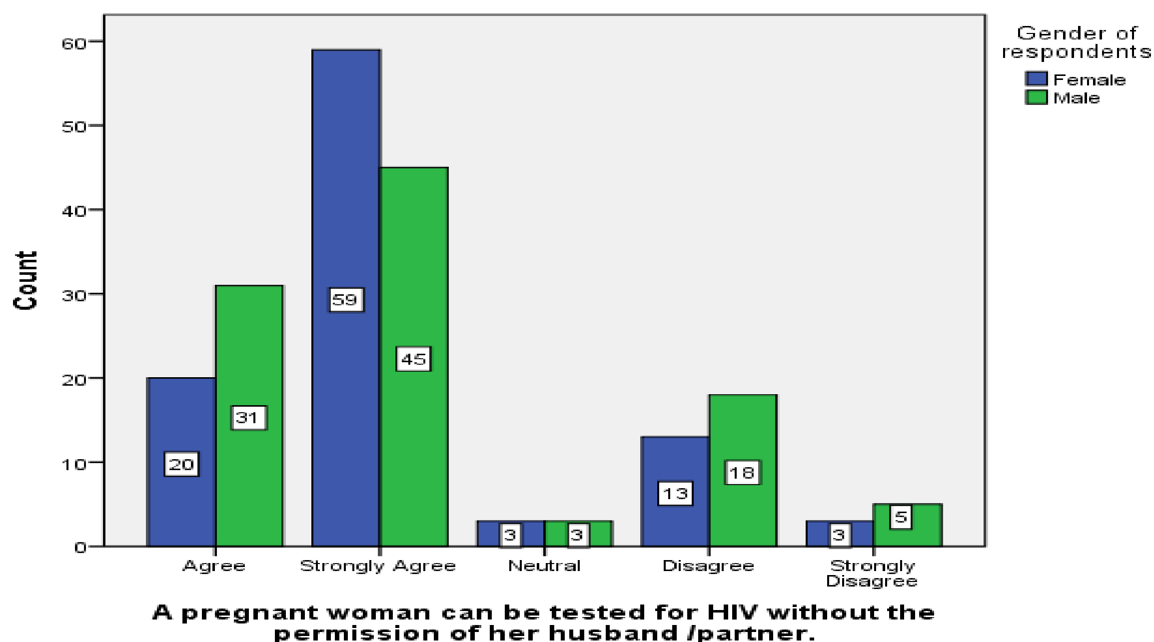
6.2.3. Influence of Cultural Beliefs and Practices on Rural Women's Participation in PMTCT

Items under this section tried to address the research question which reads: **'Do cultural beliefs and practices influence the participation of rural women in PMTCT initiatives?'**

Item 1: A pregnant woman can be tested for HIV without the permission of her husband/partner (n = 200)

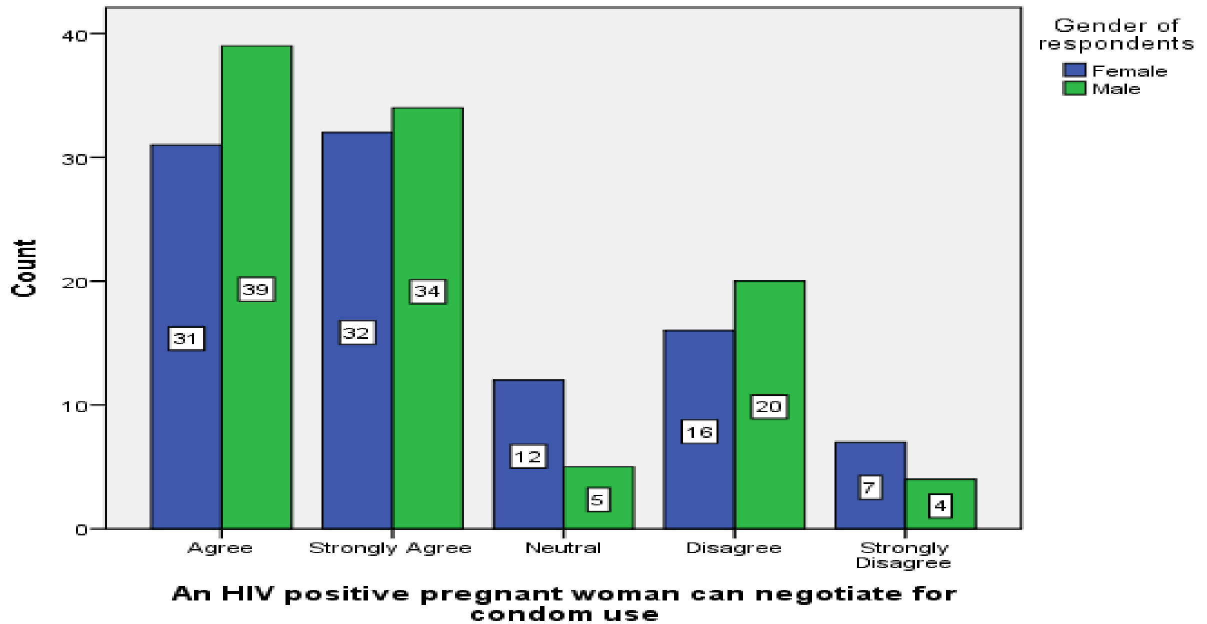
The graph, Figure 6.4 below, shows that amongst those who agreed with the view that a woman can be tested for HIV without the permission of her partner or husband, 39.2 % were females against 60.8 % males. However, among those who strongly agree, 56.7% were females while 43.3 % were males. When combining these two categories, it is clear that slightly more females than males subscribed to this view as 39.5% of all participants who agreed or strongly agreed were females and 38% were males. But amongst those who disagreed, 41.9% were females, and 58.1% were males and among those who strongly disagreed, 37.5% were females while 62.5% were males. When combining the two categories, 8% of women and 11.5% of men were not in favour of this view. This may indicate that generally, the majority of the community approves that women should possess the power to know their HIV status without restrictions from or consulting their partners.

Figure 6.4. *HIV testing of women without partner permission (n = 200)*



Item 2: An HIV positive pregnant woman can negotiate for condom use (n = 200).

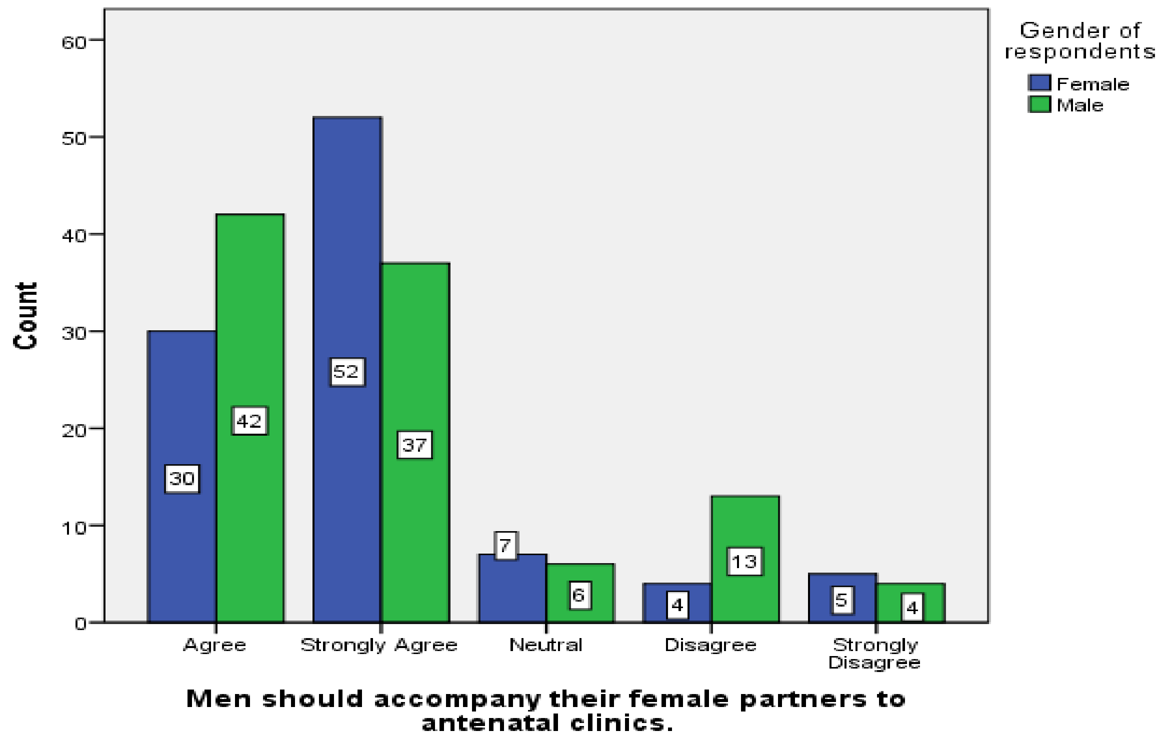
Fig. 6.5. **Women's Ability to Negotiate for Condom Use (n = 200)**



The graph, Figure 6.5 above, shows that of all the participants who agreed that if a pregnant woman tests positive she should be free to negotiate with her partner about condom use, 44.3 % were females and 55.7% were males. In addition, of all those who strongly agreed, 48.5% were females, and 51.5 % were males. Thus, overall those who shared the same sentiments on this view comprised of less than half of the whole sample. But a relatively significant percentage were in disagreement which may be a reflection there are still women who are being denied permission to make decisions concerning their health and those of their children.

Item 3: Men should accompany their female partners to antenatal clinics (n = 200).

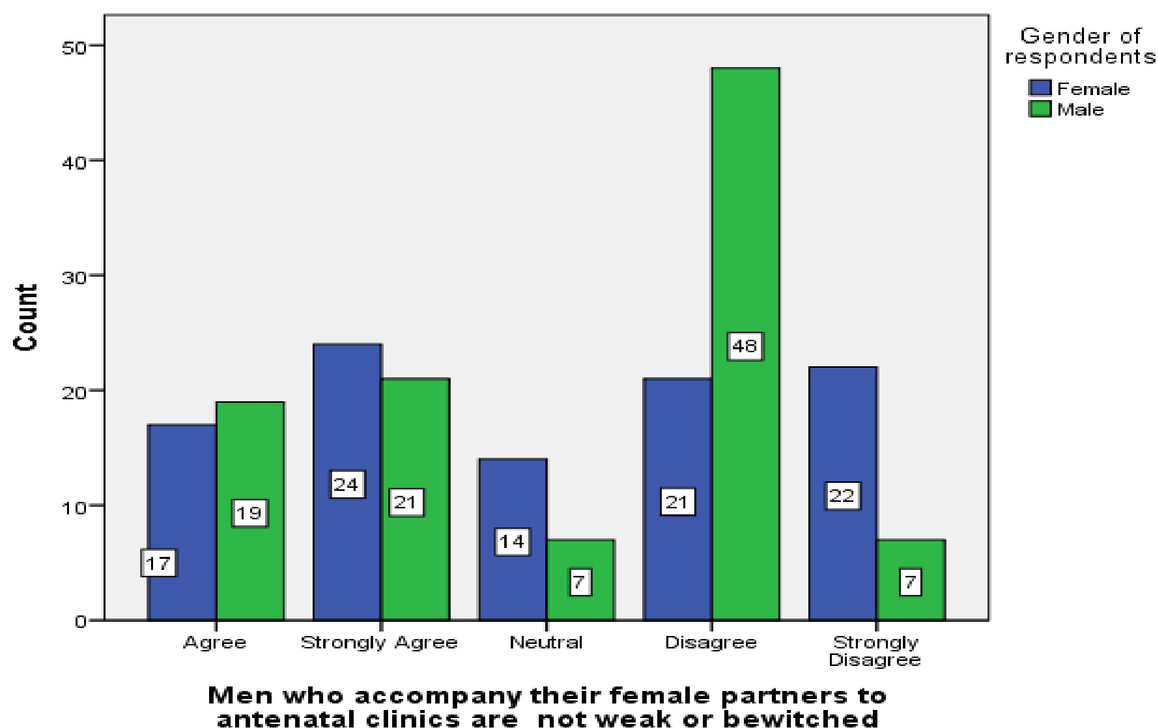
Figure 6.6. *Men should accompany their female partners to antenatal clinics (n = 200)*



From the graph above (Fig 6.6), it can be noted that of all the participants who concurred with the view that males should be found escorting their partners to antenatal clinics when they are pregnant, 41.7% were females, and 58.3% were males. Also, for those who strongly agreed with this view, 58.4% were females and 41.6% were males, which may reflect that the majority knew the importance of having couples supporting each other during the gestation period. But amongst all those who disagreed with this view, 23.5% were females, and 76.5% were males. For those who strongly disagreed, 55.6% were females, and 44.4% were males. Overall, more males (8.5%) than females (4.5%) refuted this view. Though the percentages are low they may indicate that men do not value pregnancy issues which could be due to gender stereotyping that maternal issues are meant for women, not for men.

Item 4. Men who accompany their female partners to antenatal clinics are neither weak nor bewitched (n = 200)

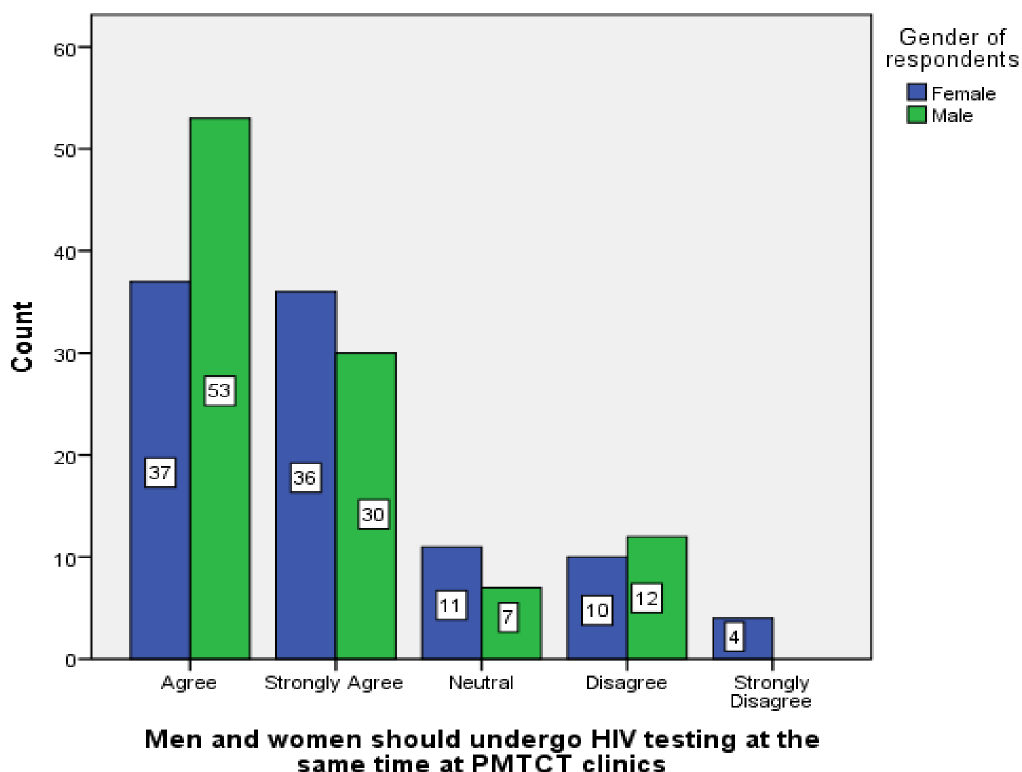
Fig. 6.7. Men who escort their partners to ANC are not weak/bewitched (n = 200)



The graph above, Figure 6.7, shows that of all the participants, 20.5% females and 20% males either agreed or strongly agreed with the view that men who accompany their female partners to antenatal clinics are neither weak nor bewitched. But of all the participants, 21.5% females and 27.5% males either disagreed or strongly disagreed with this view reflecting that more males than females assume that men who support their female counterparts with maternal issues have problems of some description. Thus, the statistics may be showing that the society, especially men still regard issues to do with pregnancy and childbearing as women's issues to the extent that if a man is found involved, he will be regarded as a weakling. The implication for PMTCT initiatives is that most men may be less involved for fear of being labelled.

Item 5. Men and women should undergo HIV testing at the same time at antenatal clinics (n = 200).

Fig 6.8. Men and women to be tested for HIV at the same time (n = 200)



A significant number of all the participants concurred with the view that couples must be tested simultaneously for HIV at antenatal clinics, this comprised 36.5% females and 41.5% males, reflecting the society's positive move towards preventing vertical transmission of HIV with the scale weighing heavily on the male side. However, 12.5% females and 9.5% males of all the participants disagreed or did not open up about this issue. This indicates there are still some individuals, especially females, in the communities who need to be assisted so they can appreciate the value of having couples being tested for HIV at the same time.

Item 6. An HIV positive woman can decide on her own not to breastfeed her child to reduce HIV transmission (n = 200).

Fig 6.9. An HIV positive woman can decide on her own not to breastfeed her child to reduce HIV transmission (n = 200).

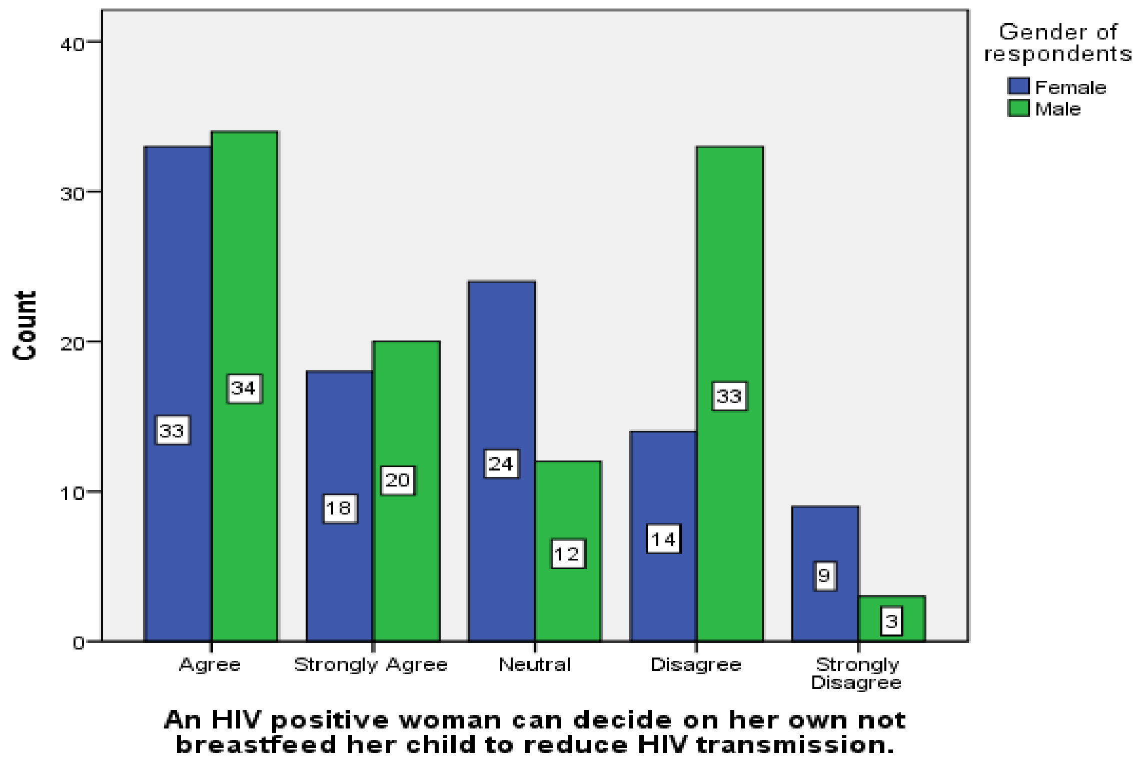


Figure 6.9 above, reflects that from all the participants 25.5% females and 27% males shared the same view that an HIV positive woman can solely decide not to breastfeed her child to avoid HIV transmission. But 11.5% of females and 18% males refuted this view. This may reflect that in some rural communities, women lack decision-making power even in matters relating to their reproductive health. Also, that people, especially men, still think that breastfeeding a child is mandatory even when the mother is HIV positive or when it is risky to the child.

Item 7. It is not a taboo for women to discuss with their male partners about HIV testing during pregnancy (n = 200).

Figure 6.10. ***Taboo for women to discuss with their partners about HIV testing during pregnancy (n = 200)***

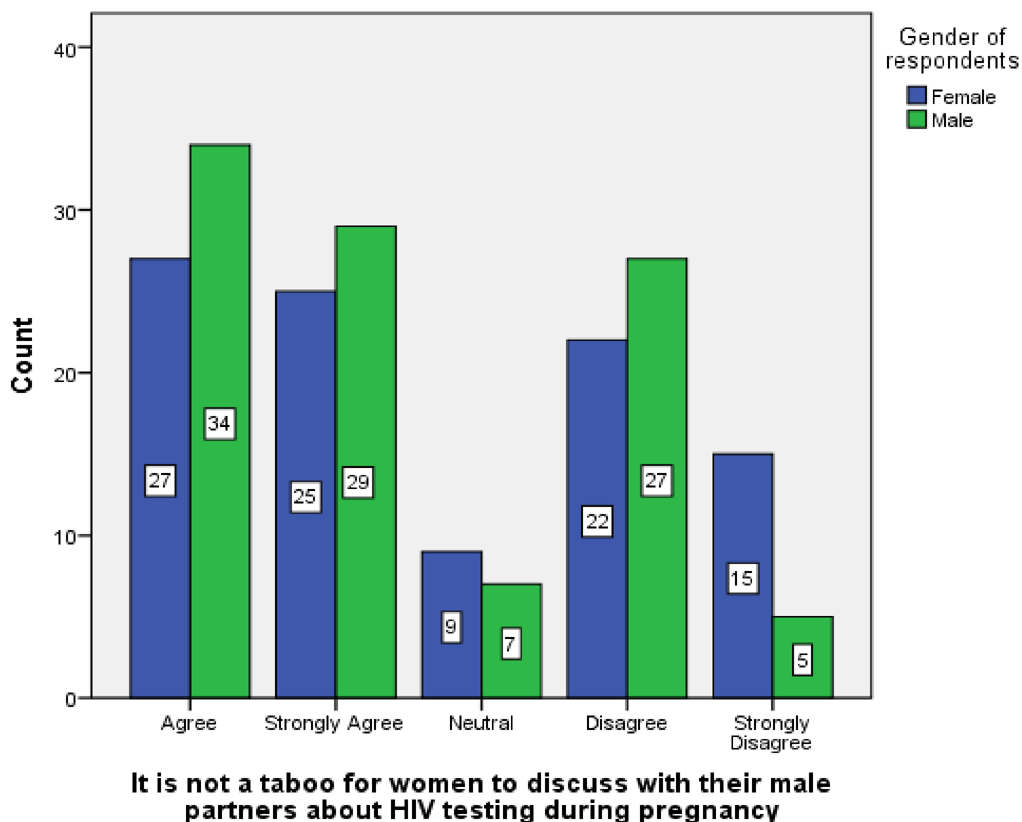
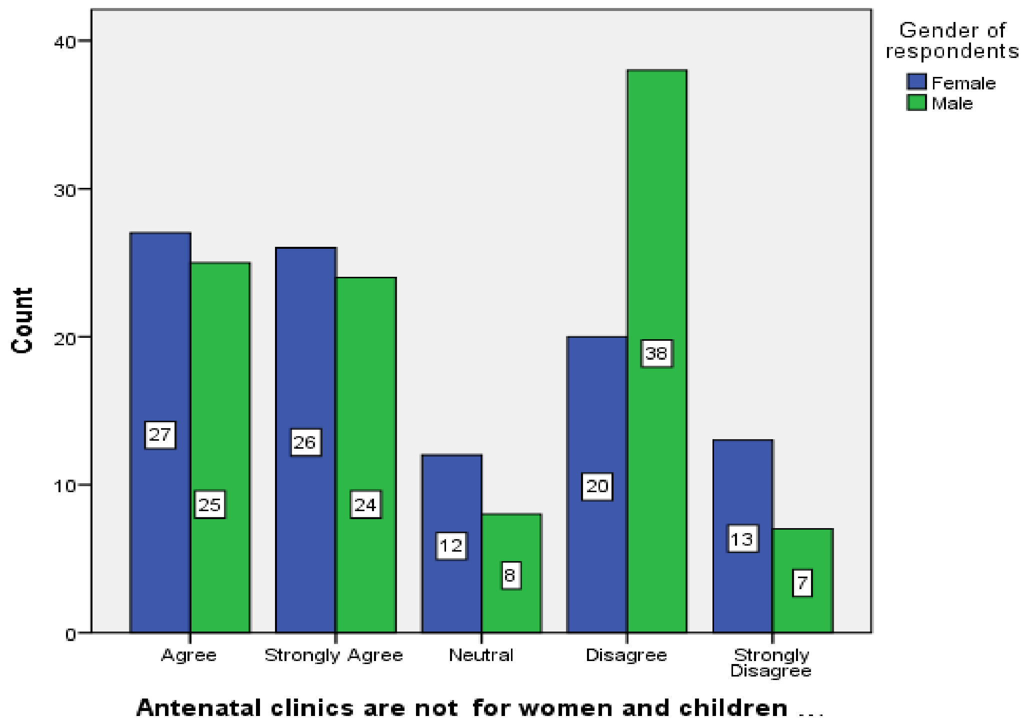


Figure 6.10 above shows that of all the participants 27% females and 31.5% males shared the same view it is not abominable for women to talk about HIV testing with their partners during pregnancy. But 18.5% of females and 16% males from all the participants, disagreed with this view showing they ascribed to it being forbidden for women to talk about HIV testing with their partners during pregnancy. The percentage differences between men and women's views are low, which may indicate how their long-held societal beliefs influence their expectations on how women should relate to their male counterparts.

Item 8. Antenatal and maternal clinics are not for women and children only (n = 200).

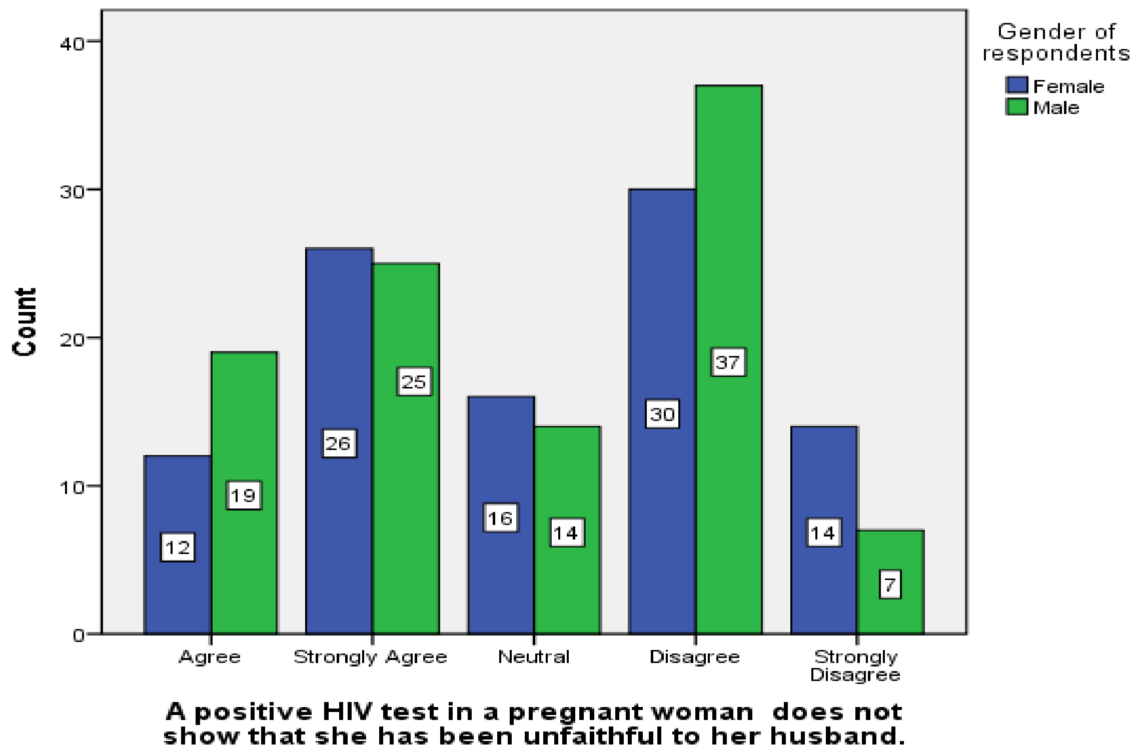
Figure 6.11 Antenatal and maternal clinics are not for women and children only (n = 200)



The bar graph above (Fig. 6.11) shows that 26.5% females and 24.5% males of all the participants shared the same sentiments that antenatal and maternal clinics are not restricted to women and children only and that even men should attend. On the negative side, 16.5% females and 22.5% males of all the participants disagreed with the view meaning they ascribed to the view that antenatal and maternal clinics are for women and children only and the scale weighed heavily on the male side. This may indicate there is still a significant number of men and women in rural communities who believe that men should not be found at antenatal or maternal clinics, perhaps because maternal issues are usually regarded as women's matters.

Item 9. An HIV positive test in a pregnant woman does not show that she has been unfaithful to her husband (n = 200).

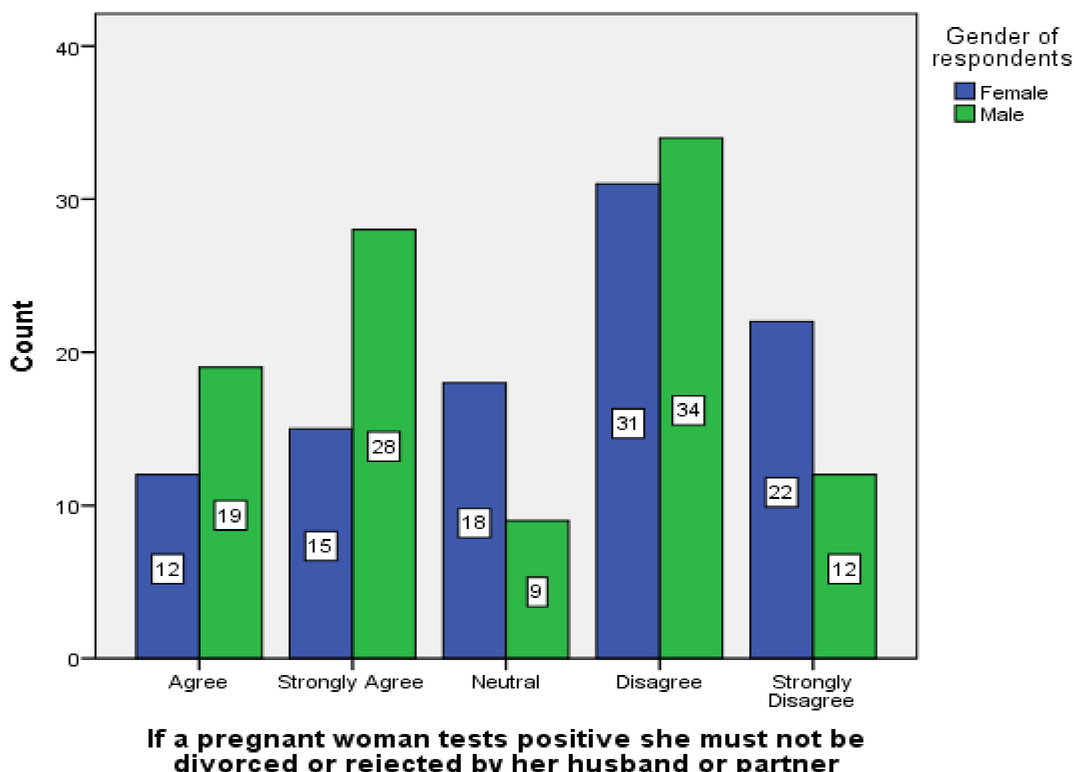
Figure 6.12. An HIV positive test result in a pregnant woman does not mean infidelity (n = 200)



The graph above (Fig. 6.12) shows that 19% females and 22% males subscribed to the view that if a woman is HIV positive during pregnancy it is not a sign of infidelity. In contrast, 22 % females and 22% males disputed this, implying they regard a pregnant woman's HIV positive result a sign of infidelity. These statistics may reflect that parts of society still grapple with the idea that a faithful woman can still get a positive HIV test result because the infection may come from the partner who might be unfaithful.

Item 10. If a pregnant woman tests HIV positive she must not be divorced or rejected by her partner (n = 200).

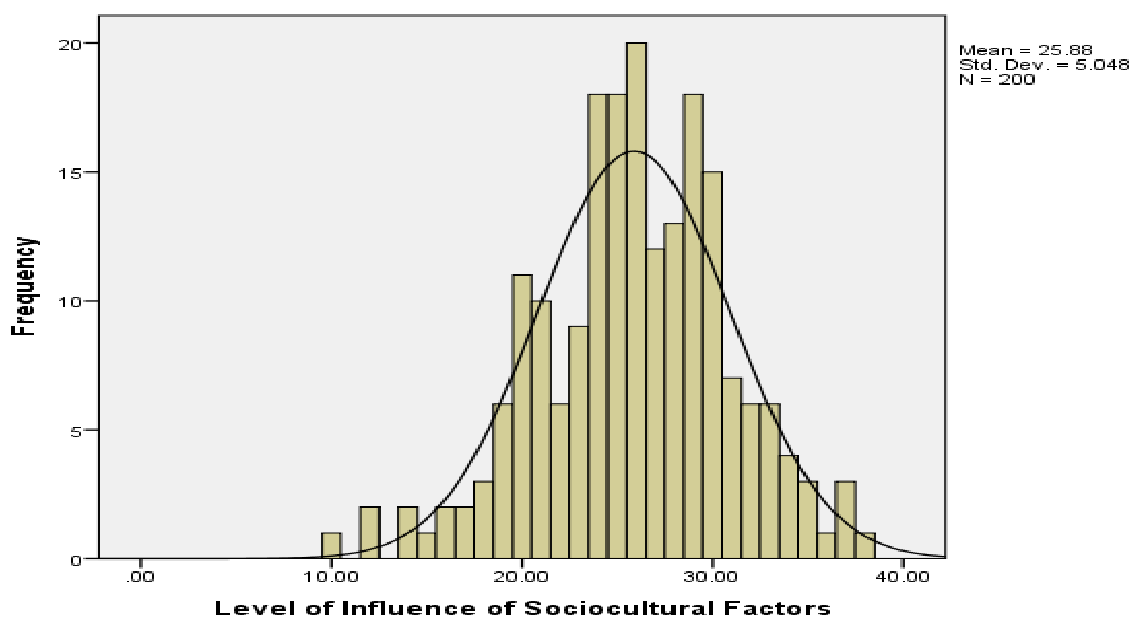
Figure 6.13. A positive HIV test in a pregnant woman does not warrant divorce or rejection by partner (n = 200)



The graph in Figure 6.13 above, shows that less than half of all the participants comprising 26.5% females and 13% males disagreed that a pregnant woman who tests HIV positive during pregnancy should not be divorced or rejected by her partner. They believed that testing HIV positive during pregnancy is the gateway for a woman to lose her marriage or partner. Only 13.5% females and 24.5 % males agreed that a woman should not be divorced or rejected after testing HIV positive during pregnancy. The rest (13.5%) did not disclose their thoughts. These statistics show that testing HIV positive during pregnancy becomes a double burden for the infected woman, affecting her biologically and socially.

6.2.3.1. Composite Measure on the Influence of Cultural Beliefs and Practises on Rural Women's Participation in PMTCT Programmes (n = 200).

Figure 6.14. Composite measure on the level of influence of cultural beliefs and practices on rural women's participation in PMTCT programmes (n = 200)



The composite measure of the influence of cultural beliefs and practices on women's participation in PMTCT programme for each participant was measured by the Likert scale's total score with a possible highest score of 40. Generally, the higher the score, the higher the influence of cultural beliefs and practices on the participant's involvement in PMTCT initiatives. The distribution of scores in Figure 6.14 indicate that the total score among participants varied from 10 to 38 with a mean of 25.88 and a standard deviation of 5.048.

Table 6.16. ***Level of influence of cultural beliefs and practices on rural women's participation in PMTCT programmes (n = 200)***

Level of influence of cultural beliefs and practices on rural women's participation in PMTCT programmes	Score	Frequency	Per cent	Cumulative Per cent
Very High Level of influence	31-40	32	16.0	16.0
High level of influence	21-30	136	68.0	84.0
Low level of influence	11-20	31	15.5	99.5
No influence	0-10	1	.5	100.0
Total		200	100.0	

The score in Table 6.16 above show that the majority alluded to the view that cultural beliefs and practices have an influence on community members' involvement in PMTCT initiatives. Only 0.5% stressed that cultural beliefs have no influence, while the balance support the view in varying degrees. This reflects that community people have identified the impact of some cultural beliefs and practices on PMTCT programmes, which is usually negative.

6.2.4. Views on Strategies to Empower Women in PMTCT Initiatives

This section addresses the research question: **' Which empowerment strategies assist in the design of PMTCT interventions for rural women?'** The question aimed, to get the participants' basic views on the suggested strategies, while in-depth views were later sought through focus group discussions and interviews.

Item 1. Men and Women of Childbearing Ages Should Receive Information on PMTCT at the same time (n = 200).

Table 6.17. Childbearing men and women should receive PMTCT information at the same time (n = 200)

Responses to proposed strategy 1	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	46	23.0	23.0	23.0
Strongly Agree	135	67.5	67.5	90.5
Neutral	7	3.5	3.5	94.0
Disagree	9	4.5	4.5	98.5
Strongly Disagree	3	1.5	1.5	100.0
Total	200	100.0	100.0	

Almost all respondents agreed that both men and women should receive PMTCT information at the same time, while 6% disagreed. This indicates that the respondents might have noticed the importance of having all people equipped with PMTCT information if the programme is to be fruitful.

Item 2. Men and Women of Childbearing Ages Should be Encouraged to regularly get Voluntary Counselling and Testing for HIV and AIDS (n = 200).

Table 6.18 Encouragement of childbearing men and women to have regular VCT of HIV and AIDS (n = 200)

Responses to proposed strategy 2	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	75	37.5	37.5	37.5
Strongly Agree	94	47.0	47.0	84.5
Neutral	10	5.0	5.0	89.5
Disagree	14	7.0	7.0	96.5
Strongly Disagree	7	3.5	3.5	100.0
Total	200	100.0	100.0	

A high majority of the respondents concurred that childbearing women should be encouraged to have regular voluntary counselling and testing for HIV and AIDS. The balance refuted this view. These statistics may reflect the community's willingness to try to prevent vertical transmission of HIV through regular VCT of HIV encouraged by their positive views towards PMTCT.

Item 3. Income-generating Projects as a way of Promoting the Economic Empowerment of Young and Middle-aged women (n = 200).

Table 6.19 Economic empowerment of young and middle-aged women through income-generating projects (n = 200)

Responses to proposed strategy 3	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	73	36.5	36.5	36.5
Strongly Agree	81	40.5	40.5	77.0
Neutral	17	8.5	8.5	85.5
Disagree	20	10.0	10.0	95.5
Strongly Disagree	9	4.5	4.5	100.0
Total	200	100.0	100.0	

The respondents supported the view that young and middle-aged women should be encouraged to engage in income-generating projects for economic empowerment. As shown in Table 6.19 above, a high percentage concurred while some refuted it. Thus, pointing to the importance of economic empowerment of women in making a PMTCT programme effective.

Item 4. Importance of Training Women in Peer Education on PMTCT Issues (n= 200).

Table 6.20 Importance of training women in peer education on PMTCT issues (n = 200)

Responses to proposed strategy 4	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	75	37.5	37.5	37.5
Strongly Agree	74	37.0	37.0	74.5
Neutral	23	11.5	11.5	86.0
Disagree	19	9.5	9.5	95.5
Strongly Disagree	9	4.5	4.5	100.0
Total	200	100.0	100.0	

The majority of all the respondents supported the idea that women must be trained as peer educators on PMTCT issues. This was refuted by a small percentage (14%). A further 11.5% did not air their views. Those who supported the view might have done so with the belief that some people learn better and quickly accept information if delivered by someone familiar to them. But those who refuted might have been influenced by the assumption common in some societies that women cannot educate others, while others might have the view that incorporating men as peer educators could be fruitful on PMTCT.

Item 5. It must be Mandatory for Men to Escort their Spouses/partners to Antenatal Clinics (n = 200).

Table 6.21 Men *should have an obligation to escort their spouses/partners to antenatal clinics (n = 200)*

Responses to proposed strategy 5	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	74	37.0	37.0	37.0
Strongly Agree	90	45.0	45.0	82.0
Neutral	18	9.0	9.0	91.0
Disagree	13	6.5	6.5	97.5
Strongly Disagree	5	2.5	2.5	100.0
Total	200	100.0	100.0	

The view that men must have a mandate to escort their spouses or partners to the antenatal clinic during the gestation period was supported by a high majority (82%) comprising 38.5% females and 43.5% males. Only 9% disagreed (equal split between men and women) while the other 9% remained neutral. The great support might have been triggered by the realisation that men's involvement in PMTCT matters is crucial for the programme's success and community health. Some strong held societal beliefs might have influenced the few who fell on the negative side that pregnancy is a women's issue.

Item 6. Constant Involvement of Men and Women of Childbearing Ages in Workshops on Sexuality Issues Related to the Gestation Period (n = 200).

Table 6.22 Constant involvement of men and women of childbearing ages in sexuality workshops (n = 200)

Responses to proposed strategy 6	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	80	40.0	40.0	40.0
Strongly Agree	83	41.5	41.5	81.5
Neutral	18	9.0	9.0	90.5
Disagree	13	6.5	6.5	97.0
Strongly Disagree	6	3.0	3.0	100.0
Total	200	100.0	100.0	

A high majority supported the idea that both men and women should be found consistently participating in workshops on sexuality issues. The rest of the respondents disagreed. While the numbers are encouraging, they show that the community still needs to be educated about sexuality issues as they affect their health and that of their children.

Item 7. Suggestion of Long Opening Hours of Antenatal Clinics to Accommodate Men (n = 200).

Table 6.23 Long opening hours of antenatal clinics (n = 200)

Responses to proposed strategy 7	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	58	29.0	29.0	29.0
Strongly Agree	87	43.5	43.5	72.5
Neutral	17	8.5	8.5	81.0
Disagree	27	13.5	13.5	94.5
Strongly Disagree	11	5.5	5.5	100.0
Total	200	100.0	100.0	

The majority agreed that antenatal clinics should have extended opening hours, including weekends and holidays to allow men, usually busy during the day, to escort their partners to those clinics. This idea was refuted by a few participants. Still, the numbers show that the community also wishes to see men being involved in PMTCT programmes and that some people still need to be assisted to understand the importance of male involvement in PMTCT programmes.

Item 8. Periodic Door-to-Door Awareness Campaigns by Professionals on PMTCT (n = 200).

Table 6.24 Periodic door-to-door public awareness campaigns by professionals (n = 200)

Responses to proposed strategy 8	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	66	33.0	33.0	33.0
Strongly Agree	90	45.0	45.0	78.0
Neutral	25	12.5	12.5	90.5
Disagree	12	6.0	6.0	96.5
Strongly Disagree	7	3.5	3.5	100.0
Total	200	100.0	100.0	

The majority agreed with the view that professionals working under the PMTCT programme must periodically engage in door-to-door awareness campaigns on PMTCT targeting adolescents and adults. Over nine per cent rejected this view. A relatively significant percentage were neutral, raising the proportion of those on the negative side. That many people supported the view may be telling that the community values one-on-one interaction as a way that professionals should use in educating them on PMTCT issues. Others do not seem to find it important to be continuously reminded or educated about PMTCT matters.

Item 9. Addressing Cultural Barriers and Gender Stereotypes before PMTCT Initiatives Implementation (n = 200)

Table 6.25 Addressing cultural barriers and gender stereotypes before PMTCT initiatives implementation (n = 200)

Responses to proposed strategy 9	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	65	32.5	32.5	32.5
Strongly Agree	83	41.5	41.5	74.0
Neutral	26	13.0	13.0	87.0
Disagree	19	9.5	9.5	96.5
Strongly Disagree	7	3.5	3.5	100.0
Total	200	100.0	100.0	

Most participants applauded the view that before service providers introduce their PMTCT initiatives, they must address cultural barriers and gender stereotypes. Thirteen per cent refuted this view, and a further 13% did not give their opinions. This may be reflecting that community members know the negative influence of some cultural norms and values and gender stereotypes on the success of PMTCT programmes. Hence, these require attention before PMTCT implementation.

Item 10. Women of Childbearing Ages Should be Given an Opportunity to Initiate Programmes for PMTCT (n = 200).

Table 6.26 Childbearing women to be given an opportunity to initiate PMTCT programmes (n = 200)

Responses to proposed strategy 10	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	70	35.0	35.0	35.0
Strongly Agree	100	50.0	50.0	85.0
Neutral	12	6.0	6.0	91.0
Disagree	9	4.5	4.5	95.5
Strongly Disagree	9	4.5	4.5	100.0
Total	200	100.0	100.0	

A significant percentage agreed to the view that women must be initiative in community activities, while 9% disagreed and 6 % remained neutral. These statistics show that the community advocates for women empowerment in PMTCT programmes where they play a leading role in bringing their own empowerment.

Item 11. Women Involvement in Community Issues Related to PMTCT (n = 200).

Table 6.27 Women involvement in community issues related to PMTCT (n = 200)

Responses to proposed strategy 11	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	70	35.0	35.0	35.0
Strongly Agree	100	50.0	50.0	85.0
Neutral	10	5.0	5.0	90.0
Disagree	14	7.0	7.0	97.0
Strongly Disagree	6	3.0	3.0	100.0
Total	200	100.0	100.0	

A high proportion agreed there is need for women to be involved in community issues about PMTCT. Only 10 % disagreed, and 5% remained neutral. The numbers may reflect that the community understands the crucial position that women occupy in PMTCT involvement. However, some individuals in society still undermine the value of women in the prevention of vertical transmission of HIV and AIDS.

Item 12. Establishment of Antenatal Clinics Nearer to Every Community (n = 200)

Table 6.28 Establishment of antenatal close to communities (n = 200)

Responses to proposed strategy 12	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Agree	50	25.0	25.0	25.0
Strongly Agree	116	58.0	58.0	83.0
Neutral	15	7.5	7.5	90.5
Disagree	12	6.0	6.0	96.5
Strongly Disagree	7	3.5	3.5	100.0
Total	200	100.0	100.0	

A high majority concurred that antenatal clinics should be established very close to the communities for easy and swift accessibility. A minority (9.5%) did not agree while 7.5 % remained neutral. Perhaps the majority embraced the idea because, in many rural communities, people travel very long distances to access antenatal services which is not healthy.

Item 13. Overall Level of Respondents' Participation in PMTCT Initiatives (n = 200).

Table 6.29 Respondents' overall levels of participation (n = 200)

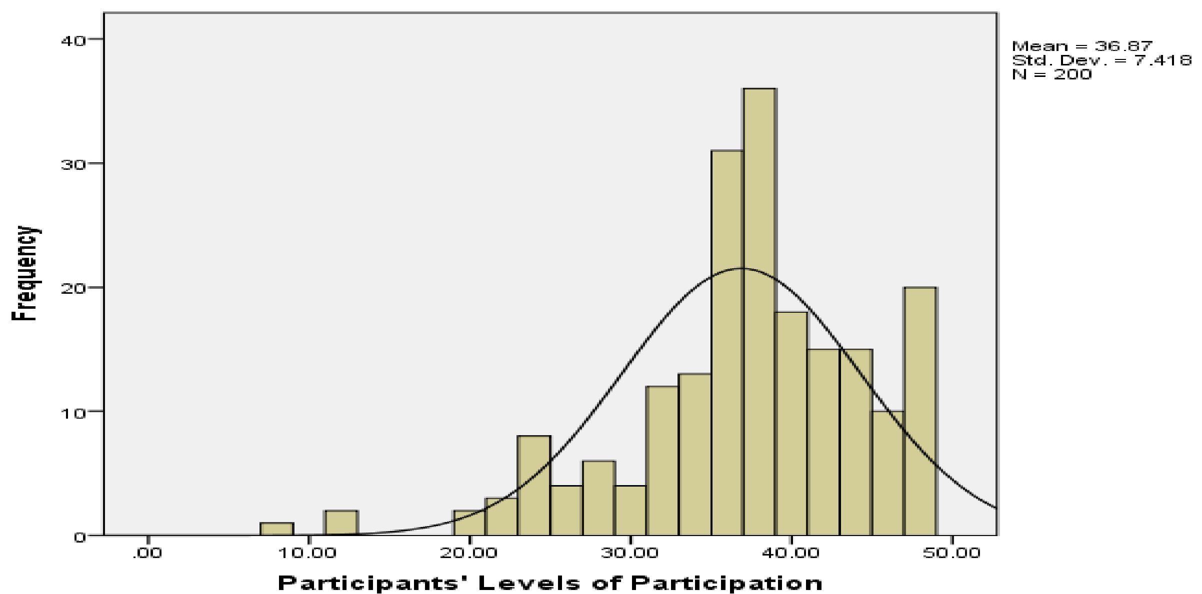
Respondents' overall levels of participation	Score	Frequency	Per cent	Cumulative Per cent
High Level of participation	48-40	66	33.0	33.0
Moderate Level of participation	39-30	106	53.0	86.0
Low Level of participation	29-20	25	12.5	98.5
No participation	19-0	3	1.5	100.0
Total		200	100.0	

In Table 6.29 above, the scores show levels of involvement in PMTCT initiatives where the majority (53%) fell in the range of moderate level of participation while one-third fell in the high level of participation. Just 12.5 % fell in the range of low participation, and 1.5% were not involved. A high percentage of people in the community make an effort to be involved in PMTCT activities.

6.2.4.1. Composite measure of participants' level of participation (n = 200).

The composite measure of each participant's level of participation was measured by the total score on the Likert scale with a possible highest score of 48. Generally, the higher the score, the higher the likelihood of getting involved in PMTCT initiatives. The findings portray that the total score among participants varied from 8 to 48 with a mean of 36.87 and a standard deviation of 7.42. The histogram below (Fig. 6.15) shows the distribution of these scores.

Figure 6.15 Composite measure of participants' levels of participation in PMTCT (n = 200)



6.2.3. Hypothesis 1: Gender has a Significant Effect on Rural People's Participation in PMTCT Initiatives

Hypothesis 1 tested the two variables gender and level of participation in PMTCT programmes using a Chi-square test of independence. The findings in Table 6.30 below, show that participation in PMTCT depends on gender as noted by an X^2 value of 0.018 at 3 d.f. which is less than the p-value of 0.05. This means we reject the null hypothesis and conclude that participation in PMTCT initiatives in rural areas depends on one's gender. The frequencies indicated that more women participate in these initiatives than men perhaps owing to an unequal distribution of power between men and women.

Table 6.30 Effect of gender on rural people's participation in PMTCT initiatives (n = 200)

Hypothesis 1	Value	d.f.	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.074[a]	3	.018
Likelihood Ratio	10.435	3	.015
Linear-by-Linear Association	2.101	1	.147
N of Valid Cases	200		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 1.47.

6.2.4. Hypothesis 2: Cultural Beliefs and Practises have a Significant Effect on Rural Women's Participation in PMTCT Initiatives

The second hypothesis claimed that cultural beliefs and practices have a significant effect on rural women's participation in PMTCT initiatives. The hypothesis alluded to the idea that if cultural issues are addressed before PMTCT programming, it helps make community members involved in PMTCT programmes because those cultural factors which may affect negatively on PMTCT initiatives will be dealt with beforehand. The findings in Table 6.31 below, reflect an X^2 value of 0.001 at 27 d.f. which is below the p-value of 0.05. Hence we reject the null hypothesis and accept the alternative hypothesis that cultural beliefs and practices have a significant effect on rural women's participation in PMTCT initiatives meaning participation also depends on one's cultural background.

Table 6.31 Effect of cultural beliefs and practices on rural women's participation in PMTCT initiatives (n = 200).

Hypothesis 2	Value	d.f.	Asymp. Sig. (2-sided)
Pearson Chi-Square	56.212[a]	27	.001
Likelihood Ratio	49.126	27	.006
Linear-by-Linear Association	3.803	1	.051
N of Valid Cases	200		

a. 28 cells (70.0%) have expected count less than 5. The minimum expected count is .02.

6.2.5. Hypothesis 3: Age Influences Rural Women and Men's Involvement in PMTCT Initiatives

Hypothesis 3 alluded to the view that rural men and women's involvement in PMTCT initiatives depends on one's age. The assumption was that the younger the person, the more involved they are in PMTCT programmes. However, Table 6.32 below, shows that age and participation in PMTCT are not dependent on each other as we have an X^2 value of 0.163 at d.f. 24 and p-value of 0.05. The X^2 value is greater than the p-value of 0.05; hence we reject the alternative hypothesis and accept the null hypothesis that age does not influence rural men and women's involvement in PMTCT initiatives. This means that whether someone is of childbearing age or not, does not affect one's participation in PMTCT. Those who are still young and without children, for example, adolescents and some early adults, also need to participate to prepare for the future; those that are past the age of childbearing still need to be involved to assist their relatives still bearing children.

Table 6.32 Influence of age on rural men and women's involvement in PMTCT initiatives (n = 200).

Hypothesis 3	Value	d.f.	Asymp. Sig. (2-sided)
Pearson Chi-Square	30.701[a]	24	.163
Likelihood Ratio	33.216	24	.100
Linear-by-Linear Association	.007	1	.932
N of Valid Cases	200		

a. 20 cells (55.6%) have expected count less than 5. The minimum expected count is .18.

6.2.6. Hypothesis 4: Rural Men and Women's Levels of PMTCT Knowledge and Awareness have a Significant Influence on their Involvement in PMTCT Programme

Hypothesis 4 focused on establishing if rural men and women's involvement in PMTCT programmes depended on one's level of knowledge and awareness of PMTCT issues. The assumption was that the more one knows about PMTCT matters, the more one becomes willing to be involved in the programmes. The findings in Table 6.33 below, reflect an X^2 value of 0.001 at d.f. 9 and p-value of 0.05 meaning we reject the null hypothesis and accept the alternative hypothesis that rural men and women's levels of PMTCT knowledge and awareness have a significant influence on their involvement in PMTCT programmes. Hence, participation depends on one's level of knowledge and awareness of PMTCT issues. Thus, if someone is knowledgeable about PMTCT, they will be aware of the virtues of adhering to what will prevent vertical transmission of HIV and AIDS, hence promoting participation.

Table 6.33 Relationship between level of knowledge and involvement in PMTCT programmes (n = 200).

Hypothesis 4	Value	d.f.	Asymp. Sig. (2-sided)
Pearson Chi-Square	30.208[a]	9	.000
Likelihood Ratio	21.072	9	.012
Linear-by-Linear Association	8.647	1	.003
N of Valid Cases	200		

a. 8 cells (50.0%) have expected count less than 5. The minimum expected count is .05.

6.2.7. Hypothesis 5: Rural Women's Level of Formal Education has a Significant Influence on their Participation in PMTCT Initiatives

The final hypothesis focused on testing whether the level of formal education influenced one's participation in PMTCT initiatives. The assumption was that the higher the level of education attained the better the understanding of PMTCT and the higher the level of participation in its initiatives. Table 6.34 below, shows an X^2 of 0.013 at d.f. 231 and p-value of 0.05. Thus, we reject the null hypothesis and accept the alternative hypothesis that rural women's levels of formal education has a significant influence on their participation in PMTCT initiatives. This could be because formal education creates a foundation for better understanding of PMTCT issues hence promoting meaningful involvement in the programme.

Table 6.34 Influence of formal education on participants' level of involvement in PMTCT programmes (n = 200)

Hypothesis 5	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	281.316[a]	231	.013
Likelihood Ratio	241.750	231	.300
Linear-by-Linear Association	7.270	1	.007
N of Valid Cases	200		

a. 265 cells (97.4%) have expected count less than 5. The minimum expected count is .05.

6.3. QUALITATIVE DATA ANALYSIS AND PRESENTATION OF THE MAIN THEMES FROM FOCUS GROUP DISCUSSIONS AND KEY INFORMANT INTERVIEWS

Qualitative data were gathered through focus group discussions and key informant interviews. These were conducted with the community people, community gatekeepers and professionals involved with PMTCT issues. Eight focus group discussions comprising twelve people at most and nine were conducted with community members. Two focus groups per site were conducted and these comprised men only and women only groups aged between 15 and 60. The targeted sample was twenty-four men and women per site. However, for various reasons the research team worked with eighty-two people for all four sites which included twenty-four people at the first site, twenty at the second, eighteen at the third, and twenty people at the final site. The participants were drawn from those who completed the questionnaire using uncontrolled quota sampling, and age and gender were the variables that determined the selection.

Semi-structured interviews were conducted with twenty community gatekeepers, specifically five per site and these comprised of chiefs, councillors, village heads and headmen. The sample for these interviews was not balanced in terms of gender because there were eighteen men and two women as traditionally men are supposed to occupy positions of influence hence the few women involved are among the few who got into local leadership due to government efforts to empower women in running the nation. For this group of people, age was not a determinant of participation.

The other semi-structured interviews were conducted with professionals working under the PMTCT programme. For this group again, age and gender did not determine participation as they were selected based on the roles they played in the organisation, their

availability and convenience. Twenty such professionals were contacted with the majority, specifically, ten being midwives from health centres and the other ten came from other parastatals and NGOs. There were more midwives than other professionals because these are health practitioners who engage pregnant women and nursing mothers daily, educating them on PMTCT issues and other related matters. From the remaining ten, two professionals were selected per organisation using purposive sampling. The organisations included National AIDS Council (NAC), a national HIV and AIDS coordinating organisation; Zimbabwe Community Health Intervention Research Project (ZiCHIRe), a local non-governmental organisation involved in disseminating information on PMTCT and HIV Voluntary Counselling and Testing; Elizabeth Glaser Paediatric AIDS Foundation in Zimbabwe (EGPA –Zimbabwe), an NGO seeking to prevent paediatric HIV infection and to eliminate paediatric AIDS through research, advocacy, prevention and treatment programmes; Médecins Sans Frontières in Zimbabwe (MSF–Zimbabwe) which mainly offers medical support to HIV and AIDS patients and Family AIDS Caring Trust (FACT) a local NGO promoting facility-based mother support groups on retention in care and PMTCT.

Qualitative data analysis was undertaken to add detail to the quantitative findings. The researcher analysed the two sets of data. Quantitative data gave breadth to the study so the researcher assumed that getting depth through the qualitative portion of the study on some of the same issues, would facilitate ideas for strategies that could be proposed for empowering women under PMTCT programmes. Thus, the finds were balanced even though the qualitative data played a complementary role.

In analysing the data derived from focus group discussions and key informant interviews and their transcripts, ten main themes emerged from the findings regarding the views of

community men and women, community gatekeepers and professionals. The outline below indicates the themes and their source(s). As a result of the participants' debates, the key themes identified by the research team are:

1. Level of PMTCT knowledge and Awareness (focus group discussions).
2. Type of relationship between PMTCT professionals and community members (focus group discussions and interviews).
3. Level of male partner involvement in PMTCT programme (focus group discussions and interviews).
4. Challenges experienced by rural women in participating in PMTCT programme (focus group discussions and interviews).
5. Suggested roles for rural women in PMTCT initiatives (focus group discussions and interviews).
6. Roles of community gatekeepers in PMTCT programmes (interviews with community gatekeepers).
7. Factors that promote or hinder PMTCT programme (focus group discussions and interviews).
8. Challenges encountered by organisations in implementing the PMTCT programme in the community (interviews with professionals).
9. Professionals' perception of the influence of gender and age on the failure or success of PMTCT programme (interviews with professionals).
10. Strategies to improve rural women's participation in the PMTCT programme (focus group discussions and interviews).

These themes helped in informing the strategies proposed later in the next chapter. The table below shows a summary of the themes, categories and subcategories identified in the

data analysis of the transcripts of the focus group discussions conducted with rural men and women and key informant interviews conducted with community gatekeepers and professionals. The generation of the basic, organising and global themes was influenced by the thematic analysis chosen. A detailed explanation of how it was used was highlighted in Chapter 4.

Table 6.35. Overview of the themes, categories and subcategories coming out of focus group discussions with men and women and key informant interviews with community gatekeepers and professionals

Basic Themes	Organising Themes	Global Themes
1. Participants' perceptions of PMTCT knowledge	1.1. Knowledge as a power or as a protective factor 1.2. Views on lack of knowledge	1.1.1. Possessing basic knowledge of PMTCT 1.2.1. Inadequate PMTCT knowledge 1.2.2. Lack of constant update of acquired knowledge
2. Type of relationship between PMTCT professionals and community members	2.1. Traditional type of relationship 2.2. Modern type of relationship	2.1.1. Expert-client relationship 2.2.1. Facilitator-partner relationship
3. Level of male partner involvement in PMTCT programme	3.1. High male partner involvement 3.2. Low male partner involvement	3.1.1. Male partners regarded as supportive 3.2.1. Male partners regarded as less supportive 3.2.2. Lack of time to allow male involvement 3.2.3. Lack of privacy at antenatal clinics as a hindrance to male involvement

4. Challenges experienced by rural women in participating in PMTCT programme	4.1.Cultural challenges	4.1.1. Women obliged to adhere to traditional child rearing ways even when they conflict with PMTCT recommendations
	4.2.Social challenges	4.2.1. Inequalities between men and women
		4.2.2. Social expectations on women
	4.3. Economic challenges	4.3.1. Lack of resources
	4.4. Negative influences of religion	4.4.1. Religious doctrine which prohibits seeking of medical services
5. Suggested roles for rural women in PMTCT initiatives	5.1.Educative roles	5.1.1. Mentoring
		5.1.2. Peer education
	5.2.Facilitative roles	5.2.1. Encouraging each other to attend antenatal clinics
6. Roles of community gatekeepers in PMTCT programmes	6.1. Educative roles	6.1.1. Community-based approach
	6.2. Facilitative roles	6.2.1. Encouraging significant others to offer support
7. Factors that promote or hinder PMTCT programme	7.1. Socio-cultural factors	7.1.1. Unequal treatment between men and women in the society
		7.1.2. Use of traditional birth attendants
		7.1.3. Lack of decision- making power among women
		7.1.4. Stigma and discrimination from the community
		7.1.5. Ensuring lineage continuity and posterity

	7.2. Religious factors	7.1.6. Family pressure to breastfeed 7.2.1 Religious doctrines which prohibit seeking medical services
	7.3. Programmatic factors	7.3.1. Top to bottom approach 7.3.2. Antenatal clinics established far away from the community 7.3.3. Offering PMTCT services with other general services at the clinic
8. Challenges encountered by organisations in implementing the PMTCT programme in the community	8.1. Lack of resources	8.1.1. Limited funds to contact everyone in the community 8.1.2. Lack of manpower to run the programme
	8.2. Low male involvement	8.2.1. Absence or low numbers of men in the programme being a hindrance to PMTCT adherence
9. Influence of gender and age on the failure or success of the PMTCT programme	9.1. Gender as a stumbling block	9.1.1. Pregnancy regarded as a women's issue
	9.2. Age as a hindrance to PMTCT participation	9.2.1. Little cooperation from adolescents and young adults
10. Strategies to improve rural women's participation in the PMTCT programme	10.1. Community based-strategies	10.1.1. Door-to-door visits 10.1.2. Engaging local leaders to encourage participation in PMTCT
	10.2. Relationship and gender-based strategies	10.2.1. Encouraging couple testing 10.2.2. Family support 10.2.3. Women-based strategies
	10.3. Technical strategies	10.3.1. Establishing clinics nearer to communities

	10.4. Structural-based strategies 10.5. Educative strategies	10.3.2. Addressing socio-cultural issues before programming 10.3.3. Adjusting consultation times at health care centres 10.3.4. Separating antenatal clinics from general clinics 10.4. 1. Government to be fully committed to the running of the programme 10.4.2. Establishment of stringent policies to encourage cooperation from all 10.5.1. Constant provision of education to communities by health practitioners 10.5.2. Catch them young: School-based approach to PMTCT education 10.5.3. Capacity building of traditional leaders

Table 6.36 Demographics for Qualitative Research Participants

Research Instrument	**No. of males**	**No. of females**	**Participants per site**	**Total for the whole study**
Focus Group Discussions (8)	12 males in male-only group	12 females in female-only group	24	96
Key Interviews with community gatekeepers	18	2	5	20
Key Interviews	8	12	5	20

6.3.1. Theme 1: Participants' Perceptions of PMTCT Knowledge

One theme that emerged from focus group discussions with men and women concerned their perceptions on PMTCT knowledge. The majority revealed that they had knowledge of PMTCT though it was elementary and sometimes outdated. This helped support the finding from quantitative data which indicated that the participants possessed only very basic knowledge of PMTCT.

Category 1.1. PMTCT knowledge as a Power or as Protective Factor.

For most of the participants from focus group discussions, possession of basic knowledge on PMTCT played a protective role to the couple and the unborn child and the community. It gave them hope to attain an AIDS-free generation. Possessing this knowledge was also regarded as power as it gave them confidence that they were in control of their health issues.

Sub-category 1.1.1. Possessing basic knowledge on PMTCT

The findings helped confirm what was obtained from quantitative research that most had basic knowledge of PMTCT. They echoed that they were happy to possess this knowledge as it helps protect themselves and their future children from HIV infection. This is evident from these statements:

'Yes we have heard about PMTCT and we know that it aims to prevent infection between an HIV-positive pregnant mother and child. This knowledge is very handy to us as it helps us protect ourselves and our children from this deadly disease.' **(FGD female participant)**

'In my community, most people know about this programme. They know that when a woman gets pregnant, she must be tested for HIV and follow the recommendations coming from health

practitioners if found positive. If one is found negative also, he or she should get advice from nurses on how to remain so.' **(Male community gatekeeper)**

Category 1.2. Views on Lack of Knowledge.

Besides confirming that the community knew of PMTCT, some participants also highlighted their perceptions of the lack of PMTCT knowledge. Two sub-themes emerged that clarified the danger of inadequate PMTCT knowledge and lack of constant updates on the knowledge.

Sub-category 1.2.1. Inadequate PMTCT Knowledge.

Participants highlighted that possessing incomplete knowledge was very dangerous as sometimes men assume that PMTCT issues are meant for women only. This could be witnessed in statements like:

'Uhmmm, my brother lack of knowledge is as good as death. These women need more knowledge on PMTCT as they are lacking. They possess very little knowledge which may be a peril to their health and those of their children.' **(FGD male participant).**

'People (both men and women) must be fully equipped with knowledge on PMTCT to avoid taking shortcuts which may harm themselves and their children.' **(Male community gatekeeper)**

Sub-category 1.2.2. Lack of Constant Update on Acquired PMTCT Knowledge.

In expressing their views on the lack of PMTCT knowledge, more than half attributed inconsistent dissemination of such knowledge, to health practitioners. This can be deduced from the following statement:

'Yes we have been equipped with PMTCT knowledge by nurses and other health practitioners however the challenge is that they came long back and their visits are inconsistent. The ideal

thing for them to do is to continue coming so that we will not forget. If they come after more than five years, we as a community will lag behind as we will lack recent updates and developments on this issue.' **(Female Community gatekeeper)**

6.3.2. Theme 2: Type of Relationship between PMTCT Professionals and Community Members

Community psychology talks of changing the relationship between professionals and community members in which emphasis is on creating an environment where both parties operate from the same platform. They encourage the transition from the traditional relationship, where the relationship is that of an expert and a client, to a modern type of a facilitator or collaborator and a partner. Such type of relationship facilitates the empowerment of disadvantaged groups of people. These two relationship types were portrayed in this study with the majority alluding to the traditional relationship.

Category 2.1. Traditional Type of Relationship.

Most participants from focus group discussions and interviews highlighted that the relationship between professionals and participants aligned more to the traditional type. This is a relationship where the professional is viewed as a think tank, someone who possesses knowledge and solutions to all the community's problems, with the latter being just passive recipients.

Sub-category 2.1.1. Expert-client Relationship.

The traditional relationship is that of an expert and a client. This relationship places the two parties at different levels of operation with the expert or professional possessing more power than the client or community members. The following statements are from interviews with community gatekeepers and professionals:

‘As a community we will be waiting for the professionals to come and teach us as they understand our problems better than us and they have to provide solutions to our health problems’ **(Male community gatekeeper)**

As the Ministry of Health we do not involve the community in our planning and evaluation of the programme. What we do is to provide them with information and screen, counsel and test them for HIV then advice (sic) accordingly.’ **(Professional)**

Category 2.2. Modern Type of Relationship.

The modern relationship is one in which there is full inclusion of the community whereby they are also given a role to plan, implement and evaluate the programme. A minority from this study portrayed that such a relationship occurred between professionals and the community. The community in this relationship is also regarded as knowledgeable people who can contribute effectively to the programme. They will be active recipients.

Sub-category 2.2.1. Facilitator-partner Relationship.

The modern relationship promotes a relationship that places the professional and the community at the same level, with equal power between a facilitator or collaborator and partner, or the professional and the community. These statements help in portraying such a relationship.

‘Yes we hold monthly and quarterly meetings with the community councillors and stakeholders, planning and implementing programme, seeing what we have achieved and correcting wrongs. Also mapping a way forward in achieving set goals.’ **(Professional)**

‘We have amicable relationship with the professionals. They treat us with respect, and we are given an opportunity to share our own views as well.’ **(Female FGD participant)**

Yes we include the community, our approach involve all relevant stakeholders namely, local authorities, police, community leaders, service providers like nurses and doctors. Focus group discussions are done, referral pathways are created and the best approach is from the people being guided by the philosophy that nothing for the community without the community.' **(Professional)**

6.3.3. Theme 3: Level of Male Partner Involvement in PMTCT Programme

Male involvement in PMTCT programmes has also been regarded as a crucial factor, especially in African contexts where there is much male dominance. Without full involvement of men, adherence to PMTCT recommendations becomes very difficult for women who found themselves HIV positive whilst pregnant. Male partner support, therefore, plays a role in women empowerment under PMTCT initiatives. Under this theme, two sub-themes emerged that highlighted that there is high male partner involvement, but the majority stated there is low male partner involvement.

Category 3.1. High Male Partner Involvement.

Very few participants alluded to males' involving themselves fully in PMTCT programmes. They echoed that males who participate, escort their partners to antenatal clinics and work with their partners in adhering to PMTCT recommendations if they test HIV positive. But those found to be HIV negative also try to cooperate in maintaining their negative sero-status.

Sub-category 3.1.1. Male partners regarded as supportive.

Very few participants from both interviews and FGDs reiterated that males in the community were very supportive of their female counterparts under the PMTCT programmes. This can be backed up these views:

They are very supportive it is only that they will be busy at work but they allow their women to go and participate in such programmes and the fact that they award their women permission to go and get screened and tested for HIV whilst pregnant, shows that men like and support the programme. **(Male community gatekeeper)**

'Sometimes as men we may escort our wives to antenatal clinics which is a sure indication of love for our wives and our support for the programme.' **(Male FGD participant)**

'Ever since we started talking about PMTCT we have seen men escorting and supporting their women.' **(Male community gatekeeper)**

Category 3.2. Low Male Partner Involvement.

The majority indicated that males were less or not supportive of the programme. They spoke of low male involvement. Two sub-themes emerged from this sub-category. Specifically that men were less supportive, they did not have time to get involved in the programme and could not be involved because of lack of privacy at antenatal clinics.

Sub-category 3.2.1. Male Partners Regarded as Less Supportive.

Most participants from both interviews and FGDs including some males stated that males were less supportive of the programme. The following statements back this up:

'I think we should continue educating these men so that they will end up accepting the programme. Men of all ages are not very supportive.' **(Female community gatekeeper)**

'Male partners are not supportive of the programme.' **(Professional)**

'The issue of lack of male support is really a problem under this programme. We will be expecting males to be fully involved as they are equal partners with women in this issue

however we do not see them escorting their wives or partners neither do they go and get tested for HIV as well. As men we are sabotaging women as well as the programme here.' **(Male community gatekeeper)**

'*Men are really a stumbling block in this programme. They do not want to go with us to the antenatal clinic. They assume that PMTCT is a women's business. Wish something could be done to coerce these men to support us too.'* **(FGD female participant)**

Sub-category 3.2.2. Lack of Time to Allow Male Involvement.

In response to involvement, some male participants in focus group discussions indicated that time constrains contribute to low levels of male involvement in PMTCT programmes. The following statement supports this view:

'As men we really want to be involved but time factor is our major concern. Consultation times at clinics clash with our working times so we cannot abandon our sources of livelihoods for the sake of PMTCT.' **(FGD male participant)**

Sub-category 3.2.3. Lack of Privacy at Antenatal Clinics as a Hindrance to Male Involvement.

A significant number of men in focus group discussions pointed to the lack of privacy at antenatal clinics as hindrances to their involvement. Some complained about PMTCT services being offered at the same centre as other primary health care services, which may compromise privacy. Views of the following nature were echoed:

'You know what, as men we want to support our women but there is no privacy at clinics. It would have been better if antenatal clinics were just meant for maternal issues only. The

environment at clinics where everyone will be looking at you wondering whether you tested positive or negative creates discomfort in most men that is why the majority of us end up leaving it all to women.' **(FGD male participant)**

'The government must separate PMTCT services from other general health services. We want centres which stand on their own so that one will not feel embarrassed to access PMTCT services and also we want to ensure that if one is HIV positive, privacy is surely guaranteed.' **(FGD male participant)**

6.3.4 Theme 4: Challenges Experienced by Rural Women in Participating in PMTCT Programme

Among the themes coming out was that women experience challenges which affect their willingness to get involved in the PMTCT programmes fully. The challenges highlighted ranged from cultural, social, economic and religious ones.

Category 4.1. Cultural Challenges.

Some cultural factors were regarded as stumbling blocks to women's participation in PMTCT programmes. The one being referred to frequently was that in some cases women faced the dilemma of adhering to PMTCT recommendations from health practitioners whilst abiding by traditional ways of rearing children.

Subcategory 4.1.1. Women Obliged to Adhere to Traditional Child-rearing Ways Even When They Conflict with PMTCT Recommendations.

Several female participants from FGDs highlighted that some experience the dilemma of having to follow advice from health practitioners whilst simultaneously following the traditional way of rearing children. This made them experience cognitive dissonance as

sometimes they had to breastfeed their children or give them water even after being taught the dangers by health practitioners. These statements back up this view:

'*Some pregnant women find themselves in a dilemma after giving birth. In some cases health practitioners tell them not to breastfeed but significant others tell them it's mandatory to do so.'* **(FGD female participant)**

'Health practitioners advise us on how to raise children free of HIV ... traditional ways conflict with those from the health centres. We wish to adhere but we find ourselves at loggerheads with our cultural expectations when it comes to raising of babies.' **(FGD female participant)**

'It really asks for a lot of courage for HIV positive women to adhere to PMTCT recommendations after giving birth. On one hand health practitioners make their recommendations and on the other hand norms and customs dictate the opposite.' **(FGD female participant)**

'Self-stigma and social withdrawal for those who happened to be HIV positive are some of the challenges experienced by women in fully participating in this programme. Some happened to be chastised by their husbands due to harmful cultural and religious beliefs.' ***(Professional)***

Category 4.2. Social Challenges.

Women also experience challenges embedded in the families and societies to which they belong. The participants talked about women's position in society and some societal demands as some challenges which block their full involvement in the PMTCT programme.

Subcategory 4.2.1. Inequalities between Men and Women.

Several participants mainly from interviews and some from FGDs echoed that most women occupy a despised, disadvantaged position in the families they belong to, making them fail to make decisions even ones that affect their health. This is so because of unequal distribution of power between men and women in many societies. This could be evidenced in these statements:

'Fears of discrimination and sharing (disclosure) of results with spouse if tested alone and comes out positive becomes a challenge to some women as they may end up experiencing violence.' **(Professional)**

*'Decision making on all aspects of life are done by male partners and elders of a particular family hence there is nothing a woman can do without their approval. She may be willing to be in the programme but without approval of male figures in the family it does not work.'***(Professional)**

'A woman may go and get tested but if her male partner is not involved it becomes difficult for her to adhere to PMTCT activities if the man who happens to be the head of the family is not involved.' **(FGD male participant)**

Subcategory 4.2.2. Social Expectations of Women.

Some participants attributed the challenges to the demands of society on women. These statements portray that view:

'Our society does not allow women to be on the forefront of men hence even in participating in these programmes, women are not expected to initiate anything without the approval of men.' **(Female community gatekeeper)**

'Women are expected to do too many household chores so they are not able to participate'. **(Professional)**

'Society always expects pregnant women to be HIV negative hence some end up giving wrong contact details to avoid follow-ups and for fear of being known and labelled hence some discrimination is still lurking.' **(Professional)**

Category 4.3. Socio-economic Challenges for Women.

Socio-economic challenges were referred to by both professionals and community members as hindrances to women's full participation in the PMTCT programmes. The sub-theme which frequently came up was that of limited resources amongst many women.

Subcategory 4.3.1. Lack of Resources.

The majority in FGDs reiterated that some women fail to participate in PMTCT due to lack of resources to participate in such programmes, including material and human resources. These statements alluded to that:

'Government must provide all material needed for child-birth because they are not affordable, for example cotton wool, methylated spirit and so on. They should not just say we provide you with midwifery services only, they should also help us with other materials as well.' **(FGD male participant)**

'Poverty is a major hindrance to women's participation in this programme because sometimes they are told not to breastfeed but they have no money to buy alternative feeding for their babies.' **(FGD male participant)**

'Sometimes women are willing to participate but the organisations involved cannot provide a full complement of professionals who can work with these women. The few available are not adequate for all.' **(Community gatekeeper)**

Category 4.4. Negative Influences of Religion.

Belief systems also play a crucial role in people's health issues. Some participants raised religious factors as playing a detrimental role in the success of PMTCT programmes. The most dominant factor was religious doctrines which prohibit accessing medical services.

Subcategory 4.4.1. Religious Doctrine which Prohibits Seeking Medical Services.

A significant number of participants from both focus group discussions and interviews reiterated that one of the biggest stumbling blocks to some women's participation in the PMTCT programme was religious indoctrination discouraging the use of medical services. These statements support this view:

'Some churches do not want to participate so they cannot gather and be tested even when they are encouraged to go and get tested they do not go. They say they do not need medical services.' **(FGD female participant)**

'Some religious beliefs especially Christianity like some apostolic faith churches are disturbing this programme because they do not want to be involved as they are strongly discouraged by their church leaders.' **(Male community gatekeeper)**

6.3.5. Theme 5: Suggested Roles of Rural Women in PMTCT Empowerment initiatives

Community psychology emphasises that if any disadvantaged groups in society need to be empowered, they must play a pivotal role in bringing about their own empowerment. From this point, the participants were asked about the roles they assumed to be played by rural women to bring about their own empowerment under PMTCT programme. The roles that came out were categorised as educative and facilitative ones.

Category 5.1. Educative Roles.

The majority believed that women must take it upon themselves to share information and educate each other. The participants proposed this should come through mentoring and peer education.

Subcategory 5.1.1. Mentoring

Under this sub-category several participants from both FGDs and interviews proposed that women must be able to counsel, advice and teach each other. Some talked of identifying mentor mothers who could then offer such services to the younger generation. This can be evidenced by some statements below echoed during focus group discussions and interviews:

'Those knowledgeable must show that they know and be given opportunities to share information. They must share information amongst themselves as women. On the other hand, those being given the information must be ready to receive it not just to be non-responsive.' **(FGD male participant)**

'Nowadays, women engage in micro-financing projects and other groupings at church; hence they should educate each other on these PMTCT issues.' **(Male community gatekeeper)**

'Yes, there is participation and dissemination of health-related information through health centre committees where mentor mothers are trained on how to mentor others on maternal issues.' **(Professional)**

Subcategory 5.1.2. Peer Education.

Many participants from both interviews and FGDs also reiterated that it is easier for women to learn about PMTCT from those close to them with whom they always interact and trust. Henceforth, peer education was emphasised as another role that women must engage in under the PMTCT programme. This was evidenced by the following statements:

'Women must be encouraged to teach each other about PMTCT issues whenever they meet. It is better to be educated by someone whom one is used to.' **(Community gatekeeper)**

'Health practitioners must give some monetary incentives to motivate those amongst us, selected to be peer educators. Such motivation can make women more interested in getting involved in this programme.' **(FGD female participant)**

'Yes there are organisations in this community like Seke Rural Home Based Care Programme which take women and educate them on PMTCT so that they can educate others.' **(FGD female participant)**

'We involve women in social activities like netball tournaments where we talk about the programme and importance of them being involved. The objective being that after they become equipped with knowledge they will educate other women as well.' **(Professional)**

Category 5.2. Facilitative Roles.

Some participants echoed that women must play facilitative roles in the community where they become listeners of others' issues, facilitate involvement through encouraging one another and facilitating workshops.

Subcategory 5.2.1. Encouraging Each Other to Attend Antenatal Clinics.

Encouraging one another to attend antenatal clinics on time was the facilitative role most spoken about. This can be evidenced by the following statements:

'Community health workers called behaviour change facilitators (BCFs) are trained to be paraprofessionals where three quarters of them are women who will then work within their community to promote desirable behaviours towards PMTCT interventions.' **(Professional)**

'As women, this is our health therefore we should take it upon ourselves to encourage each other to be involved in programmes that have to do with maternal health.' (**FGD female participant)**

6.3.6 Theme 6: Roles of Community Gatekeepers in PMTCT Programmes

Community gatekeepers are proximal agents within the community which have been identified as key in PMTCT programmes. Their positions in the community can be of paramount importance in women empowerment. Several participants alluded to the view that these community gatekeepers like village heads, councillors and chiefs must play educative and facilitative roles in trying to make the PMTCT programmes a success.

Category 6.1. Educative Roles.

Educative roles mean that the community gatekeepers must be able to educate their community members on maternal issues, including PMTCT. Most participants alluded to the

view that gatekeepers usually adopt a community based-approach in educating their community members.

Subcategory 6.1.1. Community- based Approach.

Several community gatekeepers said they teach their communities on PMTCT issues within their community. This was backed by statements like the one below:

'One of our duties as leaders is to educate the community whenever we gather them for, example like now, when we know that there is a programme that we have just heard we try to educate everyone. Within our wide community wherever we go, we try to educate people at ward level.' **(Community gatekeeper)**

Category 6.2. Facilitative Roles.

Facilitative roles mean that community gatekeepers ensure that the programme succeeds through different activities. Two most common actions highlighted were encouraging significant others to support their family members to participate in the PMTCT programmes and inviting professionals to hold workshops and meetings with the community on PMTCT issues.

Subcategory 6.2.1.Encouraging Significant Others to Offer Support.

Most community gatekeepers stated that they always urge people close to those of child bearing ages to encourage them to participate in PMTCT programme. The following statement reflects that:

‘As community leaders, we value the family system, and we believe it is crucial in promoting health communities; therefore we usually encourage families and partners to support each other in PMTCT programmes.’ (**Community gatekeeper)**

Subcategory 6.2.2. Inviting Professionals to Educate the Community.

Some community gatekeepers stressed that they periodically invite professionals to come and educate their community on maternal health issues, including PMTCT. This can be noted in the following statements:

‘As a community, we will be waiting for professionals to come and teach us. Sometimes when we do our village assemblies, we request village health workers to share with us what they get from workshops.’ **(Community gatekeeper)**

‘We gather people at ward centres and invite health professionals to come and share knowledge about health issues, including PMTCT.’ **(Community gatekeeper)**

6.3.7. Theme 7: Factors that Promote or Hinder PMTCT Programme

Participants from both focus group discussions and interviews highlighted factors that either promote or hinder PMTCT programme. Many factors raised were those that hinder the success of the PMTCT programme. The factors raised included social, cultural or traditional, religious and programmatic. These factors may be perceptions, enablers or nurturers. Perceptions include positive or negative knowledge, beliefs and attitudes that influence decisions and actions towards PMTCT. Enablers mean the availability, accessibility, acceptability and affordability of resources that either necessitate or block decisions and actions towards PMTCT. Nurturers refer to the influence of family or community contexts positively or negatively moulding decisions and actions towards PMTCT uptake.

Category 7.1. Socio-cultural Factors.

The majority alluded to unequal sharing of power between men and women in society as the major hindrance towards promoting PMTCT programme. They echoed that women lack decision making power even in crucial matters like their sexual reproductive health. Other subcategories which emerged under this theme include the use of traditional birth attendants, stigma and discrimination from the community, desire to ensure lineage continuity and posterity and family pressure to breastfeed.

Subcategory 7.1.1. Unequal Treatment between Men and Women in Society.

Numerous participants alluded to the view that women's positions in society disadvantages them even regarding their health issues. Most women are treated unfairly compared to the treatment men get in society. This was evidenced by statements like the one below:

'We, as women, are not being treated fairly in society. We do not have any resources registered in our names all wealth belongs to the men; hence even if the man is a hazard to your health you cannot leave him because you cannot sustain yourself. This makes us risk our lives, sometimes especially in the face of HIV and AIDS.' **(FGD female participant)**

Subcategory 7.1.2. Use of Traditional Birth Attendants.

A significant number of participants supported the use of traditional birth attendants as a positive way in child rearing. They just advocated for the government to include them in PMTCT programme. This was supported by statements of the following nature:

'Our traditional culture is very helpful, for example, in the past we used to have traditional birth attendants who used to be very knowledgeable on giving birth. They used to help our children very well.' **(Community gatekeeper***)*

'There are no traditional ways which are affecting childbirth. If a person gives birth at home (though rare) we quickly look for transport to take the woman and child to the clinic.' **(FGD male participant)**

'Traditional birth attendants are very helpful during childbirth, and we support their existence. I would rather get the services of a traditional birth attendant who, unlike nurses, does not give us unfriendly attitudes …. They also provide us with important information on the local customs, traditions and perceptions regarding childbirth and new-born care. The government must just recognise them in PMTCT activities.' **(FGD female participant.)**

Subcategory 7.1.3. Lack of Decision Making Power among Women.

Many female participants and some professionals emphasised that women are disempowered in society which may become a risk in their lives as they lack decision making power even in issues to do with their health. These statements reflect that:

'Men dominate us in sexual behaviour so we cannot initiate anything with regard to sexuality issues.' **(FGD female participant)**

'It is very difficult for us as women to make decisions in society and in our marriages and families, even those decisions that have to do with our sexual reproductive health.' **(FGD female participant)**

'In most cases we are supposed to act to please men all the time even if it's dangerous to our lives like in this case even if you know that you are HIV negative and your man is HIV positive you cannot propose any safer sexual practice because it is against the norm.' **(FGD female participant)**

'Lack of decision- making power for females is a stumbling block towards our programme. Decision making on all aspects of life are done by male partners and elders of a particular family which may not necessarily be in favour of females.' **(Professional)**

Subcategory 7.1.4. Stigma and Discrimination from the Community.

Numerous participants pointed out that many people do not involve themselves in PMTCT programmes because of fear of stigma and discrimination from close people like family and community members. This is evidenced by the following statements:

'*We are really willing to participate in this programme but we have fear of being labelled after people get to know one's HIV positive status. The worst part is that you receive exclusion from people close to you so it's better to remain ignorant of one's HIV status.'* **(FGD female participant)**

'Some women fail to participate in PMTCT programmes due to fear of discrimination and sharing (disclosure) of results with spouse if tested alone and comes out positive.' **(Professional)**

Subcategory 7.1.5.Ensure Lineage Continuity and Posterity.

One of the nurturing factors a few FGD participants highlighted was that HIV positive women and some men had the willingness to participate in PMTCT programmes due to the

desire to reproduce and ensure lineage continuity and posterity. This could be noted in the following statement:

'In our culture we value children therefore I cannot stop recreating just because I am HIV positive. I would rather follow advice from healthcare practitioners and give birth to as many children as I want to ensure that our lineage continue to exist and grow.' **(FGD female participant)**

Subcategory 7.1.6. Family Pressure to Breastfeed.

A significant number of participants also talked of another negative nurturer, which hinders PMTCT participation. This factor is family pressure to breastfeed even if it will be against recommendations from healthcare workers. Statements like the one below were used to back up this view:

'Some HIV positive women fail to adhere to PMTCT recommendations when it comes to child-rearing due to expectations from the society and family. For instance, one may be told not to breastfeed yet the family values breastfeeding so much especially in the early days. ... besides compiling with family demands even though it endangers one's health and that of the baby.' **(FGD female participant)**

'Breastfeeding is mandatory in our society even when it may be a risk to the baby; one has to comply to avoid stigma and discrimination.' **(FGD female participant)**

Category 7.2. Religious Factors.

Participants discussed belief systems contributing either negatively or positively towards the PMTCT programme's success. Religion persisted as one factor which can

negatively affect the programme as the participants highlighted that some religious sectors prohibit their members from seeking medical services.

Subcategory 7.2.1. Religious Doctrines which Prohibit Seeking Medical Services.

Many participants emphasised some religious doctrines strongly prohibit accessing medical services, thereby impacting negatively on PMTCT programme. This was backed up by the statements below:

'*Some religious groups indoctrinate their members at tender ages so that they will strongly believe in their own convictions which usually cause them not to accept PMTCT information as it may conflict with the knowledge that they already have.'* **(FGD female participant)**

'Traditional beliefs have no negative influence on this programme but religious beliefs like some from the apostolic sector who do not seek medical help. We however encourage children from such families to be taught about health issues at schools so that they can share with their elders at home.' **(Community gatekeeper)**

'There are some Christian sectors which prohibit people from seeking medical services. Those are the problems that we face and the worst part is that many women go to those religious sectors hence the family will not get an opportunity to become educated on such reproductive health issues.' **(Community gatekeeper)**

Category 7.3. Programmatic Factors.

Programmatic factors focused on how the programme is being conducted. The findings of this study indicated that the approach used in offering PMTCT services, the distances of clinics from the community, and stigma and discrimination from healthcare providers acted as some factors that negatively impacted the programme.

Subcategory 7.3.1. Top- to- bottom Approach.

Some participants were not very pleased with the way the PMTCT programme was being handled. According to them, the programme seemed beneficial more to the professionals than the community as they had no contribution to it. The community was just on the receiving end; hence some felt they had no ownership of the programme hence were not that motivated to participate. This could be witnessed in statements like the one below:

'It seems these PMTCT professionals just come to fulfil their own agenda not the interests of us as the community. They should not just dictate everything to us we also want to be valued in this programme so that we can participate happily.' **(FGD female participant)**

Subcategory 7.3.2. Antenatal Clinics Established Far Away from the Community.

The majority from FGDs highlighted that they could not participate in the PMTCT programme because the clinics were too far from them. This was also supported by some professionals. The following statements reflect this drawback:

'Some community members want to participate in PMTCT programmes but distance becomes a barrier to them. Most clinics are established far away from the communities making it difficult for pregnant women to access health centres.' **(Professional)**

'We want to be part and parcel of this programme but hey, the clinics are too far from us thus we end up either using traditional birth attendants or just going there when the pregnancy is due.' **(FGD female participant)**

'The programme is very good, but most health centres which offer PMTCT services are too far. It is very disturbing to see a pregnant woman travelling for more than 15 kilometres to access health services.' **(FGD male participant)**

Subcategory 7.3.3. Stigma and Discrimination from Healthcare Providers.

Stigma and discrimination from health care providers also came out loudly during focus group discussions. The participants stated that such attitudes draw them back from PMTCT interventions. The following statements alluded to that:

'These healthcare workers must welcome us warmly even when we are HIV positive. Some of them make us feel dejected and valueless. They look down upon us and sometimes label us and judge us negatively just because we are HIV positive and pregnant.' **(FGD female participant)**

'Sometimes we opt for traditional birth attendants to avoid negative attitudes from the nurses. The majority of them are not patient with us.' **(FGD female participant)**

'The treatment from nurses especially for HIV positive pregnant women is very disturbing. They receive insults and are usually offered services after the majority of the patients have been served even when they come early.' **(FGD female participant)**

6.3.8. Theme 8: Challenges encountered by Organisations in Implementing PMTCT Programme in the Community

The professionals from organisations involved in the PMTCT programme and a few community gatekeepers highlighted some of the challenges they encountered in the community which retard the programme's progress. The two major challenges highlighted included lack of resources and low male involvement.

Category 8.1. Lack of Resources.

During the interviews done with professionals, the majority stressed that in as much as they had the willingness to make the programme a success they were incapacitated by lack of resources. Two sub-themes emerged: scarce funds to reach out to everyone in the community and lack of adequate human resources to conduct the programme.

Subcategory 8.1.1. Limited Funds to reach out to everyone in the Community.

The majority of the professionals and a few community gatekeepers echoed that in as much as the professionals had the zeal to work with the community in promoting PMTCT, they could not reach out to everyone. Due to this constrain they just selected some sections of the community leaving out others. The following statements can support this:

'*We are willing to expand the programme but obviously resource constraints especially monetary, restrain us. In addition to that prolonged protocols delay programming/implementation.'* **(Professional)**

'The programme is conducted fairly well however it fails to progress properly because of our economy. These programmes need funding but it is hard to come by.' **(Professional)**

'Our economy also needs to be improved so that professionals can continue coming periodically like after every three months to offer refresher courses.' **(Community gatekeeper)**

Subcategory 8.1.2. Lack of Human Resources to Run the Programme.

Several key informants emphasised that shortage of human resources had a negative impact on the progress of the programme. Views like the one below backed this:

'The programme is a noble one but our efforts are sometimes retarded by inadequate manpower. This makes us fail to expand our initiatives to all sections within the community. The limited manpower available sometimes become overwhelmed to an extent that service provision become compromised.' **(Professional)**

Category 8.2. Low Male Involvement.

Involvement of men in PMTCT programmes is crucial as they are equal partners with women in reproduction. Low male involvement was highlighted as a challenge that professionals experience in their effort to make PMTCT a success.

Subcategory 8.2.1. Lack of Men in the Programme being a Hindrance to PMTCT Adherence.

A number of professionals reiterated that PMTCT programme needs the inclusion of males for it to be effective, however the situation on the ground is contrary to that requirement. They emphasised that most men were not concerned with PMTCT which then affect adherence to PMTCT recommendations. This can be supported by the following statement from one of the participants and at least one similar sentiment by some community gatekeepers:

'As an organisation we expect both men and women to come and participate in PMTCT initiatives however male involvement still remains low.' **(Professional)**

'I think we should continue educating these men so that they will end up accepting it. Men of all ages are not very supportive.' **(Community gatekeeper).**

6.3.9. Theme 9: Professionals' Perceptions on the Influence of Gender and Age on the Failure or Success of the PMTCT Programme

Gender and age are some of the variables mentioned in interviews with professionals as contributing either negatively or positively toward PMTCT. In most interviews, the two were regarded as hindrances to the effectiveness of the programme.

Category 9.1. Gender as a Stumbling Block.

The majority alluded to the issue of gender as a stumbling block due to men being regarded as uncooperative in the programme. Two sub-themes emerged specifically that pregnancy is regarded as a women's issue and that women have no influence on issues to do with their health.

Subcategory 9.1.1. Pregnancy is regarded as a Women's Issue.

During interviews, the majority of the participants stated that maternal concerns were generally regarded as women's issues or business. This included issues to do with pregnancy. Because of such perceptions, most men have been reported to be less or not supportive of the PMTCT programme as they assume it is meant for women. This was backed up by statements like the one below:

'Male partners are not supportive of the programme. They regard pregnancy as a women's issue or business.' **(Professional)**

Subcategory 9.1.2. Lack of Women's Decision- making Power over their Health.

The other prevalent sub-theme was that women lack decision making power in society even on issues to do with their reproductive health. This makes them fail to decide solely on whether to follow PMTCT recommendations or not without the approval of their male

counterparts. The participants during interviews brought out this view in the statements below:

'Most women believe that males are the ones who decide for them and have a final decision towards women's health.' **(Professional)**

'Age and gender have an influence since younger adults and females cannot decide on their own reproductive health issues.' **(Professional)**

Category 9.2. Age as a Hindrance to PMTCT Participation.

The variable age was also highlighted as a hindrance sometimes to people's full involvement in the PMTCT programme. The main sub-theme that came out of this was that the younger generation was not supportive.

Subcategory 9.2.1. Little Cooperation from Adolescents and Young Adults.

The majority of the interviewed professionals reiterated that they were having challenges with the younger generation who were not forthcoming in this programme or did not adhere to advice from health practitioners. The following views reflect this sentiment:

'Yes, age does have a negative impact on the programme as the younger generation are not coming forth, and their participation is very low as compared to the older generation. In addition to that female participation is by far commendable than that of males.' **(Professional)**

'Young women fail to negotiate for safer sexual practice due to intergeneration relationships and cultural issues. This makes PMTCT programme less successful.' **(Professional)**

'To an extent yes, some adolescent mothers do not want to mix with those outside their age groups.' **(Professional)**

6.3.10. Theme 10: Strategies to Improve Rural Women's Participation in PMTCT Programme

Strategies refer to the ways that were proposed by the community and professionals in trying to improve the implementation of PMTCT programmes. During focus group discussions and key informant interviews it was noted that there are some loopholes which impact negatively on the programme hence, participants suggested ways of correcting them. Several strategies were proposed and have been categorised as community-based, relationship and gender-based, technical, structural-based and educative strategies.

Category 10.1. Community-based Strategies.

Community-based strategies focused on ways to work exclusively with the community in bringing success to the PMTCT programmes. Under this category, two strategies were very common: door-to-door visits and engaging local leaders to encourage community participation in the PMTCT programme.

Subcategory 10.1.1. Door-to-door Visits.

The majority from FGDs and some from interviews proposed that it was crucial to have communities being educated about PMTCT at their homesteads. This can help others who are shy to enquire from professionals, and it assists in contacting males who were reported to be less or not supportive of the programme. These statements backed up these suggestions:

'It is better for us to have professionals and any other knowledgeable people come and engage in door- to- door training of couples. This can help in catching up with men who are a great stumbling block in the success of this programme.' **(FGD female participant)**

'Whenever professionals come to communities, they must give the community HIV self-testing kits, because some are embarrassed to go to clinics for fear of being asked their HIV test results by other community members which may be difficult to answer if one is positive. It's supposed to be my secret hence it is better to do it at home on my own.' **(FGD male participant)**

'One way of addressing low participation could be through making information on HIV infection, spreading, prevention and available treatment be disseminated everywhere in the community even on all gatherings.' **(Professional)**

Subcategory 10.1.2. Engaging Local Leaders to Encourage Participation in PMTCT.

The participants also proposed engaging local leaders fully in PMTCT issues to encourage community involvement in PMTCT programme. Local leaders are authority figures who have so much influence and are well respected by the community that their word will be greatly respected. These statements backed up this view:

'Personally, I think involving headmen and chiefs in the rural areas in PMTCT activities may contribute a lot toward the success of this programme as they are among the most respected and feared figures within the community. They have a positive influence on these women.' **(Professional)**

'I suggest that there be social alignment and talks on reproductive health issues in all social and political gatherings with the help of our local leadership.' **(Professional)**

Category 10.2. Relationships and Gender-based Strategies.

Some of the proposed strategies were based on relationships and gender issues. The assumption was that close relationships either promote or distort the PMTCT programmes' progress; hence, it was crucial to find ways of encouraging positive relationships that could affect one's participation in PMTCT programmes. Another issue concerned women, where the participants suggested there should be women-centred strategies that can assist in having meaningful women involvement as they are the primary target of PMTCT. Three suggestions emerged, namely encouraging couple testing, encouraging family support and implementing women-centred strategies.

Subcategory 10.2.1. Encouraging Couples Testing.

The majority from FGDs and a few community gatekeepers reiterated that sometimes PMTCT activities fail to reach the targeted outcomes because of lack of harmony and unity amongst couples themselves. Couples fall in the microsystem that is very crucial with PMTCT initiatives. Henceforth, anyone working under the PMTCT programme must endeavour to promote couple testing which can be done if couples work together. Couples, themselves must also be found encouraging and supporting each other to participate in PMTCT activities. These statements reflect these suggestions:

'I think that for this programme to be successful there must be ways and means of creating harmony and collaboration of couples on childbearing.' **(FGD female participant)**

'Government, private organisations and NGOs must assist us by educating these men; because the men hide behind women. Some assume that their wives' HIV status automatically become theirs too even without them being tested.' ***(Community gatekeeper)***

'Men must also continue encouraging their women that is, reminding them to book pregnancy early and going together for HIV testing. In the past it used to be regarded as a women's issue because it was not important for us men to go with them but now we have been enlightened.' **(FGD male participant)**

*'In the past we used to think that if a woman tests positive her status was automatically her husband's as well but we now know that couples may be discordant, thanks to health education. A knowledgeable man should educate his wife and the opposite also applies to women.' **(FGD male participant)***

Subcategory 10.2.2. Family Support.

Family wellness also means individual wellness. Therefore family support plays a pivotal role in encouraging individual participation in PMTCT activities. The majority subscribed to this view in this study, and the following is an example of some statements highlighted that support this view.

'A lot should be done, we must start by having household heads teaching their families. Hence household heads must be knowledgeable. Charity begins at home. When one has family backup, that individual becomes motivated to be involved in PMTCT programme.' **(Community gatekeeper)**

Subcategory 10.2.3. Women-targeted Strategies.

The primary target of this study were women therefore the majority of participants during interviews suggested purely women-centred strategies. Empowered women were regarded as the backbone of a successful PMTCT programme. These statements subscribed to this view.

'One way to address the problem of low participation in PMTCT programme is to encourage formation of support groups for women living with HIV.' **(Professional)**

'Involving women meaningfully in policy making and in talks involving women's health and decision making can contribute a lot to the success of this programme.' **(Professional)**

'One of the strategies which is very vital is to encourage gender equity and mainstreaming in all our district- based programmes.' **(Professional)**

'Health education on the importance of adherence to ART can also work as a preventive measure against MTCT. For instance we have an NGO which funds workshops for mothers, where they study the developmental milestones of the exposed infants. At the end of it we come up with knowledgeable mothers.' **(Professional)**

Category 10.3. Technical Strategies.

The other category of strategies concerned the practical part of the programme mainly how it is conducted. From the discussions with the participants, it emerged that some practicalities promoted the programme while others pulled it down. In this vein, these strategies were proposed:

Subcategory 10.3.1. Establishing Clinics Nearer to Communities.

The majority echoed that some distances that communities had to travel to reach clinics were too much, especially for pregnant women. Thus, they suggested that the authorities and other well-wishers should strive to establish clinics nearer to all communities. In relation to this, one said:

'The Government must also be considerate! Clinics must not be too far; we must not have our pregnant women walking 3 to 4 kilometres to access services. Someone who is pregnant comes from so far to access transport to the clinic so something must be done there.' **(Community gatekeeper)**

Subcategory 10.3.2. Addressing Socio-cultural Issues before Programming.

The majority mainly from professionals suggested there is need to address socio-cultural issues that affect PMTCT participation before programming. This helps in safeguarding the sexual reproductive rights of women. The following statements back up this view:

'As implementing organisations we must establish gender equity and mainstreaming in all our district- based programmes before implementation of our activities.' **(Professional)**

'If we want to achieve our objectives in relation to PMTCT we must address cultural issues first. A culture that tolerate diversity is a way to go.' **(Professional)**

'Men have been talked about as less supportive of this programme we must therefore introduce transformation dialogues targeting man and community leaders in the communities that we operate in.' **(Professional)**

'Our societies have different traditions and convictions which also influence PMTCT involvement. I therefore suggest that for this programme to be successful there must be involvement of traditional healers and other cultural groups like zvigure cults as some women are from these cults.' **(Professional)**

Subcategory 10.3.3. Adjusting Consultation Times at Healthcare Centres.

The issue of time came out loudly as one of the stumbling blocks in meaningful involvement of people in PMTCT activities mainly from the male side. Participants stressed that some consultation hours at antenatal clinics were not compatible with their day to day schedules which contribute to their livelihoods; therefore, they proposed there be amendments to those consultation hours. This was echoed through these statements:

‘The issue of time is a serious one as it does not accommodate most men. I suggest that there should be no time limits like having consultations from Monday to Friday during the day. This programme must be accessible even up to ten during the night. It must not disturb my work schedule I must go there when I am free.’ **(FGD male participant)**

‘When I visit antenatal clinic with my wife we must be attended timeously and welcomingly because, we as men quickly get bored by inconveniences.’ **(FGD male participant)**

Subcategory 10.3.4. Separating Antenatal Clinics from General Clinics.

During FGDs, participants also mentioned that their privacy at antenatal clinics was compromised as they were at the same location as general clinics. They, therefore, proposed a separation of the two. These statements alluded to this:

‘I suggest that there should be establishment of purely antenatal clinics not general clinics so that people can simply go there for pregnancy issues only. In the past, we used to have traditional birth attendants who would work independent of the health centres, so we are advocating for such a way of operation for antenatal clinics.’ **(FGD female participant)**

'Health centres must be established nearer to communities. They should be manned by midwives and traditional birth attendants, and they should be exclusively for maternal issues.' **(FGD female participant)**

Category 10.4. Structural-based Strategies.

A reasonable number of participants also proposed structural-based strategies as a way of improving PMTCT programme. It emerged that the main stakeholder of this programme which is the government was also not contributing fully to implementing the PMTCT programmes in the community. Two major strategies proposed were that the government should be fully involved and establish stringent measures against those who contributed negatively towards the programme.

Subcategory 10.4.1. Government to be Fully Committed to the Running of the Programme.

A significant number of participants during both FGDs and interviews noted that the government should show full commitment towards implementing the programme. This could be shown from the planning, implementation and evaluation of the programme. These statements supported this view:

'We are pleading with the government to provide all materials needed for child birth because they are not affordable. They should not just talk of free child delivery but on the other hand asking expecting mothers to bring other necessities required during delivery.' **(FGD female participant)**

'Advocacy, lobbying, sensitisation can be very instrumental if we are to harness quality service delivery concerning PMTCT programmes. Above all political will is another area to

be considered if we are to have a multi-sectoral approach towards a better community participation.' **(Professional)**

Subcategory 10.4.2. Establishment of Stringent Policies to Enforce Cooperation from all.

Some participants proposed that the government must come up with stringent measures to enforce the programme's implementation. This was backed up by the following statement:

'Government and other policy makers must put up stringent policies that make it mandatory for men to get tested with their female partners to avoid intimate partner violence and also to encourage PMTCT participation.' **(FGD female participant)**

Category 10.5. Educative Strategies.

Some participants reiterated the power of possessing knowledge. They, therefore, suggested that implementers must come up with educative strategies targeting various sectors within the community. Three sub-themes emerged: constant provision of education to communities by health practitioners, introducing PMTCT information in children's curriculum, and capacity building of traditional leaders and church leaders.

Subcategory 10.5.1. Constant Provision of Education to Communities by Health Practitioners.

The majority from FGDs stressed there was no consistency in the delivery of PMTCT information within the communities, which makes them lag in the scientific community, thus compromising their health. They, therefore, proposed there should be constant and consistent dissemination of PMTCT knowledge to the community. This is witnessed in these statements:

‘Health practitioners and other policymakers must take it upon themselves to constantly educate traditional birth attendants on PMTCT.’ **(FGD male participant)**

‘Health educators must target those churches whose doctrines prohibits seeking of medical services and enlighten them on the virtues of participating in PMTCT programmes because some do not go due to lack of knowledge. Those people who are prohibited from going to clinics are the ones who perpetually engage in child bearing.’ **(FGD female participant)**

‘There is need for constant and consistent education of the community on PMTCT issues. Information must consistently be disseminated to the community because HIV and AIDS issues are vital so they should continue being publicised through media and other forms to ensure that every ear receives the message.’ **(FGD male participant)**

‘PMTCT information dissemination must be done through various means like the use of small radios. You can also use posters for example when there was cholera outbreak, posters were everywhere in beer halls, buses, taxis everywhere so that should also happen with PMTCT’ **(FGD female participant)**

‘This programme should not just be a once-off thing; it must always be there so that people gain adequate information. The Ministry of Health and Child Care must constantly and consistently keep educating the community.’ **(Community gatekeeper)**

Subcategory 10.5.2. 'Catch them young' - School-based Approach to PMTCT Education.

This sub-theme focused on educating people while still young, as young minds are malleable hence easy to retain information for future use. The participants from both FGDs and interviews pointed to the school as one of the best systems that can create a base for disseminating PMTCT information. These statements back up this view:

'Comprehensive sexuality education, including PMTCT issues, must be incorporated in the school curriculum. The government should have ensured that when they introduced this new curriculum thing, PMTCT information must be included as well. Children must start learning about PMTCT at a tender age so that they grow up knowing.' **(FGD male participant)**

'I suggest that children should be continuously taught about this programme at schools so that they will be talking about it at home and parents may become interested and get involved too.' **(Professional)**

Subcategory 10.5.3. Capacity Building of Traditional Leaders and Church Leaders.

Traditional leaders and church leaders have been regarded as proximal agents within the community who should have skills and knowledge for the promotion of PMTCT within the community. Therefore, most participants talked about capacity building these influential figures within the community, which can help promote meaningful involvement of women in PMTCT programmes. This view was backed by these statements:

'It is very necessary to educate religious sectors on PMTCT issues at their meeting places starting with the leaders themselves so that they can also disseminate it to their followers.' **(FGD female participants)**

'Traditional leaders must be knowledgeable and be up to date about PMTCT so that they can share with their communities. They must also be taught skills on how to educate the community.' **(Community gatekeeper)**

'Health educators must target church leaders. Men in those churches who discourage use of clinics must be approached and get educated, must change their mind-sets. In most cases the

leaders go to hospitals yet discouraging church members so the leaders must be targeted.' **(FGD male participant)**

6.4 CHAPTER SUMMARY

This chapter presented the analysis of both quantitative and qualitative data collected from the participants. Analysis of the data using mixed methods provided breadth and depth to the understanding of the topic under study. The researcher also gained corroboration of the two different types of data while offsetting the weaknesses inherent to using each approach by itself. The findings reflected that variables like age, gender, cultural background, level of PMTCT knowledge, and the highest level of formal education played significant roles in influencing PMTCT initiatives' involvement. In addition, socio-cultural factors and socio-economic factors also have a bearing in participation in PMTCT initiatives. Henceforth it becomes crucial to attend to these issues in women empowerment. The analysis provided a base for the proposed strategies which will be elaborated on in the following chapter. Therefore, the next chapter will discuss the findings and proposed strategies to empower rural women under PMTCT programme.

CHAPTER 7

DISCUSSION OF FINDINGS, PROPOSED STRATEGIES, LIMITATIONS AND RECOMMENDATIONS

7.0. CHAPTER OVERVIEW

This chapter discusses the findings explored in the previous chapter. The findings were aligned to the literature reviewed in relation to the theory of empowerment developed under the field of Community Psychology and in connection to PMTCT studies conducted in line with the concept of empowerment. The discussion endeavours to address the aim of the study which was to explore strategies that can be utilised in incorporating empowerment programmes in PMTCT initiatives from a Community Psychology perspective. They also met the objectives and answered the research questions. The research questions included:

- Do cultural beliefs and practices influence the participation of rural women in PMTCT initiatives?
- Does the level of PMTCT knowledge and awareness of rural men and women influence their participation in PMTCT programmes?
- Does a redefinition of the role of the relationship between PMTCT health professionals and rural women influence the latter's participation in PMTCT programmes?
- Does male partner involvement play a role in women empowerment under PMTCT initiatives?
- What challenges do rural women experience in trying to participate in PMTCT initiatives?
- What roles can rural women and proximal agents (community gatekeepers) in the community espouse in PMTCT empowerment initiatives?
- Which empowerment strategies assist in the design of PMTCT interventions for rural women?

Based on the findings, the researcher also proposed strategies that may be embraced to try to promote the empowerment of rural women in their participation under PMTCT initiatives. The chapter also explored the limitations encountered in the study and the measures adopted in trying to alleviate their ill effects. Last, the chapter will present the recommendations that will assist future researchers, policymakers, implementers and the community.

7.1. DISCUSSION OF FINDINGS

7.1.1. Knowledge Power

7.1.1.1. Knowledge of HIV Transmission during Pregnancy.

This study's findings reflected that the participants (both men and women) had better knowledge on the aspect that an unborn child may be infected by HIV during pregnancy. There existed a difference between the frequencies of the two genders, but it was marginal for all the responses. This may be a reflection that both men and women had acquired basic knowledge on PMTCT issues. Tesfaye et al. (2014) and Malaju and Alene, (2012) found related findings though the percentages were low. These findings correspond with those found by Deressa et al. (2014), in which respondents to their questionnaire mentioned transmission during pregnancy as the second common way of mother-to-child-transmission of HIV. However, the same researchers noted that most of their focus group discussion participants knew that HIV could be transmitted from mother-to-child, but they failed to mention the ways of transmission. This reflects that people know of MTCT of HIV though sometimes the knowledge will be inadequate and characterised by some misconceptions. This may affect their motivation and determination to take proactive measures in preventing HIV infection in an unborn child.

7.1.1.2. Knowledge of HIV Transmission through Breastfeeding.

The majority were knowledgeable that HIV may be transmitted through breastfeeding with the frequency of males who knew this fact being slightly above that of women. Generally, the findings portray that more females than males did not know about the preventive effect of avoiding breastfeeding to reduce HIV transmission. In connection with this, Tshibumbu (2006) and Central Statistics, Zambia and ORC Macro (2004b) also discovered that the majority of their male participants knew MTCT can occur during breastfeeding. In a related study, Deressa et al. (2014), found that most of their respondents knew that HIV could be transmitted via breastfeeding. Generally, women would be expected to be more knowledgeable on this issue than males; however, the new findings portray a different picture hence asking for further research to confirm this. These results may reflect that women are less empowered even with information that could be due to power dynamics within society.

7.1.1.3. Knowledge of the Possibility of HIV Transmission during Delivery.

The majority concurred there is a possibility of vertical transmission during delivery which reflects a small difference between males and females. But more females than males did not know about this which may indicate that in some communities, gender also determines one's level of exposure to information including sexual reproductive health information. Concerning this, nearly half of the participants (49.5%) in a study by Deressa et al. (2014), alluded to MTCT occurring during delivery. This was supported by 27.5% of participants in the study by Tesfaye et al. (2014). Having this knowledge coupled with motivation and action, becomes crucial in preventing vertical transmission of HIV.

7.1.1.4. Knowledge on the Possibility of Reduction of MTCT due to ART.

The findings reflected that slightly more than half of both men and women agreed with the view there is a chance of reducing MTCT through ART. But some participants rejected this view. In addition, few participants had no idea of the role that ART may play in addressing MTCT of HIV. An assessment of these findings may point to the idea that many people in the rural community have no confidence, faith or trust in ART to reduce MTCT of HIV. Despite the low percentages in this study, Machacha (2012), discovered knowledge levels that ARVs could reduce MTCT were high, however, he noted that prohibition of modern medicine led to the loss of follow up on their participants which may indicate that possessing knowledge does not always correspond to preventive behaviours or adherence to treatment.

In another related study, Tesfaye et al. (2014), found that 44.4% of their respondents had an insight that ART drugs given to HIV positive mothers could reduce the risk of HIV transmission. These findings were like those found by Abajobir and Zeleke, (2013), which confirmed the preventive nature of antiretroviral drugs when given to seropositive pregnant women. Though the findings reflect that in several communities people knew about the preventive effect of ART, the low percentages mean there is still need to come up with activities that can help build people’s confidence in the power of modern medicine in preventing HIV transmission from mother to child. This also points to the view that knowledge alone without confidence, faith or trust may not be enough in making people welcome ART. People also need to possess the courage to accept ART because in some communities significant, otherwise may show resistance towards it.

7.1.1.5. Knowledge of the Possibility of Reduction of MTCT due to Caesarean Delivery.

Based on these results, less than half of all the participants knew there is a possibility or reducing MTCT through caesarean delivery with more males than females subscribing to this view. But some participants refuted this view with the highest percentage coming from males though it was slightly higher than that of females. The percentages of those who did not know were relatively high, with around one-third of all females and under a quarter of all males indicating that they had no idea. These findings reflect that a noticeable number of rural men and women do not know that caesarean delivery may reduce MTCT with the most significant proportion coming from the female side. The results are in line with low percentages also obtained amongst participants in a study by Tshibumbu (2006) where only 38.6% knew that caesarean delivery could help prevent HIV transmission between mother and child. Malaju and Alene (2012), found that of the mothers they studied, only 11% knew that elective caesarean section delivery could prevent MTCT of HIV. In a worse off situation, only 2.3% of the participants in a study by the Central Statistics Office, Zambia and ORC Macro (2004b), knew that MTCT could be reduced using this delivery. These statistics may indicate that several people lack comprehensive information on PMTCT or maybe women fear caesarean section as a strategy towards PMTCT.

7.1.1.6. Knowledge of the Possibility of Reduction of MTCT by Avoiding Breastfeeding.

Regarding the view that avoiding breastfeeding has a possibility of reducing MTCT, the findings of this study portrayed that more than half of all the participants subscribed to this. However, some participants either refuted the view or indicated that they were not knowledgeable about it. In a related study by Malaju and Alene (2012), 18% knew that avoiding breastfeeding can prevent MTCT of HIV. In a study by Tesfaye et al. (2014), only

6.4 % spoke of avoiding breastfeeding as a preventive measure. Deressa et al. (2014), also found that some of their participants knew that HIV transmission could also be prevented if HIV positive women avoid breastfeeding or engage in exclusive breastfeeding during the first six months. In as much as participants from different studies highlighted that they knew the preventive effects of avoiding breastfeeding, the statistics show there is still need for continual dissemination of such information in many communities.

7.1.1.7. Knowledge about Prevention of Mother-to-Child-Transmission (PMTCT) Programme.

The majority from this study generally knew about the PMTCT programme. This may indicate that basic knowledge on PMTCT has been disseminated well to the rural people. However, there was also a minority group which indicated that they did not know about the programme. In Deressa, et al. (2014), 90.3 % knew about PMTCT. Other related studies also discovered that the majority knew the PMTCT programme for example, Jebessa and Teka (2005); Perez et al. (2008). These high levels of knowledge about the programme may be attributed to various health education programmes being conducted both at health facility and community levels and through broadcasting via mass media means. In addition, such levels of knowledge about MTCT are crucial for the prevention of MTCT of HIV hence programmes of this nature must utilise various means of increasing the community's knowledge and awareness through proper IEC material and BCC interventions.

7.1.1.8. Knowledge of the Availability of PMTCT Services at Local Clinic.

The majority of both males and females confirmed that PMTCT services were available at their local clinics. Of those who did not know, the scale weighed heavily on males, reflecting their low involvement in PMTCT activities. Yende et al. (2017) discovered that their male participants reflected low levels of knowledge about services offered at ANC

besides pregnancy monitoring. In a related study, Tshibumbu, (2006), found that 54.9% of his male participants knew about the availability of theses service at a local clinic. Though the percentage is marginally higher than that from this study, it still shows that most men are not aware of the PMTCT services being offered at their local clinics. This could be because of the assumption that pregnancy is a women's business and this may derail women's efforts to get involved in the programme.

7.1.1.9. Awareness of the Availability of HIV Voluntary Counselling and Testing Services at the Antenatal Clinic.

The majority, knew the availability of HIV voluntary counselling and testing at the antenatal clinic. Very few indicated that either the services were not there or they did not know about such services at the clinic. Most of those who fell on the negative side were males, which may reflect their low involvement. Deressa et al. (2014), found similar results in which the majority (90%), of the women who participated in their study, knew the availability of HIV voluntary counselling and testing at a local clinic. In another study, Tshibumbu (2006), found that a relatively moderate percentage (60.6%) of his male participants knew about this service. Contrary to this, Nyblade and Field-Nguer, (2001) found that generally, most men do not know if this service was offered at a local clinic. Hence perhaps on this aspect, women are more knowledgeable than men because they are the ones who are usually educated on PMTCT when they make their pregnancy booking and because most men are not cooperative with HIV voluntary counselling and testing during partner's pregnancy.

7.1.1.10. Involvement in Voluntary Counselling and Testing During Last Pregnancy.

The majority specifically had gone through voluntary counselling and testing during one's or partner's pregnancy. However, some participants indicated that they did not go through that process. The rest either forgot or they had never been or their partners had never

been pregnant. There is still a small difference between men and women's responses, indicating that men are not fully involved in voluntary counselling and testing during their partners' pregnancies. Deressa et al. (2014) also discovered that 60% of their female participants knew that their partners were tested when they were pregnant, and 35% said the opposite and the reasons they highlighted included that the partners had no time or lived in another place, was tested before current pregnancy, were faithful, lack awareness on the importance of HIV testing and some feared testing HIV positive.

In a related study, Bajunirwe and Muzoora (2005), found that 20% of their participants reported that their husbands disapproved partner's decision to test for HIV. Mirkuzie, Hinderaker and Morkwe (2010) reported on health facility data for sub-cities in Addis Ababa where they highlighted that the percentage of partner tested for HIV decreased from 6.4% in 2004 to 5.3% in 2009 which portrayed a negative development on male partner involvement in HIV voluntary counselling and testing. Tshibumbu (2006) discovered that 48.8% of his male participants knew that their partners had been tested for HIV during last pregnancy which leaves more than half without that knowledge. Generally, the findings from these studies including this one portray a picture that most men are not interested in getting tested for HIV during partner's pregnancy, which is a hazard to them as a couple and the unborn child. Such actions also block the desire of many nations to create healthy communities with AIDS-free generations.

7.1.1.11. Participants' Reflection on the Process of Acquiring Knowledge about PMTCT

One finding from focus group discussions concerned the participants' views on acquiring PMTCT knowledge and implications of lack of it. The majority revealed that they knew of PMTCT though it was very basic and, in some cases, outdated. This supported

findings from the quantitative part of this study, indicating that the participants possessed only basic knowledge of PMTCT. Possession of this knowledge was labelled as a protective factor to the couple, the unborn child and the community. Having the knowledge instilled hope for a future AIDS-free generation in the participants. Possessing this knowledge was also regarded as power. It gave them confidence they were in control of their health issues which is another aspect brought out by the empowerment theory from a community psychology perspective.

These views were like those found by Deressa et al. (2014), whose FGD participants expressed the importance of getting tested for HIV during pregnancy associated with ensuring the foetus' health. Participants in this study also highlighted their perceptions of the implications of lack of PMTCT knowledge. They reiterated that it was dangerous to lack PMTCT knowledge as some males were reluctant to go for couple counselling and testing leading them to just assume that their partners' HIV negative sero-status was identical to theirs which poses a danger of re-infection and vertical transmission. Participants also noted a lack of constant updates on PMTCT information, making them lag and exposing them to danger.

Poor knowledge regarding PMTCT was noted as a hindrance to the success of the programme (Arulogun et al. 2007, Adeneye et al. 2006; Ekanem & Gbadegesin, 2004). A study conducted in Western Nigeria indicated that participants did not know how to correctly use condoms to prevent pregnancy and HIV and AIDS infection (Amoran, Salami & Oluwole, 2012). In south-eastern Nigeria, one study found that a significant number of HIV positive women discontinued use of iron tablets and ARV drugs fearing giving birth to big babies and threatened abortion (Enwereji & Enwereji, 2010). In a study in south-western Nigeria, some participants' believed that termination of pregnancy could be a method of preventing mother-

to-child-transmission of HIV (Olugbenga-Bello et al. 2013). It was also found there was a positive and significant impact of health education on the awareness and acceptability of strategies for PMTCT (Ugwu, Iyoke & Nwagbo, 2012). Therefore this reflected that the majority had little knowledge and sometimes, misconceptions on PMTCT which could be because of lack of self-motivation and courage which are crucial elements in engaging or not engaging in PMTCT programmes.

7.1.1.12. Influence of Rural Men and Women's PMTCT Knowledge and Awareness on their Involvement in PMTCT Programmes.

The study also tested the hypothesis to establish whether there was a relationship between rural men and women's involvement in PMTCT programmes and their levels of knowledge and awareness on PMTCT issues. The assumption was that the more one knows about PMTCT matters, the more one becomes willing to be involved in the programmes. The results portrayed that rural men and women's levels of PMTCT knowledge and awareness have a significant influence on their involvement in PMTCT programmes. This means that participation depends on one's level of PMTCT knowledge and awareness. The implication being that, if someone is enlightened on PMTCT, they will know the pros and cons of adhering to PMTCT recommendations leading to the prevention of vertical transmission and promotion of participation in the programme. These findings align with those by Tshibumbu (2006), in his Zambian study, where he found a positive association between possession of knowledge and men's involvement in PMTCT programmes.

Findings of the same nature were also attained by the Population Council, (2005) in India and South Africa where men were very supportive of PMTCT programmes after being fully informed and involved from initial stages. This is also per the Diffusion of Innovation Theory (DOI), which postulates that recipients' adoption of programmes is influenced by their

levels of knowledge and awareness (Glanzt et al. 2002). Besides this, Bajunirwe and Muzoora (2005) came up with related findings in their comparative study where their results indicated that rural and urban women had the same level of knowledge of MTCT and its prevention which played a crucial role in their involvement. In a nut shell, one can say that individuals generally need to have full knowledge about a programme for them to effectively participate.

7.2. INFLUENCE OF CULTURAL BELIEFS AND PRACTICES ON WOMEN'S EMPOWERMENT IN PMTCT PROGRAMME

7.2.1. A Pregnant Woman can be tested for HIV without the Permission of her Husband/partner

A significant proportion of the participants alluded to the view that women can be at liberty to be tested for HIV without their husbands' permission. This may indicate that the rural community has also been enlightened on the need to empower women on issues relating to their sexual reproductive health. These results are contrary to others found in some studies. For example, Chigevenga (2013), discovered that most of the respondents believed that women should consult their husbands or partners first before getting tested. In another study on the barriers to implementing PMTCT programmes, Bajunirwe and Muzoora (2005), found almost similar results. Also, Tshibumbu (2006), also found related findings in which 66.9% of his male participants supported that men should be consulted first before women get tested for HIV. It could be that the current study found contrary findings because of the changing times where most women have become more enlightened on the importance of one knowing her HIV sero-status especially during pregnancy. However, variations may still be noted in relation to one's socio-economic background, level of education and social class.

7.2.2. HIV Positive Pregnant Women on Negotiating Condom Use.

In response to the issue of women having the power to negotiate for condom use, it was discovered that most of the participants applauded this view. They reiterated that if a

pregnant woman tests positive, she should be free to negotiate with her partner on condom use. However, the remaining percentage refuted this view, which may be a sign that some women are still being restricted in making decisions concerning their health, including those of their children. The minority view supported earlier findings by Part et al. (2011), who pointed out that adherence to traditional gender roles related to sexual behaviours is stronger among females than males, making it difficult for them to negotiate for safer sex in marriage unions. This was also supported by Marston and King, (2006) who further state that women are restricted, yet their male partners might be found not using condoms in their extramarital affairs posing a danger of re-infection for their wives. Other researchers also supported this view by pointing out that in some intimate unions, condom use is usually restricted or dismissed as unnecessary (UBOS, ICF International Inc. 2012; Chimbiri, 2007), because in such relationships faithfulness and trust are expected, and regular sexual activity is viewed as a conjugal right especially by male partners (Ahmed et al., 2001). In support of this, Kambarami (2006), says that women lack the power to negotiate for safer sexual practices and initiate sex or refuse it when they are unwilling to engage.

7.2.3. The Role of Men on Women's Participation in PMTCT Initiatives

Most of the respondents from this study, concurred with the view that males should escort their partners to antenatal clinics when they are pregnant, which may reflect that the majority of the participants know the importance of having couples supporting each other during the gestation period. The minority, however, refuted this view which may indicate that some people advocate for a situation whereby women take charge of PMTCT without depending on men as this also promotes their empowerment. Findings from other studies indicated that very few men would escort their wives or partners in practical ways. This was found in randomised control trials by Mohlala et al., (2011) who randomly allocated women

in South Africa to receive an invitation letter for their male partners to attend antenatal clinics. However, only a few, less than half of the appointed women were accompanied by their male counterparts in their next first. In Uganda, Byamugisha. et al. (2011), conducted a similar study with a sample of 1060 pregnant women who received invitation letters for their male partners to attend ANC (intervention) or disseminate basic information on pregnancy (control). Findings show there was no significant difference between the two groups concerning the number of males who accompanied their partners for ANC visits. However, the researchers noted that both groups reflected a rise of over 10% from a baseline rate of 5% male partner attendance in ANC (Busza, 2012), indicating that offering a formal invitation for ANC services to men carries a potential impact on male involvement. It was also noted that the difference between the two studies occurred because in South Africa, the intervention came after some information campaigns and community sensitisation tasks to promote male involvement more widely. Hence men rarely escort their pregnant women to antenatal clinics, yet it is crucial for PMTCT programme effectiveness.

7.2.4. Men who accompany their Female Partners to Antenatal Clinics are neither weak nor bewitched

Less than half of the participants did not accept that if a man escorts his partner to antenatal clinic it does not prove that he is weak or bewitched. This has been opposed by others who agreed with the view that males who escort their partners to antenatal clinics are not weak or bewitched. These findings may be showing that the society still regards issues to do with pregnancy and childbearing as women's issues to the extent that if men are found interested in these issues, they will be regarded as weaklings. Tshibumbu (2006) also discovered that most of his male respondents refuted the idea that men who escort their partners to antenatal clinics are bewitched or weaklings. However, this is contrary to Horizon's findings (2002) who conducted a study in Zimbabwe and found that communities

regarded those men who escorted their wives publicly to antenatal clinics as weak or bewitched. Thus, one may say that communities still have mixed attitudes on the involvement of men in pregnancy issues henceforth, empowerment strategies must aim to educate such communities on the benefits of couples supporting each other during the gestation period and beyond.

7.2.5. Level of Women's Decision- making Power Concerning Breastfeeding

This study's findings reflected that slightly above half agreed to the view that an HIV positive woman can solely decide not to breastfeed her child to avoid HIV transmission. The other half refuted this view. It was also established during focus group discussions, that one of the significant challenges experienced by women was to adhere to PMTCT recommendations from health practitioners while abiding by the traditional ways of rearing children. This made them experience cognitive dissonance as sometimes they had to breastfeed their child or give them water even after being taught of the dangers by health practitioners. In relation to this, it has been documented that lack of social support towards HIV pregnant and breastfeeding women may also negatively affect PMTCT utilisation since it disturbs drug adherence (Ware et al. 2009; Nachega et al. 2006) and discourages them from adjusting traditional breastfeeding and weaning procedures (Falnes et al. 2011; Cames, et al. 2010). In support of this, Falnes et al. (2011) and Byamugisha et.al. (2010) emphasised that gender roles that may determine women's socio-economic status in society also play a significant role in PMTCT involvement. Iwelunmor et al. (2014), reiterated that for new HIV positive mothers, stigma and family pressure to breastfeed influenced mixed feeding patterns. This was also observed in a study by Anoje et al. (2012), who noted that family members' input regarding culturally and socially accepted feeding methods coupled with poor access to proper feeding counselling support, influenced high rate of mixed feeding practices. The

scholars reiterate that unequal distribution of power between men and women lower the socio-economic standing of women which rob them of decision-making power concerning their health, including sexual reproductive health. These findings from different scholars may also reflect that people still think that breastfeeding a child is mandatory even when it endangers the child's life.

7.2.6. Socio-cultural Constraints on Couples' Ability to Discuss HIV Testing during Pregnancy

Findings from this study show that slightly above half, agreed with the view that it is not abominable for women to talk about HIV testing with their partners during pregnancy. But the remaining percentage disagreed hence showing they ascribed to it being forbidden for women to talk about HIV testing with their partners during pregnancy. Related findings were obtained in Botswana in which 55% of the female respondents reported to have discussed HIV testing with their partners (Maule-Nkhwalume, 2003). In Zambia, Tshibumbu (2006) discovered that 45.6% of his participants regarded it taboo for females to discuss HIV testing with their partners. Findings from these studies, including this one, may indicate long-held societal beliefs on how women should relate with their male counterparts on issues to do with sexual reproductive health.

7.2.7. Cultural and Societal Expectations and Views on HIV Positive Pregnant Women

Less than half of the participants subscribed to the view that if a woman is HIV positive during pregnancy, it is not a sign of infidelity. But some disputed this, implying that they regard that an HIV positive result on a pregnant woman as a sign of infidelity. Views like this, hinder some women to disclose their HIV positive status to their partners. However, disclosure of HIV status also plays a role in PMTCT utilisation as failure to do so might pose a challenge in their adherence to medication and its storage (Wouters et al. 2009) and in

following infant feeding recommendations (Bii et al. 2008). Other studies also support that failure to disclose HIV sero-status by pregnant women to their intimate partners due to fear poises as a barrier that blocks completion of PMTCT interventions (Jasseron et al. 2013; Sagay et al. 2006; Olagbuji et al. 2011). This is coupled with lack of decision-making power concerning access to resources within the family also cited as a barrier to PMTCT uptake (Perez et al. 2008; O'Gorman et al. 2010). This means that such a lack of decision- making power makes some women afraid of disclosing their positive HIV sero-status as it is associated with the withdrawal of economic resources vital for survival by their male counterparts. In addition, Bajunirwe and Muzoora, (2005) and Tchendjou et al. (2011), noted that some women refuse to have blood tests or do not collect their results fearing disapproval from their partners or intimate partner violence as reducing PMTCT enrolment. The fear discussed mostly emanates from cultural and societal expectations found in many African contexts which stress that a decent woman should not be found suffering from sexually transmitted diseases as it will be a sign of infidelity on her part.

7.2.8. Challenges Faced by HIV Positive Pregnant Women within their Intimate Relationships

Nearly half of all the participants disagreed with the view that a pregnant woman who tests HIV positive during pregnancy should not be divorced or rejected by her partner. This means that the participants believed that testing HIV positive during pregnancy is the gateway for a woman to lose her marriage or partner. Contrary to this, some participants agreed that a woman should not be divorced or rejected after testing HIV positive during pregnancy, and the rest did not disclose their views on this. In light of these statistics, one may deduce that testing HIV positive during pregnancy becomes a double burden for the infected woman as it will affect her biologically and socially. In relation to this, it was found that fear of knowing one's own HIV status, stigma and discrimination following disclosure of one's HIV status to

partner, family and community and opposition from the male partner (Kebaabetswe, 2007; Nyasulu & Nyasulu, 2011), were regarded as some barriers to PMTCT adherence. In support of this, evidence from a multi-site study in Burkina Faso, Kenya, Malawi and Uganda found that disclosure rates remain very low (Hardon et al. 2012). Also, a study in South Africa discovered that one of the major hindrances to women's disclosure was fear of the partner's reaction if the woman tested HIV positive (Varga & Brookes, 2008) which Msellati, (2009) also supported. Marman, Mbwambo, Hogan, Kilonzo and Weiss (2000) in Tanzania found that 54.9% of HIV positive women had been physically abused by their partners due to their HIV status. But a few researchers for instance Kassaye et al. (2005), in Ethiopia, discovered that 75.9% of female respondents reported that they experienced no abuse from their partners because of their HIV status. The male counterparts' negative reactions instil fear in females as they cannot stand stigma and discrimination directed towards divorced and unmarried women within the society since marriage is highly valued in many African contexts.

7.2.9. The Influence of Cultural Beliefs and Practises on Rural Women and Men's Participation in PMTCT Initiatives

The study tested the influence of cultural beliefs and practices on rural women's participation in PMTCT programme to ascertain if culture-specific empowerment strategies can enhance participation in the PMTCT programme. The findings show that the majority alluded to the view that sociocultural factors influence community members' involvement in PMTCT initiatives. Specifically, the majority either said that such factors have very high influence or just have high influence. A few participants stated such factors have low influence or do not influence PMTCT initiatives. Tshibumbu, (2006), also found that strong socio-cultural beliefs and opinions may have a negative influence on men's involvement in PMTCT programmes. Kachere, (2012), and Mushavhi, (2012), supported the notion that

strong cultural beliefs constrain women's PMTCT participation as they both pointed out that the payment of lobola (bride price) in African contexts, robs women of their liberties to the extent they must surrender even their reproductive health to their husbands who then have the final say in all the activities that married women engage in. The findings reflected that some cultural practices and beliefs are detrimental to the programme's success hence needing to be addressed first before programme implementation. Henceforth, coming up with strategies which target addressing negative cultural influences on PMTCT participation becomes a necessity.

7.3. INFLUENCE OF GENDER INEQUALITIES ON RURAL WOMEN'S PARTICIPATION IN PMTCT INITIATIVES.

This study tested the hypothesis that gender inequalities have a significant effect on participation in PMTCT initiatives. The findings showed that participation in PMTCT depends on gender; hence the null hypothesis was rejected. It concluded that, in rural areas participation in PMTCT initiatives depends on one's gender. The frequencies indicated that more women participated in these initiatives than men. This could be due to unequal distribution of power between men and women with childbearing and rearing. Findings from focus group discussions also alluded to the view that gender inequalities and societal expectations on women crippled their efforts under PMTCT initiatives. Interviews with professionals from this study indicated that pregnancy is regarded as a women's issue, making men less involved in PMTCT initiatives. They also noted that in many societies women lack decision making power over many aspects of their lives, including sexual reproductive health. This lack of power makes them fail to solely adhere to PMTCT recommendations without approval from their male counterparts.

In a literature review, Hampanda (2012), advocated for the adoption of a social-ecological approach in addressing PMTCT issues as he emphasised that gender inequalities within the society negatively affect PMTCT programme. The same scholar stated that most interventions or studies go beyond the individual and interpersonal level in exploring the context of women, men's behaviour and decision-making power concerning PMTCT involvement and this negatively affect knowledge and ability to address constraints to PMTCT. Falnes et al. (2011), and Byamugisha et al., (2010), pointed to gender roles as one factor which determines the low socio-economic status of women in society which portrays the unequal distribution of power between men and women robbing women of decision-making power even in matters relating to their health. The irony is that this study shows that women participate more in PMTCT initiatives than men however their participation usually will be incomplete because they cannot decide to adopt PMTCT recommendations from health practitioners fully.

7.4. INFLUENCE OF AGE ON RURAL MEN AND WOMEN'S INVOLVEMENT IN PMTCT INITIATIVES.

Another hypothesis that was tested was that age has a significant influence on one's participation in PMTCT initiatives. The researcher assumed that the younger the person (15 - 35 years), the more involved they are in PMTCT programmes. However, this study's quantitative results indicated that age and participation in PMTCT are not dependent on each other. The implication here is that whether someone is of childbearing age or not, does not have a role to play in one's participation in PMTCT. Those who are still young and without children for example adolescents and some early adults, also need to participate to prepare for the future and those that are past the age of childbearing still need to be involved to assist their relatives still bearing children. This was contrary to what came out from interviews with

professionals who raised the view that the younger generation was not forthcoming with involvement in PMTCT programmes as they either did not attend antenatal clinics or did not adhere to advice from health practitioners. Malaju and Alene (2012), also found a negative association between maternal age and knowledge on MTCT and PMTCT of HIV and they argued that the reason could be that younger and older women may differ in their perceived risk of HIV and understanding of the importance of prevention methods for MTCT of HIV. Therefore one can conclude that for some, age influences one's participation in PMTCT initiatives, but for others it has no effect.

7.5. INFLUENCE OF LEVEL OF FORMAL EDUCATION ON RURAL WOMEN'S PARTICIPATION IN PMTCT PROGRAMMES

This study's findings indicated that one's level of formal education also determines his or her level of participation in PMTCT programmes. However, the most common level of education most participants had attained was secondary education. Those who had completed primary and secondary education participated better than others maybe because the majority fell within these categories and maybe these levels provided them with the basics required to fathom PMTCT knowledge. Thus, in this context, people regarded as having high levels of education were those with primary and secondary education that may differ from other contexts like in urban areas where high levels of education comprise vocational training and tertiary education. Similar results were found by Malaju and Alene (2012), who noted an association between education level with MTCT and PMTCT of HIV. They discovered that women with secondary and above education level had a high likelihood of possessing better knowledge on MTCT and PMTCT of HIV than those with no education and assumed that maybe those without formal education might have lower understanding of MTCT and PMTCT.

In other related studies in China and Ethiopia women having secondary and above education level were also found to have better knowledge on MTCT and PMTCT of HIV than those with no education (Choi Fung, 2003; Solomon &Tilahun, 2005). Hargreaves et al. (2008) also found that having formal education minimises the vulnerability to HIV, particularly among young women, and it gives them the power to negotiate for safer sexual practices. In Botswana and Swaziland, educated women had fewer chances of reporting lack of sexual control in intimate relationships, inconsistent use of condoms and intergenerational sex (Weiser et. al. 2007). Education was also reported to play a protective role against HIV infection (Kim et. al. 2016). In Nigeria, positive perceptions towards PMTCT were inspired by increasing educational level (Adeneye et al. 2006). In another study, it was also found that women with non-formal education had a high chance of wishing to have children than women with tertiary education (Erhabor, Akani & Eyindah, 2012). In support of all this, the UNAIDS GAP Report, (2014) cited that numerous studies came up with results which pointed to the view that elevating girls' and young women's educational achievement is significantly related to better HIV and sexual reproductive health outcomes while lack of access to education and dropping out of school because of pregnancy or other reasons acted as a danger on a girls' future. This discussion strongly indicates that this study produced findings which supported existing findings which point to the importance of formal education in the understanding of PMTCT issues. Information is power; therefore, possession of formal education may help in women empowerment as it puts them on a better platform or gives them the capacity to understand PMTCT information better.

7.6. THE NATURE OF RELATIONSHIP BETWEEN PMTCT PROFESSIONALS AND COMMUNITY MEMBERS

Community Psychology principles emphasize the changing of the relationship between professionals and community members to create an environment where both parties operate from the same platform. Community psychologists encourage a transition from the traditional relationship where the relationship is that of an expert and a client to a modern type where a relationship is that of a facilitator or collaborator and a partner. These two types were portrayed in this study, with the majority alluding to the traditional relationship. The traditional relationship views the expert as a think tank with vast amounts of knowledge and solutions to the community's problems. This leaves the community being passive recipients who always look up to the experts for problem-solving.

In contrast, the modern type of relationship is characterised by full inclusion and participation of community members. In this relationship, the community will be active recipients who are believed to understand their problems better than anyone else. The relationship will be that of a facilitator or collaborator and partner where the expert is the facilitator or collaborator, and the community members become the partners. The relationship is based on equal sharing of power between expert and community members. However, this study reflected that many are not yet familiarised with such kind of a relationship. Laverack (2005), points out that when community members have room for participation, they are likely to experience some degree of control as they can better define and analyse their concerns collectively and find joint solutions to act on their issues. Wallerstein (2006), reiterates that participation creates the backbone of empowerment strategies however Woodall, (2010), echoes that participation on its own does not guarantee empowerment as it can often be manipulative and passive instead of being genuinely engaging and empowering.

Empowerment cannot be imposed on people, the concerned individuals should bring their own empowerment as they understand their own situation better than all other people. Health practitioners and other professionals come in as collaborators and facilitators, not experts thus promoting the change of terms to enhance their relationships with the people in need. These professionals may create a situation where empowerment may be more likely, through facilitation and support however community empowerment can only be fully realised when groups of people gain their momentum, acquire skills and advocate for their change (Wallerstein, 2006).

These views also align with those from the strength perspective which recognises the resilience of individuals and focuses on the potentials, strengths, interests, abilities, knowledge and capacities of individuals, rather than their limits (Grant & Cadell, 2009). In this way a strengths-based approach is seen to differ from traditional deficit models (Scerra, 2011). The strengths-based perspective comes in as a reaction to the problem-based approach utilised by many professionals whereby they would view clients as people with problems because of some weaknesses within them. This perspective views clients as partners with positives within them, which can be utilised in ameliorating their problems. These problems will be regarded as challenges, not problems. One principle of this perspective is that collaboration is central with the practitioner-client relationship as primary and essential however in community psychology the term client is not encouraged thus the relationship is regarded as that of partners. The findings from this study will help encourage professionals engaging in PMTCT programmes to value their clients as people with strengths that can be used to empower them and educate the community themselves about the benefits of such a relationship.

7.7. MALE PARTNER INVOLVEMENT IN PMTCT PROGRAMME

Male involvement in PMTCT programmes has also been regarded as a crucial factor, especially in African contexts, where there is much male dominance. Without full involvement of men, adherence to PMTCT recommendations becomes very difficult for women who found themselves HIV positive whilst pregnant. Participants from both focus group discussions and key informant interviews mainly alluded to the view that men's involvement in PMTCT programme was low. Some reasons associated with this low involvement included that they did not have time to attend antenatal clinics as they will be at work or engaging in self-employment. They were not willing and were not treated well at those clinics associated with lack of privacy. Several factors have been documented from various studies that support the views of the current study. These include the general worldwide view that maternal and infant health are women's responsibility, men feel unwelcome at antenatal clinics where the waiting rooms will be mainly occupied by women, experienced and anticipated bad treatment of men by healthcare practitioners and long waiting hours (Ditekemena et al. 2012; Kululanga et al. 2011; Nkuoh et al. 2010; Adelekan et al. 2014; Mullany, 2006)

Another study discovered that most men were employed; hence they would not risk losing allowance due to absenteeism caused by attending antenatal clinics (Morfaw et al. 2013). The few who said males were involved too, elaborated that such men escorted their wives to antenatal clinics and tried to adhere to PMTCT recommendations in union with their female partners. It has been documented that males' social and economic roles within the family circle place them in a position to make crucial health-related decisions of their spouses and children hence their involvement in antenatal clinics can lead to an improvement in PMTCT outcomes (Aluisio et al. 2011; Farquhar et al. 2004). Besides their physical absence,

some men cannot even offer emotional support, empathy and compassion towards their pregnant spouses. Therefore, findings from these studies point to there being a big gap because of the absence of men in PMTCT programmes making it very difficult to close the taps that derail PMTCT initiatives.

7.8. POOR SOCIO-ECONOMIC STATUS AS A BARRIER FOR RURAL WOMEN'S PARTICIPATION IN PMTCT PROGRAMME

Findings from both focus group discussions and key informant interviews revealed some economic factors that hinder the meaningful participation of women in the PMTCT programme. These factors include lack of resources which include both material and human resources. Lack of financial resources which makes them fail to abide by PMTCT recommendation, for example, when it comes to providing alternative feeding to the baby in the case of no breastfeeding. Some related studies revealed similar findings. For instance, Falnes et al. (2011) and Byamugisha, et.al. (2010) noted that gender roles may determine the socio-economic status of women in society and play an important role in PMTCT involvement. A Malawian study whose objective was to measure the influence of cash transfers on return visits to antenatal clinics, also found that financial incentives increases use of health services (Largarde et al. 2007). Kim et al. (2008), state that women's economic vulnerability and reliance on men heighten their vulnerability to HIV and AIDS by robbing them of their capability to negotiate safer sexual practices and might also influence their decisions to engage in PMTCT programmes. Others have also found that AIDS is not a disease of inequality, usually connected to social or economic transition, rather than a disease of poverty itself (Piot, et al. 2007; Gillespie et al. 2007)

Women's economic reliance on men throughout much of the developing world has meant that women's personal resources including sexuality which also includes their ability to decide on the life and health of the unborn child during pregnancy have taken on heightened economic potential (Piot et al. 2007). In a study in Illinois with Mexican women whose objective was to examine if women's levels of economic, socio-cultural and interpersonal empowerment could be influenced by condom use, it was found that neither women's economic nor interpersonal empowerment in their intimate relationships influenced condom use (Albaraccin et. al. 2014). Conclusively, most findings from various studies including this one pointed to women needing economic empowerment to participate effectively in PMTCT programmes.

7.9. RELIGIOUS BELIEF FACTORS AS A BARRIER TO RURAL WOMEN'S PARTICIPATION IN PMTCT PROGRAMME

Matters of conviction such as religious beliefs, also play a crucial role in people's health issues. In this study, religious factors were raised by some participants from focus group discussions and key informant interviews as playing a detrimental role in the success of the PMTCT programme. The most dominant factor was the issue of religious doctrines which prohibit accessing medical services. Hampanda (2012) also found that religious affiliation may influence rural women's beliefs about health, especially sexual reproductive health. Ezeanoule et al. (2013), conducted a cluster-randomised trial in which they compared the effectiveness of a congregation-based Healthy Beginning Initiative (HBI) to a clinic-based approach on the levels of HIV testing and PMTCT completion among a cohort of church-attending pregnant women in hard-to-reach communities. They also aimed to evaluate the effect of HBI on the level of HIV testing among male partners of pregnant women and the rate of PMTCT adherence among HIV-infected pregnant women.

One finding was that contrary to the common assumption that faith-based organisations are suspicious of the scientific community, the churches were more than willing to be involved in the study. The research team had to adjust and increase their target sample as many people showed a high willingness to participate. It was discovered that a congregation-based intervention that made use of a family-centred, culturally-appropriate approach that based on religious institutions improved the quality of maternal child health services in rural hard-to-reach communities. There was a high rate of HIV testing among pregnant women and their male partners and a higher rate of PMTCT completion among HIV infected pregnant women. Muhindo et. al. (2015) also found no significant statistical association between religion and couple HIV testing and counselling. This discussion portrays that it is not always that religion has a negative influence on involvement in PMTCT programmes. Sometimes it depends on the doctrines of a specific religion.

7.10. SUGGESTED ROLES FOR RURAL WOMEN IN PMTCT INITIATIVES

Findings from this study pointed to some roles that women may play in alleviating their disadvantaged position with their involvement in PMTCT initiatives. Adoption of these roles complies with emphasis from one of Community Psychology principles which says in a bid to empower disadvantaged groups of people; the concerned people must play a pivotal role in bringing about their empowerment. Based on this view, participants highlighted that women must play educative roles through mentoring and peer education. Through mentoring women must be able to counsel, advice and teach each other which in some cases can be done through mentor mothers. This has influenced the rise of initiatives such as Mothers2Mothers (m2m) which started in South Africa and expanded to other Sub-Saharan African states with one of its goals being to empower mothers living with HIV and AIDS so they can resist stigma in their communities and to develop positive living and productive lives (Besser, 2010).

Several studies were done in Zimbabwe, South Africa and Ethiopia on the importance of peer counselling or support in PMTCT. These studies focused on support groups that used HIV positive mentor mothers who had gone through PMTCT programmes and successfully raised their children (Shroufi et al. 2013; Mundell et al. 2012; Viadro et al. 2008). The women were used to empower other HIV positive pregnant women by instilling hope in them, sharing information, and accepting their condition. Such studies showed that women living with HIV could obtain their empowerment by getting support from other women who have also gone through the same experiences as theirs.

In peer education, the emphasis was on making women learn from people they are familiar with whom they always interact with and trust. Some researchers suggested establishing a community peer support group for all nursing mothers as a way of dealing with stigmatisation and changing community norms and beliefs while providing support for HIV positive mothers, particularly young mothers who choose to exclusively breastfeed their children (Adejuyigbe et al. 2008).

Besides educative roles, the participants also talked of facilitative roles where women were to encourage each other to visit antenatal clinics or facilitate workshops. According to findings from one of the systematic reviews of peer counselling on infant feeding outcomes, community-based peer counsellors' inclusion led to improved breastfeeding initiation, duration, and exclusivity (Chapman et. al. 2010). In support of this, a randomised control trial of peer counsellors promoting exclusive breastfeeding in Bangladesh revealed a higher percentage in exclusive breastfeeding in the intervention compared to the control group (Haider et al, 2000). Tylleskar et al. (2011), replicated this study in Sub-Saharan Africa (Uganda, Burkina Faso and South Africa). The same success was noted, though in South

Africa, there was a challenge of mistrust towards the peer counsellors from the participants. According to McCleary et al., (2013), peer group interventions promote Bandura's 1982 social-cognitive learning theory, which states that increasing self-efficacy or confidence promotes behavioural change. However, in terms of sustainability through empowerment self-help groups are better than support groups as they give the participants more control of the activities and circumstances. Therefore mentoring and peer education have been found as crucial roles that women should adopt in a bid to attain their empowerment in PMTCT initiatives. They can be fulfilled through self-help or support groups.

7.11. ROLES OF COMMUNITY GATEKEEPERS IN PMTCT PROGRAMMES

Community Psychology also talks of using proximal agents within the community as key people in preventing problems in society. Proximal agents are individuals within a society who can influence others in addressing certain problems by virtue of their positions. Participants from this study identified community gatekeepers as key people with the success of the PMTCT programme. They highlighted that these people who may comprise village heads, councillors, and chiefs must play educative and facilitative roles in making PMTCT a success. It was reiterated that community gatekeepers must be equipped with information on PMTCT that they should impart to community members.

Besides possessing information, they should be people with interest, passion and commitment to issues related to PMTCT however as noted earlier on the sample of this study, most of these community gatekeepers are males who may be biased towards men, and this may pose as challenges in terms of advancing interests of women with PMTCT. In addition to the roles highlighted earlier, they must also play facilitative roles where they invite key players under the PMTCT programme to educate the community on PMTCT issues on a

periodic basis and encourage significant others to support their relatives involved in PMTCT activities. Many researchers found the importance of support from significant others towards HIV positive pregnant women associated with positive PMTCT outcomes. Iwelunmor et al. (2014), highlighted that disclosure of seropositive status and subsequent support from family members typified some of the positive nurturers influencing PMTCT in Nigeria. This was in line with findings from Iwelunmor et al. (2006) which suggested that family and community systems remain the first and best line of support for caring and supporting family members living with HIV and AIDS. In another study a high level of sero-status disclosure of HIV among some women was associated with disclosing to partners and receiving support (Ezegwui et al. 2009). Iwelunmor et al. (2014) pointed out that family support is crucial in the PMTCT programme and provides optimal access to preventive strategies such as adherence to ART therapy. Findings in connection to this were also found in Ekam et al. (2012), where disclosure of HIV status and subsequent treatment support from partners was stated to influence the level of adherence to ARVs among pregnant women. According to Oladokun, Brown and Osinusi, (2010), Maru et al. (2009), disclosure of seropositive status to partners also influenced infant feeding choice and maintenance.

Another factor found in qualitative studies in Botswana and Tanzania was that lack of concrete social networks reduces the willingness to adhere to HIV treatment (Nam et al. 2008; Mshana et al. 2006). Lack of social support towards HIV pregnant and breastfeeding women may also negatively affect PMTCT utilisation since it disturbs drug adherence (Ware et.al. 2009; Nachega, et.al. 2006) and discourages them from adjusting traditional breastfeeding and weaning procedures (Falnes et al. 2011; Cames et al. 2010). Henceforth, giving the community gatekeepers the duty of encouraging significant others to support HIV pregnant and nursing women plays a crucial role in empowering them in PMTCT programmes. This

also points to the family system needing to be empowered as it plays a crucial role in PMTCT programmes.

7.12. PSYCHOSOCIAL FACTORS THAT PROMOTE OR HINDER FULL PARTICIPATION OF WOMEN IN PMTCT PROGRAMME

Amongst the findings that came out from focus group discussions and interviews of this study are psychosocial factors that either promote or hinder PMTCT programme. Most of the factors pointed out were those that hinder the success of the programme. These factors may be perceptions, enablers or nurturers. According to Iwelunmor et al., (2014), perceptions include positive or negative knowledge, beliefs and attitudes that influence decisions and actions towards PMTCT; enablers refer to the availability, accessibility, acceptability and affordability of resources that either necessitate or block decisions and actions towards PMTCT and nurturers refer to the influence of family or community contexts positively or negatively moulding decisions and actions towards PMTCT uptake. The factors that came out include the use of traditional birth attendants and desire to ensure lineage continuity and posterity and lack of resources among professionals.

Using traditional birth attendants was regarded as a positive action within the community, so it was regarded as an enabler. The participants recommended the inclusion of these people in primary healthcare. According to Iwelunmor, (2014), some factors which facilitated PMTCT activities were existential because they are traditionally available in the community or society and support uptake of PMTCT services. Effectively using traditional birth attendants before, during and after pregnancy was also noted by Balogun and Odeyemi (2010). Iwelunmor (2014), also cited that some HIV positive pregnant women indicated that they utilised the services of traditional birth attendants due to the unfriendly attitudes of

healthcare workers and the cost of childbirth and also because the experience of childbirth is governed by numerous traditional birth attendants practices, therefore, TBAs were preferred as they provided important information on the local customs, traditions and perceptions related to childbirth and new-born care. Both rural and urban women were found to seek traditional birth attendants care as they shared similar cultural and socio-economic characteristics (Balogun & Odeyemi, 2010). Thus, based on findings of this study and those from previous studies, traditional birth attendants are valuable figures in antenatal and child care.

Another nurturing factor pointed out was that HIV positive women and some men had the motivation to participate in PMTCT programmes due to their desire to reproduce and ensure lineage continuity and posterity. Some studies from Nigeria pointed out that unique or existential perceptions reflect values or beliefs that help to explain practices within some people's culture which could influence attitudes towards PMTCT and one of them which many HIV positive men and women shared was the desire to have children (Sofolahan & Airhihenbuwa, 2012; Enwereji & Enwereji, 2010; Erhabor, Akani & Eyindah, 2012). Iwelunmor et al. (2014) commented that strong cultural attachment to having children appeared to influence this desire for childbearing among HIV positive men and women. In another similar study, it was found that broadly held social expectations regarding reproduction are experienced even more acutely by HIV-positive people (Smith & Mbakwem, 2010). Participants from other studies reported that the main reasons for wishing to procreate included ensuring lineage continuity and prosperity (Sofolahan & Airhihenbuwa, 2012; Enwereji & Enwereji 2010; Erhabor, Akani & Eyindah, 2012). The influence seemed to come from a cultural attachment placed on having children, coupled with the stigma associated with barrenness, the role of children in inheritance, importance of children in agricultural

economies, importance of child-bearing on the status of women and the role of children as caretakers of the elderly (Erhabor, Akani & Eyindah, 2012). However, contrary to this, Iwelunmor et al. (2014), stated that sometimes knowledge of seropositive status influenced decisions not to reproduce. This could be noted in a study by Erhabor, Akani & Eyindah, (2012), where HIV positive men and women highlighted that they feared to procreate for many reasons including fear of infecting one's sero-discordant partner and baby, fear of death coupled with that of leaving orphans and fear they may become too ill and fail to support the child financially. Therefore the desire to procreate amongst people living with HIV and AIDS can make them adhere to PMTCT recommendations in some circumstances.

On the negative side, participants alluded to the fact that sometimes PMTCT programmes fail to prosper due to HIV positive women's fear of stigma and discrimination from significant others in the community. Gap Report, (2014), also alluded to discriminatory social and cultural norms when converting into customary or statutory laws, lead to public denial and repression of the sexuality and autonomy of young women. In urban Rwanda and Zambia, although 91% and 47% of the couples, respectively, were willing to test jointly, stigma and fear of partner reaction were the main barriers preventing couples from getting tested together for HIV (Kelley et al. 2011). Perceptions of stigma and discrimination, such as the fear of being labelled as HIV positive, were the most common reason for non-adherence to PMTCT recommendations (Ekama et al. 2012). Some studies cited them as deterrents to voluntary counselling and testing for some pregnant women (Enwereji & Enwereji, 2010; Okonkwo et al. 2007; Ekama et. al. 2012). Other perceptions related to stigma and discrimination included the synonymous connection of HIV with death, abandonment and rejection (Enwereji & Enwereji, 2010). Because of this, some people do not get involved in PMTCT activities fearing reactions from significant others and the community. Thus, in

women empowerment, there is a need to empower the community with PMTCT knowledge which can help eliminate negative attitudes and reactions from the society towards those living with HIV and AIDS.

Amongst the enablers pointed out was the top- to- bottom approach employed by the health sector in delivering PMTCT services. Most participants were not pleased with the programme seeming to be more beneficial to the professionals than the community as they were just passive recipients. They felt they did not have ownership of the programme. The approach adopted contradicts with one of the principles of community psychology which emphasises citizen participation and empowerment and maximising community strengths. Thus, in promoting women empowerment in PMTCT, it is necessary to encourage implementing organisations to share ownership of the programme with the community.

Another factor in the negative sense was the distances travelled by the community to antenatal clinics. Community members and professionals shared the same sentiments that most clinics were too far to access, which blocks some individuals from participating in PMTCT programmes. Travelling long distances to health care centres may also negatively affect HIV testing, collection of results and health seeking behaviours (Posse et al. 2008). According to Malaju and Alene (2012), accessibility of health facility (within 5 km) was positively associated with having better knowledge on PMTCT of HIV. The possible explanation for this association could be that the less a health facility is far away from the woman’s house, the more a pregnant woman comes into contact with the health centre, the more likely she is to hear about PMTCT, among other preventive messages and services. In a study done in Thailand, it was discovered that improving access to and consistent use of antenatal clinics is a high priority for improving PMTCT of HIV (Teeraratkul et al. 2005).

Inaccessibility to PMTCT centres was amongst the reasons found by some researchers for non-participation in the PMTCT programme by some mothers (Mukhtar-Yola et al. 2006). Therefore in empowering women in PMTCT, there is also a need to address structural issues.

Most participants from focus group discussions also indicated that they were not comfortable because PMTCT services were being offered alongside other primary healthcare services. This was regarded as a hindrance to the community's full involvement in PMTCT as they reiterated that such a scenario compromised on their privacy. In evaluating pregnant women's attitudes towards VCT in Awka, Nigeria, the researchers found that assurance of confidentiality of results influenced willingness to test for HIV (Okonkwo et al. 2007). Thus, offering PMTCT services alongside other maternal issues but not general primary health issues may help assure privacy to those involved in PMTCT initiatives.

7.12.1. Effect of Stigma and Discrimination from Professionals of HIV Positive Pregnant and Nursing Women

Stigma and discrimination of HIV positive pregnant women from health care providers also came out loudly during focus group discussions. The participants stated that such attitudes drew them back from participating in PMTCT activities. A comparative study was done in five states, and findings pointed out that perceived stigma is statistically related to failure to adhere to treatment (Dlamini et al. 2009). Multiple reviews supported that anticipated stigma and fear of unfavourable health treatment services like prejudice from health staff, long queues at health centres and inadequate drug stocks fall under hindrances to treatment (Ware et al. 2009; Merten et al. 2010; Selin et al. 2007). Stigma and discrimination from nurses, including non-acceptance, unwelcome attitudes and lack of confidentiality were also found as deterrents in utilising healthcare services (Enwereji & Enwereji, 2010; Mukhtar-Yola et al. 2006). Stigma and discrimination is an important factor which needs attention in

terms of promoting PMTCT programmes. Thus, healthcare workers need to be capacitated on how to deal with HIV and AIDS-related issues to prevent disruption of some vital programmes within their system.

7.12.2. Lack of Material and Human Resources

Interviews with professionals from different organisations involved in the PMTCT programme highlighted that lack of resources hinders its progress as this incapacitates them. In elaborating on this point, they emphasised that they did not have adequate funds to contact everyone within the community. Some community members also pointed this out in focus group discussions and interviews. They also said there was a lack of adequate human resources to man antenatal clinics hence derailing the programme's success. Several organisations select a few sections within the community where they would implement their PMTCT initiatives meaning that other communities were excluded. Iwelunmor et al. (2014), cited the lack of available, accessible, acceptable and affordable resources as negatively influencing decisions and actions towards PMTCT. For example, inadequate and inaccessible voluntary counselling centres coupled with long travelling distances to the centres and long waiting lines acted as barriers to PMTCT service uptake. In south-eastern Nigeria, authors cited high treatment costs as one factor influencing the childbirth choices of HIV positive pregnant women (Enwereji & Enwereji, 2010). Ware et al. (2009); Merten et al. (2010) and Selin et al. (2007), also stated that inadequate drug stocks fall under hindrances to treatment which may include treatment under PMTCT. Other researchers point to the political environment as a barrier to PMTCT involvement for example poor social welfare services and health care services coupled with unstable economies and political arenas (Blas et al. 2008; Cavagnero et al. 2008). The PMTCT programmes are affected by several systems that

surround them which may include the nation's economic and political environment hence they need to be addressed too for the success of PMTCT initiatives.

7.13. PROPOSED STRATEGIES FOR THE ENHANCEMENT OF EFFECTIVE PMTCT PROGRAMME

Based on the findings from this study, the researcher proposed some strategies explained in this section. According to Nickols, (2016), a strategy is a perspective, position, plan and pattern. He regards it as the connection between policy or higher-order goal and tactics or concrete actions on the other. Together strategy and tactics connect the gap between ends and means. Concerning this study, the researcher adopted Nickols' (2016) definition of a strategy which states that the term refers to an intricate web of thoughts, ideas, insights, experiences, goals, expertise, memories, perceptions and expectations that generally guide definite actions in pursuit of particular ends. The PMTCT strategies proposed in this study include community-based, interpersonal based, women targeted, technical, structural-based and educative strategies. The goal of the proposed strategies will be to empower rural women under PMTCT initiatives. The researcher noted that for this empowerment to become effective, the focus should not just be on women but also their male counterparts as they are equal partners in sexual reproductive matters, including maternal issues. The strategies will also involve other proximal agents within the community like community gatekeepers, religious leaders and professionals involved in PMTCT issues.

7.13.1. Community-based *S*trategies

The community has been mentioned as a fundamental entity in women empowerment. Due to this view, numerous activities have been proposed as community-based strategies that focus on working exclusively within the community in bringing success to PMTCT. The first strategy is periodic door-door visits or awareness campaigns by the government and other

stakeholders involved in PMTCT issues that target HIV positive pregnant women. These visits will aim to educate women and their significant others on PMTCT at their places of residence where they may be very comfortable. Education should be facilitated by professionals involved in PMTCT issues. However, they should employ interactive learning where the target group also contributes effectively to their learning process to promote citizen participation, facilitation and empowerment.

The approach of having the community learn about PMTCT within their usual contexts can help others who are shy to reach out to professionals. At the same time, it helps reach males who were reported to be less or not supportive of the programme. Such a strategy can also help ensure that men and women of childbearing ages receive information on PMTCT simultaneously. Under this strategy, information dissemination can also be done through public campaigns, drama and public demonstrations and marches. This helps prevent stigma and discrimination and intimate partner violence, which may occur if only one partner gets HIV testing, especially if the person is a female. The other strategy targets to engage local leadership as agents of motivation in rural people's participation in PMTCT initiatives. Here, local leadership may include politicians, traditional leaders and religious leaders. Local leaders are respectable people within many communities and societies. Therefore, tasking them to encourage the community to participate in PMTCT initiatives positively may be a crucial step in supporting women empowerment under the PMTCT programme.

7.13.2. Interpersonal-based Strategies

Couples and family relations have been mentioned as enablers or hindrances to meaningful involvement in PMTCT programmes. The assumption was that close relationships either promote or distort the progress of PMTCT hence it was crucial to find

ways of encouraging positive relationships which could affect one's participation in PMTCT programmes. Based on that, the researcher picked strategies based on those relations which can facilitate the empowerment of women under this programme. The first strategy will be to encourage simultaneous couple testing. Couples are a microsystem which is very crucial in PMTCT initiatives. Therefore harmony and unity between the two parties can contribute positively to the execution of PMTCT initiatives. Professionals involved in PMTCT must endeavour to encourage couples to undergo voluntary counselling and testing of HIV. Besides the professionals, couples themselves must be able to encourage one another. This is one emphasis of Community Psychology that the targeted group of people must play a crucial role in ensuring their empowerment. Family relations also play a pivotal role in PMTCT programmes' success; henceforth, the other strategy would be to encourage family support towards both HIV positive and negative women of childbearing ages. This is in line with one principle of Community Psychology which promotes family and individual wellness and states that for an individual to experience physical and mental wellness, the family must be fully functioning. Individual wellness also contributes to psychological wellness also required for PMTCT initiatives to succeed. However, this cannot be attained by individual efforts alone because a person does not live in a vacuum. They are nested by several systems with the family being the immediate one. The family system also needs to be empowered to enhance couples and family members' internal and external resources. Therefore family support plays a pivotal role in encouraging individual participation in PMTCT activities.

7.13.3. Women-targeted Strategies for PMTCT Initiatives

Findings from the study also suggest in some instances, PMTCT initiatives fail due to the disadvantaged position of many women in society. This then calls for strategies which aim to target empowering such women specifically. Therefore, the researcher proposed

women-targeted strategies that can contribute to the meaningful involvement of women in the programme, who are the primary target.

The first strategy could be making use of mentor mothers and support groups. Mentor mothers refer to HIV-positive women who have gone through PMTCT services and have been trained to mentor and support other HIV-positive mothers. Support groups signify a group of people who share similar experiences or concerns and provide encouragement, comfort and advice to each other. The services offered by both mentor mothers and support groups include HIV and health education and awareness-raising; counselling and promotion of HIV testing, including partner and child testing, connections to income generation activities and to legal and social services; tracing of loss-to follow-up patients and adherence counselling. Mentor mothers offer these services through individual counselling and mother support groups they lead, along with other community or local health centres. Mentor mothers and support groups are effective in some contexts due to their cultural and social compatibility. They have also been reported to contribute to developing self-efficacy, motivation, empowerment, improved retention and increased disclosure of HIV status by the involved women. These strategies have been implemented elsewhere in Zimbabwe. However, there is a need for them to be applied in all contexts to meet the nation's target of eradicating maternal mortality and HIV infection of children by 2030.

Another strategy to be adopted under this category is the training of women to become peer educators on PMTCT issues. Peer education is that people mostly learn better when they receive information from a familiar individual they trust. Hence, making use of this strategy can become very beneficial in trying to promote women empowerment under the PMTCT programme.

The last strategy may be to introduce income-generating projects to promote economic empowerment of young and middle-aged women. Economic empowerment has been noted in literature as one factor that plays a vital role in PMTCT programme success. This empowerment can also help women attain a better, respected position in society, which helps them get a platform to be meaningfully involved in making crucial decisions in their lives including those related to their sexual reproductive health hence contributing to the success of PMTCT initiatives.

7.13.4. Technical Strategies

Findings from this study also indicated that the way the PMTCT programme is conducted affects its progress in some instances. Based on that, the researcher picked out several strategies that can be adopted to correct those impracticalities.

The first strategy is to establish antenatal clinics close to the communities where people live. Sometimes the suggestion was to establish these clinics not over three kilometres from people's residence. The programme targets pregnant women who, in some cases might be HIV positive therefore it is not healthy for them to have a double burden of being pregnant and expected to walk long distances sometimes in unsafe environments in search of health centres. Hence, the closer these centres are to people, the lesser the burden on women and the higher the likelihood of meaningful involvement in PMTCT initiatives from community members.

The second strategy would be for the government and other implementing organisations to address socio-cultural issues before programming. Community Psychology emphasises valuing diversity which includes cultural diversity. Hence for PMTCT initiatives to become a success, especially in multicultural African contexts there is a need to take note

of these cultural differences. This helps in safeguarding women's sexual reproductive rights and addressing both their practical gender needs and strategic gender needs. Women do not exist in a vacuum; they live in societies where their decision-making power is sometimes overruled by authority figures within their lives. In some cases, these figures get their powers from the society or the traditions of specific communities. The proposed strategy points out that when programmes like PMTCT are effected, the implementers should not use a one-size-fits all approach. Instead, they must be contextualised because cultures are different, and they affect the success or failure of PMTCT initiatives.

Another strategy is related to the consultation hours at antenatal clinics. Quantitative and qualitative findings from this study point to the fact that sometimes women fail to get support from their male counterparts in maternal issues because of the times in which they can access maternal services. They stated that usually antenatal clinics are open during day time and only during weekdays which coincide with the times that most men will be sourcing for a living. The strategy to be adopted should be to adjust opening hours of antenatal clinics to address this problem. Borrowing views from the participants of this study, these clinics should be in operation for 24 hours, during weekends and holidays. They should also offer PMTCT services with other maternal health services. Such adjustments can increase male partner involvement in PMTCT initiatives, which has been crucial in making the programme a success. In line with this, women empowerment also requires male involvement though these males should not take the leading role, they just need to be supportive whilst women run their agenda.

The next strategy should be to separate antenatal clinics from other primary health care centres. It was noted that when maternal issues are mainstreamed with other general

health issues sometimes, especially when dealing with HIV positive pregnant women, there is a danger of stigma and discrimination. Henceforth, participants of this study suggested there should be clinics known predominantly for maternal concerns where both males and women will be free to access services, including PMTCT services. Separating these two types of clinics will also ensure privacy and confidentiality of those living with HIV and AIDS.

7.13.5. Structural-based Strategies

The researcher also discovered that structural issues also affected the running of the programme, which then affected women's participation in it. The primary stakeholder of the PMTCT programme was noted to be the government; therefore structural-based strategies have also been proposed to advocate for full involvement of the government.

The first strategy proposed under this category was that the government should fully commit itself to implementing the programme. This commitment must be witnessed by providing adequate human resources at every antenatal clinic so that the recipients' needs will be attended to in a welcome manner. Besides providing adequate staff, it should also provide all the necessary requirements during childbirth like cotton wool, methylated spirit, gloves and others, especially to the rural community where many struggle to earn a living. If the government struggles, it is recommended that it should partner with other Non-Governmental Organisations and Church-based Organisations in ensuring these resources have been provided. The government may also show its full commitment by ensuring that National AIDS Council which is the national board that coordinates all HIV programmes warrants that all activities required for PMTCT implementation are found in every community regardless of its distance from the city for example the use of mentor mothers, peer educators and support groups. The National AIDS Council can do this by collaborating with its partners. This

supports another principle found under Community Psychology which is ensuring collaboration and partnership among different organisations and between organisations and the community.

The second strategy that the government can also adopt is to establish and enforce laws and policies that govern PMTCT initiatives. For instance, to ensure men's meaningful involvement in this programme, there should be laws and policies that make it mandatory for couples to escort each other for pregnancy booking and HIV voluntary counselling and testing. Failure to abide by such laws must be associated with stringent measures towards the defaulters. Besides promoting male involvement, they should also make it mandatory for all pregnant women to pay at least four antenatal clinic visits during pregnancy. In addition, the government should come up with, and enforce policies that promote gender equity and women empowerment and primary health care. However, these laws and policies must be implemented after comprehensive consultation from the community.

7.13.6. Educative Strategies

Findings from this study indicated there is a need to address community members' knowledge base specifically, focusing on how the information is delivered and on the frequency of information dissemination. This need arose after the realisation that most participants had only very basic PMTCT knowledge that needed to be updated. These strategies have been proposed in trying to close the knowledge gap.

The first strategy is to continually provide PMTCT information to the community, which will empower the whole community, including the researcher’s primary target, women. The information should be disseminated by health professionals and any other professionals

dealing with PMTCT issues. Continued provision of this education will make the community move with the times regarding PMTCT issues; hence they will not lag.

The second strategy is to have regular workshops on sexuality issues related to the gestation period, including PMTCT issues. These workshops will be targeting men and women of childbearing ages. The workshops will also try to keep the community updated on PMTCT developments. Such educative programmes will help close the gap noted whereby some participants stated that they only received PMTCT knowledge once. Nobody came back with refresher courses on that. Information is power; hence when the community gets adequate knowledge on PMTCT, they will become empowered, which becomes a good sign towards eliminating MTCT of HIV by 2030.

The third strategy is to adopt a school-based approach to PMTCT education. Taking it from the ecological perspective, the school is one system that is immediate to an individual which can create a base for disseminating PMTCT information. The emphasis will be on catching them whilst young with malleable minds that can easily retain future use information. The researcher proposes that the government must ensure that the curriculum includes comprehensive sexuality education from primary level up to tertiary level which should also have the component on preventing mother to child transmission of HIV. The issues addressed must try to capture the trending matters on PMTCT so school children will be acquainted with updated information that can create a base for their adult lives.

The last strategy will be to capacity build traditional leaders and church leaders and government should do this through the Ministry of Health and Child Care with its partners. Traditional leaders and church leaders have been regarded as proximal agents within the community who deserve to be equipped with the skills and knowledge to promote PMTCT

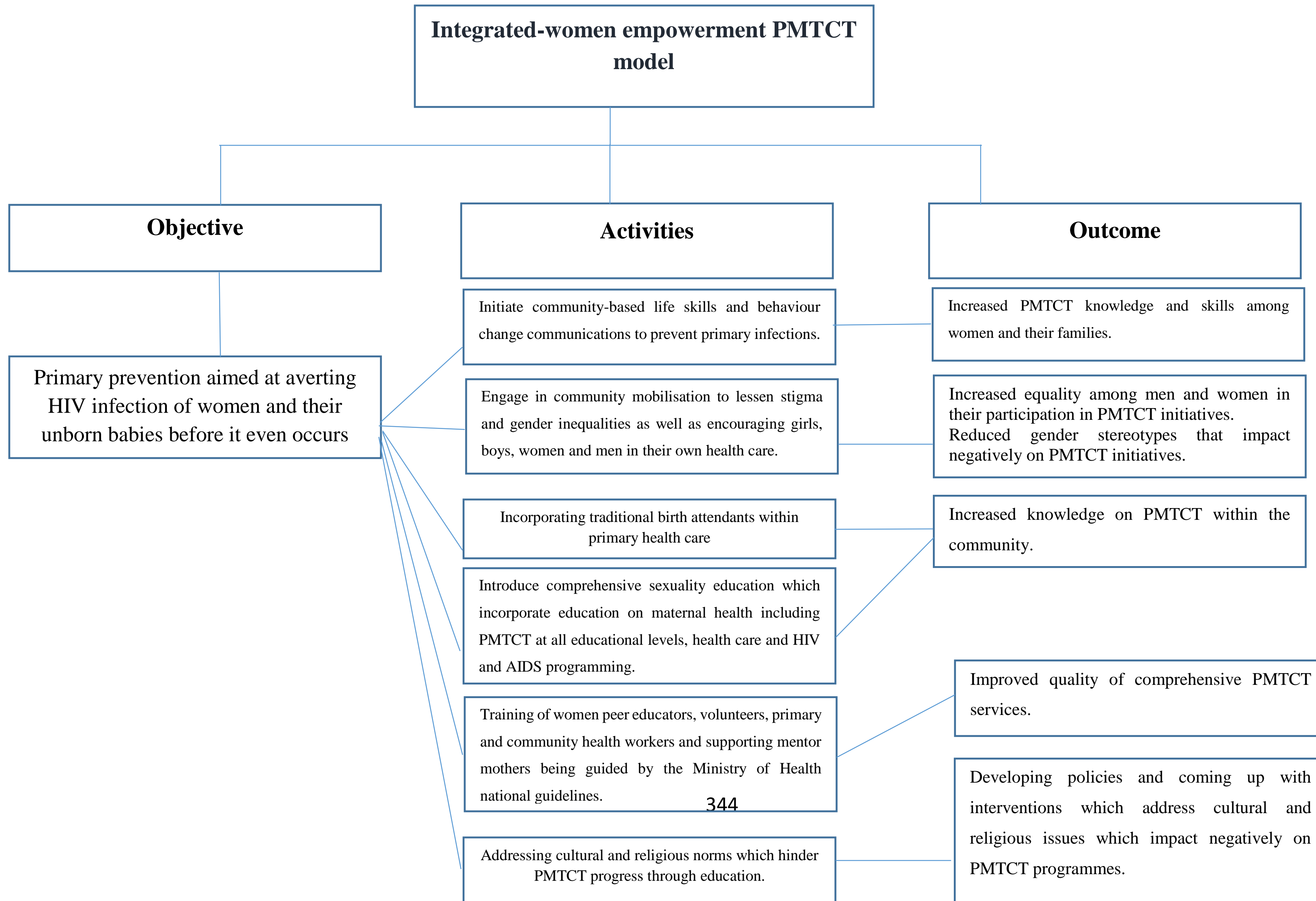
within the community. Though these figures are not supposed to overrule women's empowerment, they can use their influential positions to work with women in their involvement in PMTCT initiatives. Community leaders and religious leaders may be very instrumental in preventing and dealing with stigma and discrimination towards HIV positive pregnant women and their partners. They can also help the community grasp the importance of promoting PMTCT initiatives within the community.

7.14. PROPOSED MODEL FOR PMTCT

Based on the findings of this study, the researcher proposes the development of a model for women empowerment under the PMTCT programme. The proposed model can be termed an integrated women-empowerment PMTCT model (iwe-PMTCT model), and it will aim to promote the four prongs of PMTCT endorsed by the World Health Organisation (WHO) and UNICEF. The four prongs include primary prevention of HIV among women of childbearing age; prevention of unintended pregnancies among women living with HIV; prevention of HIV transmission from a woman living with HIV to her infant and provision of treatment, care and support to women living with HIV and their children and families. This model will also target to incorporate all the stakeholders with a role to play in the empowerment of women under PMTCT model which include women, children, men, families, community gatekeepers, the government, relevant ministries, Non-governmental Organisations and Community-based organisations. The model's emphasis will be empowerment through utilising one of the principles of Community Psychology of prevention and emphasising community level of analysis and community intervention. The principle of prevention according to Caplan's 1964 model, can be applied at three levels which are primary prevention where in this case efforts will be put to come up with empowerment strategies aimed at blocking HIV infection from occurring that is eliminating new infection in children

and their mothers, the second level is secondary prevention targeted at early detection of HIV infections in children and their parents and last, tertiary prevention aimed at the empowerment of women and children who are already infected with HIV so they remain useful in society and continue valuing themselves despite their HIV positive sero-status. The model will also incorporate views from Kelly's Ecological metaphor to analyse the interdependence of the systems that surround an individual as this will lead to the development of community interventions aimed at women empowerment under the PMTCT programme. The following diagram summarises the objectives, activities and outcomes that characterise the proposed model:

Figure 7.1 Proposed model for women empowerment in PMTCT programmes



Integrated-women empowerment PMTCT model (Continued…..)

Objective

Secondary Prevention which comprises of early detection of HIV infection in pregnant and nursing mothers as well as in new born babies for early intervention.

Activities

Promote the utilisation of HIV counselling and testing at all levels with increased use of couples counselling and testing as well as HIV self-testing.

Promoting mobile HIV counselling and testing

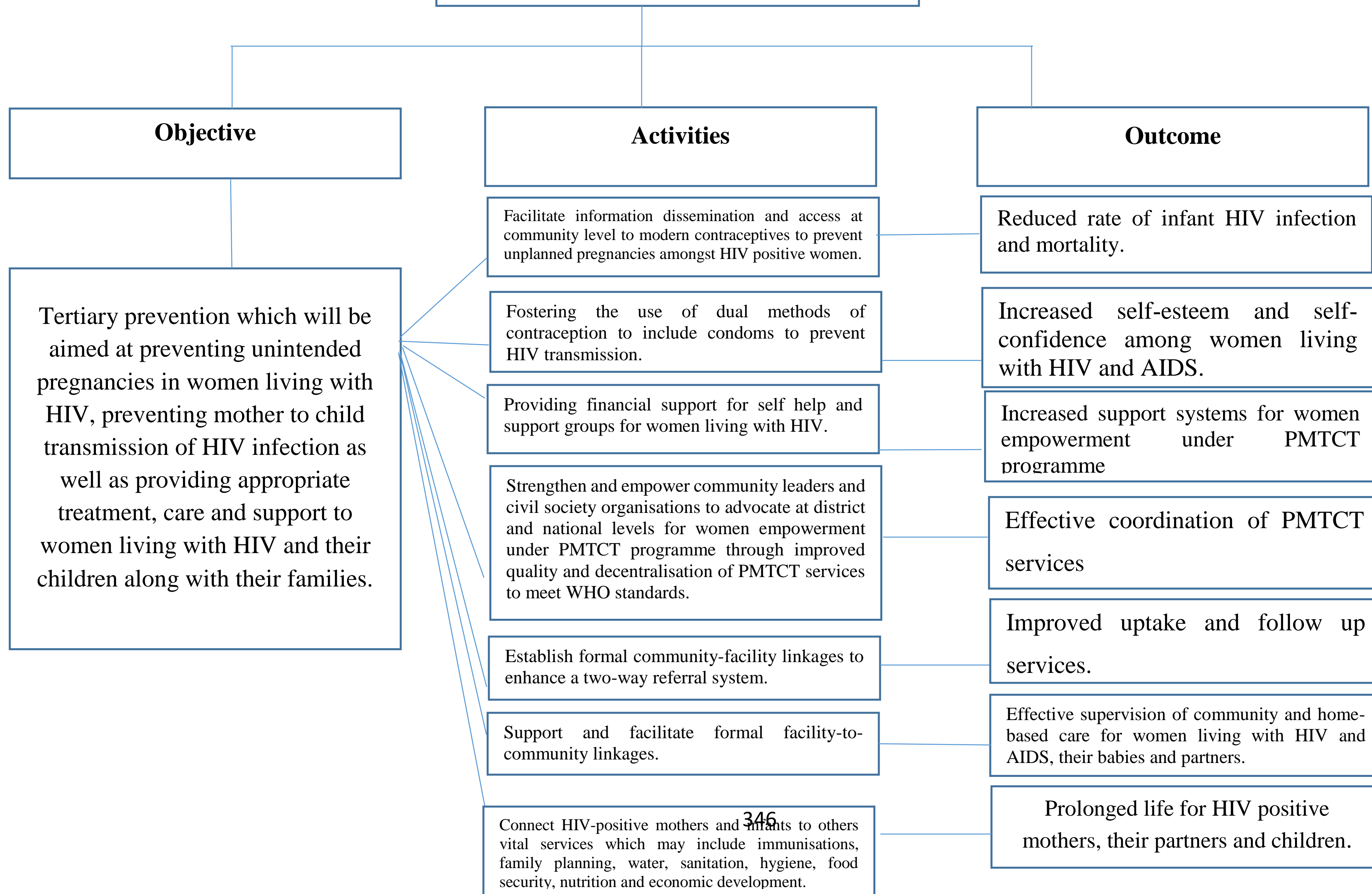
Facilitate access and encourage regular attendance to antenatal care for pregnant women.

Provide home-based and community-based counselling on PMTCT for all pregnant women and their male partners which comprises of HIV testing, continued primary prevention during pregnancy and breast-feeding, ART literacy, infant care and early infant diagnosis.

Outcome

Improved knowledge on women and their partners' HIV statuses thereby preventing new infection or re-infections.

Early detection of HIV status leading to early treatment intervention.



Integrated-women empowerment PMTCT model (Continued…..)
Objective
Activities
Outcome
Tertiary prevention which will be aimed at preventing unintended pregnancies in women living with HIV, preventing mother to child transmission of HIV infection as well as providing appropriate treatment, care and support to women living with HIV and their children along with their families.
Facilitate information dissemination and access at community level to modern contraceptives to prevent unplanned pregnancies amongst HIV positive women.
Fostering the use of dual methods of contraception to include condoms to prevent HIV transmission.
Providing financial support for self help and support groups for women living with HIV.
Strengthen and empower community leaders and civil society organisations to advocate at district and national levels for women empowerment under PMTCT programme through improved quality and decentralisation of PMTCT services to meet WHO standards.
Establish formal community-facility linkages to enhance a two-way referral system.
Support and facilitate formal facility-to-community linkages.
Connect HIV-positive mothers and infants to others vital services which may include immunisations, family planning, water, sanitation, hygiene, food security, nutrition and economic development.
Reduced rate of infant HIV infection and mortality.
Increased self-esteem and self-confidence among women living with HIV and AIDS.
Increased support systems for women empowerment under PMTCT programme
Effective coordination of PMTCT services
Improved uptake and follow up services.
Effective supervision of community and home-based care for women living with HIV and AIDS, their babies and partners.
Prolonged life for HIV positive mothers, their partners and children.

7.15. LIMITATIONS OF THE STUDY

This study was characterised by some limitations; however, the researcher did her utmost to minimise negative effects. The limitations comprised methodological and contextual issues.

First, the sampling methods posed some restrictions. The proportional stratified random sampling used in selecting survey participants ideally required a specific number of participants from each of the strata. However, this was not feasible in all circumstances as some age groups were not readily available in several communities like the 15 to19 and 55 to 60 age ranges. To cater for this, the researcher could do little but ensure that she got at least half of the expected participants for each stratum so all ages could be represented.

The other sampling methods used in selecting focus group discussion participants, community gatekeepers and professional were quota and purposive sampling, based on the convenience of the participants. In some cases, it slightly limited the representation of some groups of people. For example, several males were not patient enough to engage in focus groups after participating in the survey which reduced the expected number of participants per group from twelve to nine. However, this did not affect the study negatively as the researcher ensured that at least all groups comprised not less than three quarters of the targeted number which was sufficient representation.

Second, the researcher could not reach out to all the cultural groups found in Zimbabwe due to the sprawling nature of the country and financial constraints. Most participants came from the major cultural groups found in the country; hence some minority groups like the Tonga, Nambya and others were not fully represented. However, this was resolved by ensuring that all the major cultural groups were involved and could represent the

minority ones that evolved from the major ones. Hence, they shared similar norms and values that affected their reactions to PMTCT initiatives. In that vein, the findings can be generalised to all the cultural groups found in Zimbabwe.

Another limitation was the difficulty of accessing some houses in the rural community, which affected the selection of participants for the survey. This limited the sample to two-hundred participants instead of ideally three-hundred participants which could be more representative. Sometimes some places could not be reached by vehicles. To access those hard-to-reach areas, the research team had to use the local means of transport as the local people do. For instance, in some cases the research team had to use canoes to access the targeted groups to ensure representation. For those areas which could be accessed by a vehicle, the researcher ensured such means of transport was always available.

The last limitation came from the use of translators in areas where the researcher and her assistants were not conversant with the local language. Language plays a crucial role in research as unfamiliarity with the language used in the research instruments may restrict the participants' responses. This is why the researcher had to ensure all research instruments were in the local language and the facilitator had to be familiar with the local language. All the focus group discussions were recorded to verify the translation by an expert linguist for that language to ensure the translators were conveying the appropriate message from the participants to the researcher. Despite this, the limitations did not distort the originality and generalisability of the research findings.

7.16. RECOMMENDATIONS

Based on the findings of this study, these recommendations are directed towards different groups of people:

7.16.1. Recommendations for Rural Women

- Women empowerment in PMTCT initiatives cannot become a reality without women taking an active role; therefore, it is recommended that rural women should brace up in bringing their empowerment.
- In working towards their empowerment, these women must also include men's views and interests.

7.16.2. Recommendations for Rural Men

- Maternal concerns are not women's business only; therefore, it is recommended that men take it as an obligation to support their female partners in fighting maternal mortality and mother to child transmission of HIV. Their fear towards maternal issues, denial and gender stereotypes must be addressed.
- It is also recommended that part of women empowerment must include economic empowerment and access to quality health care as these help them engage in PMTCT initiatives. Hence men must also support such empowerment in women.

7.16.3. Recommendations for Community and Religious Leaders

- This group comprises the custodians of the community; it is recommended that legislation enforces their participation and active leadership in the communities in issues related to PMTCT and other health matters about HIV and AIDS.
- They should also support and promote initiatives aimed at educating community members about PMTCT issues, and this can be done in liaison with the government and other implementing organisations.

7.16.4. Recommendations for the Ministry of Health and Childcare

- Educational, structured support groups for HIV-positive pregnant women and male partners' involvement regarding PMTCT programmes should be implemented in all communities and developed to help facilitate acceptance in both parties.
- Health promotion legislation should make provision that health care workers and rural women are well equipped with PMTCT programme knowledge during health education sessions and workshops to become conversant and empowered.
- There should be an increase in antenatal clinics, including mobile clinics to promote the availability and accessibility of the PMTCT programme services to hard-to-reach rural, mining and farming areas.
- Adequate resources should be available to health professionals to improve their PMTCT service provision, including awareness campaigns and health education programmes.
- Emphasis should be put on including traditional birth attendants in providing maternal services to the community and educating them on PMTCT issues.
- Incorporation of PMTCT services, including ANC, labour and delivery, family planning, sexual reproductive health and EPI (Expanded Programme on Immunisation) should be practised by all the health care facilities to promote a one-stop service and prevent isolation of HIV-positive pregnant women.
- There should be extended opening hours for antenatal clinics to weekends, holidays and nights to allow women of childbearing ages to be escorted by their male partners who might be occupied during the day.

- Continuous provision of support and mentoring towards health care workers working under the PMTCT programme to improve their morale and prevent burn out syndrome.
- Promotion of a multi-sectoral approach to implementing PMTCT programme.
- Coordinate activities of other stakeholders under the PMTCT programme to avoid duplication of duties and ensure that the services cascade to all areas.
- The ministry must also be allocated funding by the government to establish support groups and self-help groups for women.

7.16.5. Recommendations for the Education Sector

- There should be the inclusion of the PMTCT programme in comprehensive sexuality education from primary school to tertiary level education and it should cascade to out-of-school young people.
- Health care workers and para-professionals should be adequately trained in PMTCT by experts.
- There should be many mentor mothers and lay counsellors training to address complex issues faced by HIV positive pregnant women such as reproductive health, family planning, domestic and sexual violence, nutritional counselling, and grief counselling.

7.16.6 Recommendations for Policymakers

- Policies must be established that promote campaigns on PMTCT programme and should be arranged and organised to raise community awareness in different communities to promote early adherence to ARV uptake, male involvement and prevent loss to follow-up, stigmatisation and discrimination.

- Community assessments should be done before implementing policies that govern PMTCT to address some socio-cultural issues that may negatively affect efforts to empower women under the PMTCT programme.
- Policymakers should establish and strengthen the PMTCT programme policies to safeguard HIV-positive pregnant women's rights regarding disclosure, discrimination, and stigma.
- In cases of policy reform, it is recommended that such changes should be disseminated to all the provinces simultaneously to ensure uniformity on how health care workers operate under the PMTCT programme.
- Policymakers must ensure there is systematic development and updating of policies governing PMTCT programme implementation.
- Development of policies, guidelines and standard operating procedures that govern PMTCT must involve different stakeholders.

7.16.7. Recommendations for Researchers

- Researchers must try to unearth the influence of religion on people's participation in PMTCT programmes, coming up with the best strategies to deal with its effects. The reason being that religion was noted as another factor which can negatively influence the programme, but little was done in this study to address that.
- Researchers must also attempt to study other cultural groups not fully represented in this study as a way of replicating the study and understanding if there could be any differences in the findings.
- Future researchers must also employ longitudinal research studies to ascertain if participation in a study of this nature contributes to positive behavioural and attitudinal change towards PMTCT interventions.

- Research is required to develop strategies to involve couples in pre-testing or couple testing for HIV before conceiving children.

7.17. CHAPTER SUMMARY

This chapter started by discussing the findings derived from the study then exploring the strategies that may be adopted in trying to empower rural women under PMTCT programme. This was done in line with the findings detailed in the previous chapter. The chapter also looked at the limitations encountered and how their negative effects were counteracted to improve the generalisability of findings. Last, recommendations were directed towards significant groups of people found having roles to play in PMTCT programme success. The final chapter will reflect on the lessons learnt or conclusions derived from this study.

CHAPTER 8

CONCLUSION: REFLECTION ON LESSONS LEARNT

8.0. CHAPTER OVERVIEW

This chapter reflects the lessons and experiences the researcher encountered through the process of this research study. The findings also answered the research questions contributing a lot to the conclusions drawn. Some conclusions were highlighted in the discussions and recommendations in the previous chapter. Thus, will indicate some of the factors that constrain women's participation in the PMTCT programme, thereby derailing or hindering their empowerment in these initiatives. They also portray factors which enable or facilitate the empowerment of women under the same programme. The findings contributed significantly to the scientific community as it portrayed the importance of empowering rural women from a holistic viewpoint and to developing effective strategies as explored in the previous chapter.

8.1. CONCLUSIONS AND LESSONS LEARNT

These conclusions were drawn from the study:

It is very feasible to make use of the empowerment theory from a Community Psychology perspective in trying to make PMTCT a success in different communities, however emphasis should be put on contextualising the initiatives as people differ in several aspects like culture, religion, age and many more and this may determine their understanding of empowerment. For a meaningful application of this theory, users must have an in-depth understanding of its basic components to avoid leaving crucial ones like psychological empowerment, valuing diversity, and so on, and to avoid adopting a general view of empowerment. Sometimes, people may not know the need for their empowerment hence it

becomes a necessity to raise awareness and engage in advocacy first before trying to promote the empowerment of such individuals.

Various demographic characteristics have been found to have significant effects on rural women's PMTCT participation. Some effects may be promoting whilst others may be constraining; hence when discussing the empowerment of rural women under the PMTCT programme, such factors must be considered. For instance, the survey findings indicated that age did not determine one's participation in PMTCT programmes. However, interviews with professionals brought out the view that the younger generation was not cooperative in this programme. Thus, taking it from the views of the professionals one can conclude that age affects women's participation in PMTCT and also the researcher noted that people within the age ranges of 15 to 19 and those above 50 were very few in this study which may indicate that age determines whether or not people participate in PMTCT.

Religious affiliation was also raised repeatedly in focus group discussions, and interviews as a strong determinant of rural women's participation in PMTCT programmes as some religious doctrines prohibit women from being involved. Another variable was marital status, also found to play a significant role in rural women's participation in PMTCT programmes. It was found that married women participate to a high degree in PMTCT programmes. This could be due to the stigma and discrimination associated with pregnant single women. The researcher had to contextualise the term 'married' as women might differently understand this marital status. Another factor noted was formal education, which was also regarded as an influencing factor in PMTCT programmes' participation. Women who have at least secondary school qualification participate more in PMTCT programmes than those with less education. Tribal background can constrain or promote rural women's participation in PMTCT programmes. Also, those tribes with strong traditional beliefs and

opinions have difficulties in participating in PMTCT programmes maybe because of conflicting interests between programme requirements and tribal expectations. Based on these facts, one concludes that with the empowerment of rural women in PMTCT initiatives such factors must be considered.

Access to, awareness and possession of updated and complete knowledge on PMTCT play an essential role in rural women's participation in PMTCT programmes. Rural women who fully possess this knowledge can meaningfully participate in these programmes because they will be equipped hence empowered. Therefore, organisations involved in PMTCT issues and health facilities must offer full knowledge and awareness to women and their significant others as their empowerment also needs this backup. However, this does not mean that women become passive recipients; instead, they will collaborate and partner with other stakeholders involved in PMTCT initiatives.

Socio-cultural, socio-economic and psychosocial factors may either constrain or promote rural women's participation in PMTCT programmes; hence empowerment initiatives must consider them. Rural women with strong traditional or cultural beliefs and opinions do not participate fully in PMTCT programmes. They have been found to mix PMTCT recommendations with traditional or cultural expectations, which endangers their lives and their children and partners. These women may not be influenced by their own beliefs and opinions only but also by their significant others. Thus, one can conclude that rural women's socio-cultural environments influence their decisions to participate in PMTCT programmes. Societal and cultural expectations may make one to engage or not to in some activities. To reduce the negative influence of socio-cultural beliefs and opinions among rural women, context-specific and culturally sensitive messages should be formulated and disseminated through health education on reproductive health and PMTCT. Also, most women belong to

the low socio-economic level which makes it difficult for them to have resources to participate effectively in PMTCT programmes and also to independently make decisions that affect their health.

Men's involvement in PMTCT programmes is a crucial determinant of women's participation in such programmes. In many African contexts, men are the heads and breadwinners of families; therefore, they need to be full participants in these programmes. Besides this, men and women are equal partners in reproduction. Thus they must be equally involved in PMTCT programmes. Therefore, one cannot talk of women empowerment concerning sexual reproductive health without involving their male counterparts, however caution must be taken that men will not override the agenda of women. When talking about women's empowerment, it should be a plus–sum game not zero-sum game. When women become empowered, it must not rob men of their power, it must bring equality between the two genders.

The approach being utilised in implementing PMTCT programmes is not exposing rural women fully to such programmes' requirements; henceforth, there is a need to employ an effective approach. The approach's major defect is that it is a top-to-bottom approach that seems more beneficial to the implementers than the intended beneficiaries. Thus, Community Psychology stresses the importance of changing the relationship between practitioners and community from expert-client relationship to facilitator-partner relationship, giving the programme community ownership. Another challenge is that, some initiatives like mentor mothers are not widespread because organisations which introduce them only target urban and peri-urban areas leaving out rural areas especially those which are hard to reach, yet they are very helpful in improving women's participation in PMTCT programme. Therefore, some services offered under PMTCT are selective, which does not promote social justice hence

implementers must ensure that their services reach out to everyone regardless of the diversity found in our communities.

The most significant challenge for women's empowerment and HIV is instigating change at the required scale to achieve widespread impact on vulnerability to HIV. This will ask for:

(i) Significant political commitment reflected in continued donor and multilateral institutions' leadership,

(ii) Improved and harmonised discussions between donor and recipient governments to ensure an adequate policy environment and tracking spending and reporting on services and programmes for women's empowerment and prevention of HIV.

Sexual and reproductive health status affects women's vulnerability to HIV. Gender inequality, poverty, stigma and discrimination, social exclusion and marginalisation of the most vulnerable populations both affect and are affected by HIV infection and sexual and reproductive health status. These negative factors may be addressed by using community-based approaches targeting at changing negative attitudes that some individuals or community might have towards their fellow community members. There is a need to educate different communities on the importance of valuing diversity within the community, one of the principles of Community Psychology and promotes the empowerment of disadvantaged groups of people.

Linking HIV prevention with women's empowerment is fundamental to giving women equitable access to prevention and stemming the tide of the HIV epidemic. This can be achieved by:

(i) Integrating HIV prevention with sexual and reproductive health information and services, including family planning, mother and child health care. This is another critical area for donor coordination and harmonisation to ensure women have access to a full range of choices to protect themselves from HIV.

(ii) Providing access to a comprehensive package of sexual and reproductive health information and services to both women living with HIV and those without and their partners. This is important for informed choice in family planning and the prevention of mother-to-child-transmission.

Use of locally available human resources to empower women in the fight against MTCT of HIV is crucial. This links well with Kelly's principle of cycling of resources which promotes locally available resources. People like traditional birth attendants, community gatekeepers and peers can help other community members to appreciate the implementation of the PMTCT programme. This then calls to include traditional birth attendants in maternal health care, capacity building of community gatekeepers, and community members' training in peer education under the PMTCT programme.

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ANNEXTURES

ANNEXTURE 1: CONSENT FORM

You have been selected by chance to participate in a study to explore the strategies to incorporate empowerment programmes for PMTCT (Prevention of Mother to Child transmission of HIV) initiatives among multicultural rural women in Zimbabwe. The study is conducted by Rosemary Chigevenga, a PhD student at the University of South Africa (UNISA).

The study is aimed at benefitting the community by providing information and suggestions that might enable professional working with the community on PMTCT issues to increase the participation of both men and women in PMTCT initiatives. This will make the community to be involved without fear of victimisation or discrimination.

The study and its procedures have been approved by the relevant authorities. In this study, the procedures for you, include just responding to questions for about 30 minutes to $1^{1}/_{2}$ hours. These questions focus on rural women's empowerment in PMTCT programmes. If you need more clarification about the study, you are at liberty to ask at any given time.

Your participation in this study is voluntary. You are not obliged to participate. You have the right to withdraw at any given time. In addition, information collected from this study will be coded so that they will not be linked to your name and your identity will not be revealed at any time in the study. All data will be kept under lock and key and will not be disclosed to anyone without your permission.

This consent form has been read and explained to me and I voluntarily consent to participate in this study.

Signature: ____________________ Date :__________________

I have explained this study to the above respondent and I have sought his or her understanding for informed consent.

Researcher/Research Assistant's
Signature:_________________Date:___________________

ANNEXTURE 2: CHILD ASSENT FORM (15-17YEARS)

Introduction

How are you? My name is ____ (Researcher or research assistant's name). I am conducting a survey for academic purposes on Strategies to incorporate empowerment programmes in PMTCT initiatives amongst multicultural rural women in Zimbabwe. The information we collect is aimed at helping the nation on how the PMTCT programme can become meaningful with full involvement of women who are our primary target. If there is anything that you do not understand, feel free to ask me to stop as we go through the information and I will take time to explain.

Whenever we have a survey with children, we talk to parents first and ask them for their permission. Your parent/guardian was asked if they allow you to be in this study, but you have to agree separately before I can begin. You can choose to say no without any negative consequences on you. Before you decide, you can talk to anyone you feel comfortable with in your family.

There will be no immediate and direct benefit to you. You will not receive payment to take part in this survey. However, your participation is likely to help us find out more about PMTCT programmes in the community which can help in informing the nation and other stakeholders on how they can improve the programme so that all women of child bearing ages will benefit.

If you do not wish to answer some of the questions included in the questionnaire because you consider them too personal or uncomfortable, you are at liberty not to. You do not have to answer any question or take part in the survey if you do not wish to do so. You will not be asked to give us any reason for not responding to any question, or for refusing to take part in the survey. Even if you first decide to participate in the survey, you are free to withdraw your consent and to discontinue participation at any time without penalty.

Any information about you will have a number on it instead of your name.The information recorded is confidential, and no one will have access to your responses without your or your guardian or parent's consent.

This assent form has been read and explained to me and I voluntarily assented to participate in this study. Signature: ____________________ Date :__________________ I have explained this study to the above respondent and I have sought his or her understanding for informed assent. Researcher/Research Assistant's Signature:_________________Date:___________________

ANNEXTURE 3: QUESTIONNAIRE

INTRODUCTION

My name is Rosemary Chigevenga, and I am here as a student from the University of South Africa conducting research to find out how rural women may be empowered so that they can fully participate in PMTCT initiatives. This work is being done for academic purposes as well as to help improve PMTCT programme in Zimbabwean communities. You have been selected to participate in this study because your views are highly valued.

INSTRUCTION: For Section 1 and 2, tick (√) in the box next to your appropriate response.

1.1 In which age range do you fall in?

15-19 ☐

20-24 ☐

25-29 ☐

30-34 ☐

35-39 ☐

40-44 ☐

45- 49 ☐

50- 54 ☐

55- 60 ☐

1.2 Gender

Male ☐

Female ☐

1.3 What is your highest level of education?

Never attended school ☐

Did not complete primary school ☐

Completed primary school ☐

Did not complete secondary school ☐

Completed secondary school ☐

Completed vocational educational ☐

Did not complete college or university ☐

Completed college or university ☐

1.4 Which cultural group do you belong to?

Karanga ☐

Ndebele ☐

Shangaan ☐

Venda ☐

Tonga ☐

Nambya ☐

Sotho ☐

Chewa ☐

Manyika ☐

Korekore ☐

Zezuru ☐

Ndau ☐

Kalanga ☐

Other (specify) ☐ ………………………………

1.5. Which religious affiliation do you belong to?

Roman Catholic ☐

Seventh Day Adventist ☐

Methodist ☐

Lutheran ☐

Pentecostal ☐

Apostolic Sect ☐

African Traditional Religion ☐

None ☐

Other (specify) ☐

……………………………………..

1.6. What is your marital status?

Married ☐

Widowed ☐

Separated ☐

Divorced ☐

Single with children ☐

Single without children ☐

1.7. For how long have been living or in an intimate relationship with your partner?

Less than 5 years ☐

5 to 10 years ☐

11 to 15 years ☐

More than 15 years ☐

Not applicable ☐

N.B. If you have selected 'Not applicable' to question 1.7 then skip questions 1.8 up and 1.9.

1.8. For the past five years which term best describes the nature of your intimate encounter?

Violent ☐

Pleasant ☐

Indifferent ☐

Very exciting ☐

1.9. For the past five years which type of intimate relationship were you involved in?

Multiple and stable intimate relationships ☐

Multiple and unstable intimate relationships ☐

Single and stable intimate relationship ☐

Single and unstable intimate relationship ☐

SECTION 2: PARTICIPANTS' KNOWLEDGE POWER ON PMTCT

2.1 Can unborn child get an HIV infection from an HIV positive mother during pregnancy?

Yes ☐ No ☐ Don't Know ☐

2.2 Can a mother who is HIV positive transmit the virus to her child through breast milk?

Yes ☐ No ☐ Don't Know ☐

2.3 Can the HIV virus be transmitted from an HIV positive mother to the child during delivery?

Yes ☐ No ☐ Don't Know ☐

2.4 Do you think giving anti-retroviral drugs to the mother and the child reduce the chance of transmission of HIV from a mother to her child?

Yes ☐ No ☐ Don't Know ☐

2.5 Do you think delivering the baby by operation (Caesarean Section) reduces the chance of transmission of HIV from a mother to a child?

Yes ☐ No ☐ Don't Know ☐

2.6 Do you think avoiding breastfeeding reduce the chance of transmission of HIV from a mother to her child?

Yes ☐ No ☐ Don't Know ☐

2.7 Have you ever heard about a programme called Prevention of Mother to Child Transmission (PMTCT)?

Yes ☐ No ☐ Don't Know ☐

2.8 Are PMTCT services offered at your local clinic?

Yes ☐ No ☐ Don't Know ☐

2.9 At antenatal clinics, are pregnant women counselled and tested for HIV?

Yes ☐ No ☐ Don't Know ☐

2.10 Were you and your partner tested the last time you or she was pregnant?

Yes ☐ No ☐ Don't Know ☐ Not applicable ☐

2.11. If you are involved in PMTCT activities, how were you introduced to them?

Through Media ☐ Public awareness campaigns ☐ At antenatal clinic ☐

By a friend, colleague or relative ☐

SECTION 3: INFLUENCE OF SOCIOCULTURAL FACTOR ON WOMEN'S PMTCT PARTICIPATION

Tick (√) under the appropriate response reflecting your opinion as follows:

Strongly Agree (SA); Agree (A); Neutral (N); Disagree (D); Strongly Disagree (SD)

	SA	**A**	**N**	**D**	**SD**
1. A pregnant woman can be tested for HIV without the permission of her husband /partner.					
2. An HIV positive pregnant woman can negotiate for condom use					
3. Men should accompany their female partners to antenatal clinics.					
4. Men who accompany their female partners to antenatal clinics are neither weak nor bewitched.					
5. Men and women should undergo HIV testing at the same time at PMTCT clinics					
6. An HIV positive woman can decide on her own not breastfeed her child to reduce HIV transmission.					
7. It is not a taboo for women to discuss with their male partners about HIV testing during pregnancy					
8. Antenatal clinics are not for women and children only					
9. A positive HIV test in a pregnant woman does not shows that she has been unfaithful to her husband.					
10. If a pregnant woman is found to be HIV positive, she should not be divorced					
Total score					

SECTION 4: STRATEGIES TO EMPOWER WOMEN IN PMTCT INITIATIVES

Tick (√) under the appropriate response reflecting your opinion as follows:

Strongly Agree (SA); Agree (A); Neutral (N); Disagree (D); Strongly Disagree (SD)

	SA	A	N	D	SD
1. Men and women of childbearing ages should receive information on PMTCT at the same time.					
2. Men and women of childbearing ages should be encouraged to regularly get voluntary counselling and testing of HIV and AIDS					
3. Young and middle aged women should be encouraged to engage in income generating projects for economic empowerment					
4. Women must be trained to be peer educators on issues to do with PMTCT.					
5. It must be mandatory for men to escort their spouses/partners to antenatal clinics throughout the gestation period.					
6. Men and women of child bearing age must constantly get involved in workshops on sexuality issues related to the gestation period.					
7. PMTCT clinics should be opened during the evening and weekends so that men may have time to escort their wives for visits.					
8. Professionals must periodically engage in door-to-door public awareness campaigns on PMTCT targeting adolescents and adults.					
9. Cultural barriers and gender stereotypes should be addressed prior to PMTCT initiatives.					
10. Women of child bearing age should be given an opportunity to initiate programs for PMTCT.					
11. Women should be involved in community issues related to PMTCT.					
12. Antenatal clinics should be established at least 3kms from each and every community					
Total score					

THANK YOU FOR YOUR TIME.

ANNEXTURE 4: FOCUS GROUP GUIDE

My name is Rosemary Chigevenga, and I am here as a student from the University of South Africa conducting research to find out how rural women may be empowered so that they can fully participate in PMTCT initiatives. This work is being done for academic purposes as well as to help improve PMTCT programme in Zimbabwean communities. You have been selected to participate in this study because your views are highly valued. There are no right or wrong answers to the focus group questions. We want to hear many different viewpoints and would like to hear from everyone. We hope you can be honest even when your responses may not be in agreement with the rest of the group. In respect for each other, we ask that only one individual speak at a time in the group and that responses made by all participants be kept confidential. We are going to engage in a discussion on the issues mentioned above and this will take about 40-45 minutes. I am accompanied with my research assistant who will assist in record and capturing the discussion as I will be facilitating. The recording will make the analysis thereafter easy.

1. May we talk about your knowledge and understanding of PMTCT?
2. Let us talk about your views and experiences of PMTCT that are being conducted in your community.
3. Which programmes do you know that are related to PMTCT?
4. Which people are involved in them and why?
5. Let us analyse the relationship between professionals involved in PMTCT programmes and the community people. Are there any areas which you think need to be improved or changed?
6. Discuss the pros and cons of this programme.
7. Let us talk about how men and women in your community support each other to fully participate in the programme?
8. What challenges are being encountered by women in your community to participate in this programme?
9. What do you think is the role or should be the role of women participating in PMTCT program?
10. What do you think should be done to improve women’s participation in this programme?

THANK YOU FOR YOUR TIME.

ANNEXTURE 5 INTERVIEW GUIDE FOR COMMUNITY GATEKEEPERS (CHIEFS, VILLAGE HEADS, COUNCILLORS RELIGIOUS LEADERS)

My name is Rosemary Chigevenga, and I am here as a student from the University of South Africa conducting research to find out how rural women may be empowered so that they can fully participate in PMTCT initiatives. This work is being done for academic purposes as well as to help improve PMTCT programme in Zimbabwean communities. You have been selected to participate in this study because your views are highly valued.

1. As a leader within the community are you aware of the PMTCT programme? If yes, what is your evaluation of how the programme is being conducted?
2. Which roles do you play as community leaders in this programme?
3. What are the pros and cons of the programme?
4. Which traditional, cultural and religious factors do you think support or hinder the success of this programme?
5. Do you think women in your community are free to participate in this programme?
6. Are men in your community supportive of this programme?
7. Do you think implementing organisations are giving the targeted group of people an opportunity to input their views on how the programme is being run? Are there areas which you think need improvement or changes?
8. What strategies do you think should be implemented to give women the room to participate without restrain?
9. What strategies do you think should be implemented to make this programme fully successful?

THANK YOU FOR YOUR TIME.

ANNEXTURE 6: INTERVIEW GUIDE FOR PROFESSIONALS

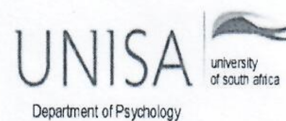
INTERVIEW GUIDE FOR PROFESSIONALS FROM IMPLEMENTING ORGANISATIONS (e.g. MINISTRY OF HEALTH, NATIONAL AIDS COUNCIL etc.)

My name is Rosemary Chigevenga, and I am here as a student from the University of South Africa conducting research to find out how rural women may be empowered so that they can fully participate in PMTCT initiatives. This work is being done for academic purposes as well as to help improve PMTCT programme in Zimbabwean communities. You have been selected to participate in this study because your views are highly valued.

1. What roles do you play as an organisation under PMTCT programme?
2. What influenced your decision to implement PMTCT among women in your area of operation?
3. As an implementing organisation how is the response of the community toward PMTCT?
4. Does your organisation involve the community from planning, implementation and evaluation of the programme? If yes specify how they are involved.
5. What empowerment strategies do you employ in your organisation to improve women's involvement in this programme?
6. What challenges have your encountered in implementing this programme in the community?
7. What challenges do you think women encounter in participating in this programme?
8. Do you think the issue of age and gender has any influence on the failure or success of PMTCT program?
9. What cultural strategies do you think may be employed to improve women's involvement in this programmes?
10. Which other strategies do you think should be implemented in the community to improve rural women's participation in PMTCT programmes and whom do you think will be the most effective in implementing them?

THANK YOU FOR YOUR TIME

ANNEXTURE 7: ETHICAL CLEARANCE LETTER



Department of Psychology

Ethical Clearance for M/D students: Research on human participants

The Ethics Committee of the Department of Psychology at Unisa have evaluated this research proposal for a Higher Degree in Psychology in light of appropriate ethical requirements, with special reference to the requirements of the Code of Conduct for Psychologists of the HPCSA.

Student Name:
Rosemary Chigevenga

Student no. 55383394

Supervisor/promoter:
Dr S. Mhlongo

Affiliation:
Unisa

Title of project:

Strategies to incorporate empowerment programmes for PMCT initiatives among multicultural rural women in Zimbabwe

Ethical clearance is provided on condition that, as stated in the proposal, informed consent is obtained from the participants and that the procedures indicated in the proposal will be applied to ensure confidentiality of both personal data of the participants and of their discussions during the focus group sessions. In addition, participants should be allowed to withdraw from the study at any stage.

Signed:

HC Janeke

Prof H C Janeke
[For the Ethics Committee]
[Department of Psychology, Unisa]

Date: 12/02/2015

ANNEXTURE 8: UNISA CONFIRMATION LETTER

To whom it may concern: Rosemary Chigevenga

This is to confirm that Rosemary Chigevenga (student no 55383394) is currently a registered PhD student in the Department of Psychology at the University of South Africa.

Kind regards

Prof Martin Terre Blanche
Coordinator: Academic M & D Programmes
Department of Psychology, Unisa

Tel: +27 12 429 8088
Email: terremj@unisa.ac.za
University of South Africa, Muckleneuk Campus
1 Preller Street, Pretoria, 0002, South Africa

19 September 2018

University of South Af

ANNEXTURE 9: APPROVAL LETTER FROM MINISTRY OF LOCAL GOVERNMENT AND PUBLIC WORKS

Ministry of Local Government, Public Works and National Housing

Telephone 263 4 707615

Fax 263 4 797706

REF: ADM/23/8

ZIMBABWE

Office of The Secretary
P. Bag 7706
Causeway,
Harare

11 November 2018

Ms Rosemary Chigevenga
Flat 18
Block 6
Odzi flats
Eastlea
Harare

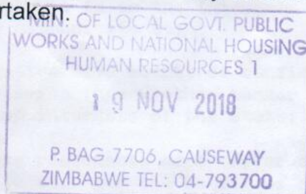
APPROVAL OF AUTHORITY TO UNDERTAKE AN ACADEMIC RESEARCH: MS ROSEMARY CHIGEVENGA: UNIVERSITY OF SOUTH AFRICA (UNISA)

The above subject matter refers;

It is my pleasure to advice you that the Head of Ministry in his memorandum dated 02 November 2018 has approved your application to undertake a field research.

Please be adviced that the research findings should not be subject to external consumption and must be solely used for academic purposes only. You are mandated to complete the Official Secrecy Act before commencement of the research project. Moreover, the final copy of the research findings should be submitted to the Office of the Secretary upon completion.

It is our hope that the research findings will help the Ministry in coming up with relevant strategies in the study area undertaken.



L. Chikuya (Mrs)
A/Deputy Director, Human Resources
FOR: PERMANENT SECRETARY FOR LOCAL GOVERNMENT, PUBLC WORKS AND NATIONAL HOUSING

Cc: The Director, Rural Development

ANNEXTURE 10: DECLARATION OF SECRECY

DECLARATION OF SECRECY

In order that all Public servants understand their responsibilities in respect of official secrecy, the relevant extracts from those Acts which relate to official secrecy are tabled below.

a) Public Service Act - Chapter 271

First Schedule - acts of misconduct.

An officer shall be guilty of misconduct if:-

"11 Except in the discharge of his official duties or with the concent of the appropriate Minister and in accordance with such directions, if any, as the appropriate Minister may from time to time give him -

a) he discloses information acquired in the course of such duties; or

b) he uses for any purpose information gained by or conveyed to him through his employment in the Service, notwithstanding that he does not disclose such information; or

c) he directly or indirectly, whether anonymously or otherwise makes any communication to the public in connection with any matter concerning the Service or any officer or department thereof, which is prejudical to the Service;

Provided that the provisions of the sub-paragraph shall not apply in respect of a communication made with the authority or by an association recognised in terms of Section forty".

b) Official Secrets Act (Chapter 97)

This Act prohibits the wrongful disclosure of any official information and provides inter alia that any person in the employment of the state who -

i) communicates information of a secret or confidential nature to any person other than a person whom he is authorised to communicate it or a person to whom it is in the interests of the state his duty to communicate it;

ii) uses information of a secret or confidential nature in his possession in any other manner prejudical to the safety or interests of the State;

iii) fails to take reasonable care of, or so conducts himself as to endanger the safety of any information of a secret or confidential nature;

iv) retains for any purpose prejudical to the safety or interest of the State any official document which he has no right to retain or which it is contrary to his duty to retain, or fails to comply with any directions lawfully given him with regard to the return or disposal of such document;

v) allows any other person to have possession of any official document issued for his use alone, or communicates any secret official code word or pass word so issued, or, without lawful authority or excuse, has in his possession any official document or secret official code word or pass word issued for the used of some person other than himself, or on obtaining possession of any official documents by finding or otherwise neglets or fails to restore it to the person or authority by whom or for whose use it was issued;

shall be guilty of an offence.

c) <u>Prevention of Corruption Act (Chapter 70)</u>

Section 3 of this Act reads:

a) If any agent corruptly accepts or obtains, or agrees to accept, or attempts to obtain from any person, for himself or for any other person, any gift or consideration as an indocument or reward for doing forebearing to do, or for having done or foreborne to do any act in relation to his principal's affairs or business, or for showing or forebearing to show favour or disfavour to any person in relation to his principal's affairs or business; or

b) any person corruptly gives or agrees to give, or offer any gift or consideration to any agent for himself or for any other person as an inducements or for himself or for any other person as an inducement or reward for doing or forebearing to do, or for having done or foreborne to do any act in relation to his principal's affairs to business; or

c) any person knowingly gives to any agent, or if any agent knowingly uses, with intent to deceive his principal, any receipt, account or other document in respect of which the principal is interested, and which contains any statement which is false or erroneous or defective in any material particular, and which to his knowledge is intended to mislaid his principal; or

d) any agent, by collusive arrangement with the seller of goods or with any person engaging to render certain services, secretly offers any consideration to an agent in regard to the sale of the goods to the employment of his services;

he shall be guilty of corruption ....

I CHIGEVENGA ROSEMARY .... acknowledge receipt of a copy of this paper on "Declaration of Secrecy".

.... SIGNED

WITNESS ....

064

DATE 20/11/2018.........

MIN. OF LOCAL GOVT. PUBLIC WORKS AND NATIONAL HOUSING
HUMAN RESOURCES 1
20 NOV 2018
P. BAG 7706, CAUSEWAY
ZIMBABWE TEL: 04-793700

ANNEXTURE 11: DEMA DISTRICT APPROVAL LETTER

MINISTRY OF LOCAL GOVERNMENT, PUBLIC WORKS AND NATIONAL HOUSING

All communications should be addressed to
"The District Administrator"
CnrMharapara/Mangwende
Makoni
Chitungwiza
Tel 263 70 21997

Office of the District Administrator
Rural Development, Promotion and Preservation of National Culture and Heritage
P O Box 48

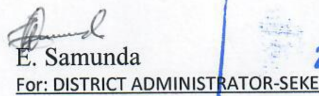
REF:

25 October 2018

Ref: PERMISSION TO CARRY OUT A RESEARCH ON STRATEGIES TO EMPOWER WOMEN UNDER **P.M.T.C.T**

To whom it may concern:

This letter serves to confirm that Rosemary Chigebenya has been permitted to carry out a research on strategies to empower women under P.M.T.C.T. Program, she is a student with UNISA College in South Africa. Please give her your maximum support during the period.



E. Samunda
For: DISTRICT ADMINISTRATOR-SEKE

ANNEXTURE 12: APPROVAL LETTER FROM CHIEF

MAMBO SEKE
BWONI VILLAGE
WARD 3 NGO
SEKE.

TO WHOM IT MAY CONCERN

DEAR SIR/MADAM,

RE: REQUEST TO CONDUCT A PMCT RESEARCH IN THE VILLAGES OF SEKE DISTRICT.

THIS LETTER SERVES TO INFORM YOU THAT ROSEMAR CHIGEVENGA ID NO 84-018975X22 HAS APPROACHED THE CHIEF'S OFFICE WITH A REQUEST TO CONDUCT A PMC RESEARCH IN OUR VILLAGES AROUND SEKE DISTRICT. SHE HAS BEEN GRANTED PERMISSION TO CONDUCT TH RESEARCH BY MAMBO SEKE AS IT IS IN LINE WITH ACADEMIC REQUIREMENTS.
THE FOLLOWING VILLAGEGES HAVE BEEN TARGETED A HER FIRST PORT OF CALL.

VILLAGE NAME	VILLAGE HEAD
BWONI VILLAGE	FANUEL BWON
CHIKORE VILLAGE	DANIEL CHIK

THANK YOU

YOURS FAITHFULLY

MAMBO SEKE
BWONI VILLAGE
01 NOV 2018

ANNEXTURE 13: CHIREDZI AND MASVINGO RURAL DA'S APPROVAL LETTER

Correspondence should not be addressed to individuals

Telephone: 263351/2/3/2266111
Fax : 2266110
Email address: pamasvingo1@gmail.com

ZIMBABWE

Reference:
MINISTRY OF LOCAL GOVERNMENT, PUBLIC WORKS AND NATIONAL HOUSING
Provincial Administration
Benjamin Burombo House
P.O. Box 595
Masvingo

10 December 2018

The District Administrator
Chiredzi
Masvingo

Authority to conduct research: Ms Rosemary Chigevenga: University of South Africa: Chiredzi and Masvingo

The above matter refers.

The head of Ministry in his memorandum dated 2/11/18 has approved Ms Rosemary Chigevenga's application to undertake a field research.

May you please render her the assistance needed. She should first complete the Official Secrecy Act before commencement of the research project.

Chigaba M
For: Provincial Administrator - Masvingo