

ABSTRACT 1

SCALE ASSESSING MALE PARTICIPATION IN PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV: THE SAMP-PMTCT

BACKGROUND

Despite its near global recognition, there is a lack of standardized scales to measure male participation in Prevention of Mother to Child Transmission (PMTCT) programs of HIV (1).

OBJECTIVE

To develop a scale to measure male PMTCT participation.

METHODS

We did a systematic review of published literature for studies reporting on male participation in PMTCT programs and used the derived information to develop a five point Likert-type scale (1. Strongly agree to 5. Strongly disagree)

RESULTS

We developed a 27-item scale:

Your partner accompanies you to antenatal clinic? (1-5)

Your partner supports antenatal testing for HIV in pregnancy? (1-5)

Your partner accepts to participate in couple counselling for HIV? (1-5)

Would/did your partner accept to get tested for HIV? (1-5)

Would/did your partner accept to disclose his HIV status to you? (1-5)

Your partner provides you with moral support since testing for HIV. (1-5)

Your partner provides you with financial support since testing for HIV? (1-5)

Your partner helps you to do physical work at home since testing for HIV? (1-5)

Your partner prays for you and supports you spiritually? (1-5)

Your partner portrays an understanding attitude towards your HIV status? (1-5)

Your partner rejects you/ refuses having sexual relationships with you since testing for HIV? (1-5)

Your partner uses condoms with you during sexual relationships since testing for HIV? (1-5)

Your partner remains faithful to you during your last/current pregnancy? (1-5)

- Your partner communicates with you concerning HIV and PMTCT? (1-5)
- Your partner supports your usage of antiretroviral drugs? (1-5)
- Your partner supports antiretroviral use for the infant? (1-5)
- Your partner supports avoidance of breastfeeding? (1-5)
- Your partner supports the use of artificial milk for the infant? (1-5)
- Your partner denies your HIV results? (1-5)
- Your partner portrays an attitude of shock and anger towards your test results? (1-5)
- Your partner blamed you for not consulting him before testing for HIV? (1-5)
- Your partner accuses you of infidelity since testing for HIV? (1-5)
- Your partner abuses you verbally because of your HIV status? (1-5)
- Your partner threatens or intimidates you because of your HIV status? (1-5)
- Your partner is physically violent towards you because of your HIV status? (1-5)
- Your partner ill-treats you because of your HIV results? (1-5)
- Your relationship has ended since testing for HIV? (1-5)

CONCLUSION

This scale possibly overcomes some of the major challenges of definition and interpretation of male participation in PMTCT.

Reference:

1. Montgomery et al J Acquir Immune Defic Syndr Volume 57, Number 5, August 15, 2011

ABSTRACT 2

Male Involvement In Prevention Programs Of Mother To Child Transmission Of HIV: A Systematic Review To Identify Barriers And Facilitators

Background:

Many reports point to the beneficial effect of male partner involvement in programs for the prevention of mother-to-child-transmission (PMTCT) of HIV in curbing pediatric HIV infections (1). This paper summarizes the barriers and facilitators of male involvement in prevention programs of mother-to-child transmission of HIV.

Methods:

We searched PubMed, EMBASE, CINAHL and the Cochrane Central Register of Controlled Trials (CENTRAL) for studies published in English from 1998 to March 2012. We included studies conducted in a context of antenatal care or PMTCT of HIV reporting male actions that affected female uptake of PMTCT services. We did not target any specific interventions for this review.

Results:

We identified 24 studies from peer reviewed journals; 21 from sub-Saharan Africa, 2 from Asia and 1 from Europe. Barriers to male PMTCT involvement were mainly at the level of the society, the health system and the individual. The most pertinent was the societal perception of antenatal care and PMTCT as a woman's activity, and it was unacceptable for men to be involved. Health system factors such as long waiting times at the antenatal care clinic and the male unfriendliness of PMTCT services were also identified. The lack of communication within the couple, the reluctance of men to learn their HIV status, the misconception by men that their spouse's HIV status was a proxy of theirs, and the unwillingness of women to get their partners involved due to fear of domestic violence, stigmatization or divorce were among the individual factors. Actions shown to facilitate male PMTCT involvement were either health system actions or factors directly tied to the individuals. Inviting men to the hospital for voluntary counseling and HIV testing and offering of PMTCT services to men at sites other than antenatal care were key health system facilitators. Prior knowledge of HIV and prior male HIV testing

facilitated their involvement. Financial dependence of women was key to facilitating spousal involvement. Conclusions: There is need for health system amendments and context-specific adaptations of public policy on PMTCT services to break down the barriers to and facilitate male PMTCT involvement.

Registration: The protocol for this review was registered with the International prospective register of systematic reviews (PROSPERO) record CRD42011001703.

ABSTRACT 3

CO-INFECTION OF HIV AND HBV OR HCV AMONG ANTENATAL CLINIC ATTENDERS IN YAOUNDE, CAMEROON.

BACKGROUND

Given the common routes of transmission, the human immunodeficiency virus (HIV), hepatitis B virus (HBV) and Hepatitis C virus (HCV) epidemics overlap (1). Yet few studies have addressed the issue of co-infection of HBV or HCV among HIV infected pregnant women in Cameroon.

OBJECTIVE

To determine the prevalence of HIV/HBV, HIV/HCV and HIV/HBV/HCV co-infection, and correlates of these co-infections among antenatal clinic attenders in Yaounde, Cameroon.

METHODS

This was a cross-sectional multicenter study carried in 3 clinics in Yaounde. The study lasted 15 months, recruiting 952 pregnant women attending routine antenatal care. Rapid tests for HIV types 1 and 2 were run, and plasma was tested for Hepatitis B surface antigen (HBsAg) and anti-HCV antibodies. Results are presented for HIV positive and negative women.

RESULTS

In the total population, the HIV, HBV and HCV antibody seroprevalences were 8.4%, 7.8% and 1.2% respectively. The mean age among the HIV positive women was 29.7±4.7 years, with a mean gravidity of 3. These women were mostly married/cohabiting (76.3%), unemployed women (71.3%) with at least secondary education (83.6%). Fifty-one (63.8%) of the HIV positive women were aware of their HIV status. Among the HIV infected pregnant women 90.0% (72/80) had HIV infection only, 8.75% (7/80) had HIV/HBV co-infection, while 1.3% (1/80) had HIV/HCV co-infection. No cases of HIV/HBV/HCV co-infection were detected. The risk of HIV infection was not increased by having HCV or HBV in the general study population (Risk Ratio [RR] 1.15, 95% CI [Confidence Interval] 0.5-2.6; p=0.73 and RR 1.16, 95% CI 0.13-8.36; p= 0.96 respectively). Three (42.9%) of the HIV/HBV co-infected patients had evidence of HBeAg (Hepatitis e Antigen) in their plasma, a marker of rapid ongoing HBV

replication, thus indicating that this proportion of patients was highly infectious for HBV, and therefore likely to transmit the virus to their offspring. There was no association between risk factors for blood borne infections and HIV/HBV co-infectivity.

The lone HIV/HCV co-infected patient was a 26 year old student gravida 3 student, without any reported risk factors for HCV infection.

CONCLUSION

HBV/HCV co-infection with HIV seems to be uncommon among pregnant women in our settings. This finding is reassuring given the challenges in the clinical management of people with HIV co-infected with HBV or HCV, and the known negative impact of HIV on HBV and HCV infections.