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Editorial

Getting to Zero: The Role of Socio-Cultural Factors in PMTCT Interventions in Resource-Limited Settings

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EDITORIAL

Every year, more than 300,000 children become newly infected with HIV and 90% acquire the virus through transmission from mother to child either during pregnancy, birth or infant feeding [1,2]. In 2011, an estimated 1.5 million pregnant women were living with HIV in low and middle income countries [1]. Furthermore, despite ambitious goals and unprecedented resources to reduce mother to child transmission of HIV (MTCT), including the Global Plan target of 90% by 2015, in 2011, only 57% of the estimated 1.5 million pregnant living with HIV women received effective antiretroviral drugs (ARV) to avoid transmission to child [1]. While UNAIDS (Joint United Nations Program on HIV and AIDS) suggests that '*virtual elimination of mother to child transmission of HIV is possible and it has been achieved in developed countries'* [1], in resource-limited developing countries, this goal continues to remain unattainable. Far too often, pregnant women in developing countries go untested for HIV and most do not access prenatal care early in pregnancy or effective ARV if needed [3]. Barriers to optimal prevention of mother to child transmission of HIV exist at the patient, provider level and health systems level [3]. If mother to child transmission of HIV is to be virtually eliminated in developing countries, a series of steps including integrating socio cultural factors into interventions programs is essential. But why focus on socio cultural factors?

Indeed, the notion that socio cultural factors play important roles in influencing health behaviors, health outcomes and utilization of health services is gaining enormous recognition in the literature [4]. Socio cultural factors matter not only with shaping decisions about health (whether positive or negative), but also with highlighting the role family and community contexts play in shaping those decision [4]. Take for example, the involvement of men in the prevention of mother to child transmission of HIV in sub Saharan Africa. It's been suggested that male partner involvement in PMTCT programs improves adherence to ARV and overall infant health outcomes [5-7]. Studies conducted in Nairobi Kenya by Aluisio and colleagues [8], suggested that male partner involvement significantly lowered the risk of HIV infection in infants of HIV infected women and enabled greater HIV free survival when compared to infants born to HIV+ women without male involvement. In Ivory Coast, Tijou Traoré and colleagues [9], suggested that when men are aware of their wife's HIV zero positive status and are involved in a PMTCT program, they play an active role in influencing decisions and practices concerning the application of preventive infant feeding options.

Despite these potential benefits and positive impact of men with PMTCT, men's involvement, remains very low. Ramirez Ferrero and Lusti Narasimhan [10] suggested that the 'historic institutionalization of reproductive health as women's health has resulted in the provision of health services that are not welcoming of men.' Musya and colleagues [11], noted that the 'traditional clinic based approach of antenatal care and PMTCT programs reaches few men' and undermines male engagement in voluntary counseling and testing. Male partner participation is also complicated by the fact that culturally, antenatal care in many African cultures is perceived exclusively as a woman's responsibility, an activity concerning the mother and her child, with no need for male involvement until childbirth and/or naming ceremony. As a result, any attempt to design interventions to promote male partner involvement maybe futile if attempts are not equally made to address the socio cultural factors governing the role of men in African cultures particularly as related to cultural norms surrounding pregnancy, child-birth and post delivery.

The same can be said for identifying ways to reach men so as to increase their engagement with PMTCT programs. As highlighted earlier, the 'traditional clinic based approach to PMTCT interventions reaches few men' [11]. Furthermore, male friendly and accessible PMTCT interventions are scare [12], and are often not based in the social or local realities of men in resource limited settings. Thus there is a need to develop social culturally feasible male oriented PMTCT interventions in places where men congregate [13]. Historically, in developing countries, churches, mosques and other faith based institutions play important role in promoting positive health behaviors [14]. These

institutions which are often large, stable, socially acceptable and well respected are also better equipped to access populations which are often described as hard to reach or difficult [15]. Furthermore, it is not uncommon for members of faith based institutions to develop strong civic ties within sub groups such as with men's fellowship associations or women's fellowship associations [14]. While a faith based approach to health holds great potential and has been used effectively in health promotion and disease prevention in communities where religion plays a prominent role [3], little evidence exists on the use of this socially acceptable infrastructure (religious institutions) in reaching men and increasing their participation with PMTCT interventions. Thus, integrating PMTCT interventions within faith-based institutions that play significant roles in the social lives of men is important with increasing male partner involvement and reducing barriers to PMTCT service uptake among HIV positive pregnant women.

As ambitious goals and unprecedented resources are currently underway to virtually eliminate mother to child transmission of HIV by 2015, integrating knowledge of socio cultural factors into PMTCT interventions are important. Socio cultural factors matter with identifying ways to increase male partner involvement and understanding the significance of socially acceptable institutions in the lives of men. Indeed, if the participation of men is crucial to success to PMTCT interventions in resource limited settings, then it is time for us to work together to develop social cultural interventions focused on identifying ways to reach men and increase their engagement.

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