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SOCIO-CULTURAL FACTORS INFLUENCING MALE INVOLVEMENT IN HOME-BASED CARE FOR PEOPLE LIVING WITH HIV AND AIDS IN MASENO DIVISION, WESTERN, KENYA
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R. K. MAKORI, R. O. ONYANGO, R. KAKAI and J. O. S. OSERO

ABSTRACT

Background: **Home-based care has emerged as an effective method of providing cost-effective and compassionate care to those infected with HIV and AIDS. Traditionally, women have been in the forefront in the provision of care for those infected with HIV and AIDS. However, there was low male involvement in home-based care services and little research has been done.**
Objective: **To investigate socio-cultural factors that influence male involvement in home-based HIV and AIDS care in Western Kenya.**
Design: **Cross-sectional, descriptive study.**
Setting: **Maseno Division Western Kenya.**
Subjects: **Two hundred and fourty eight (248) caregivers selected fromregistered support groups in Maseno Division, Western Kenya.**
Results: **Overall, 29% of the caregivers were male, 75% took care of close relatives and 59.7% of the respondents had not received formal training on home-based care. Those respondents who had no employment indicated low levels of male involvement than those who had employment (χ^2=17.18, p=0.001). Male caregivers performed fewer nursing activities such as changing soiled beddings (μ =1.97, SD=0.95) compared to the general activities like buy and carry food home (μ=2.95, SD=1.15). Respondents who had high number patients were statistically more likely to report lower levels of male involvement than those who had lower number of patients χ^2=61.69, p= 0.025. Although 92% agreed that men should be involved in care giving, over 50% said that it is taboo for men to cook or fetch water, that care giving is for women, and the men who participate in housework are considered weak or bewitched. Male involvement in home-based care variables were negatively correlated with socio-cultural variables. For example, there was a significant strong negative relationship between taboo for married man to cook with men cook and feed HIV patients (r =- 0.69, P=0.01).**
Conclusion: **Full participation of males' in HIV home care is hindered by the current socio-cultural constraints. There is need to address it through health education using context-specific and culturally-sensitive messages.**

INTRODUCTION

An estimated 33.2 million people worldwide were living with HIV at the end of 2007 hence the need to explore effective strategies for care and support (1). Home-based care (HBC) emerged as an effective method of providing cost-effective and compassionate care to those infected and affected with HIV and AIDS. HBC is not a replacement for hospital care but instead is part of a comprehensive continuum of prevention, 'care treatment' and support services that include family, community and various levels of healthcare providers (2). When AIDS enters the household, women and girls provide most of the care to the ill, as expected by society. Globally, up to 90 per cent of such care is provided in the home by women and girls (2). There is low male involvement in home-based care activities in Kenya (3, 4).

But as HIV and AIDS take its toll, it is becoming apparent that women alone cannot shoulder the responsibility of HBC work. They need their male counterparts to complement their efforts for the necessary care. Despite the magnitude of the problem, men have played a less direct role in the care of

the chronically ill. As a result, many women and girls have left work (both formal and informal) and school to provide this care, and most have taken on this role in addition to their existing reproductive and productive roles. However, there have been few documented programme and little research into the most effective ways to increase male involvement (5). Male's involvement is important for carrying out sustainable community HBC grassroots interventions. Home-based care is an appropriate patient support approach to care. Indeed, many people prefer to be cared for in their home and communities.

Due to 'traditional gender norms' and unequal relations it is the women and girls in the communities who have become caregivers, whilst often needing care themselves, and possibly being HIV positive. These 'traditional gender norms' also provide social barriers to men and boys becoming caregivers, exacerbating the burden for women and girls. The spread of HIV and AIDS is fueled by gender-based socio-cultural, legal and physiological factors. At the root of all this is gender inequality. It's clear that some culture norms play an important role in limiting men's involvement. It is important not to see culture as immutable or monolithic.

This study was designed to determine the level of male involvement in home-based care, to identify socio-cultural constraints on male involvement in home-based care and to find out the relationship between the level of involvement and the socio-cultural constraints in Maseno division, Western Kenya.

MATERIALS AND METHODS

This was a cross-sectional descriptive study done in the month of May, 2008, the study population comprised HIV/AIDS caregivers. The study used both quantitative and qualitative data collection methods. Primary data were collected from the respondents through personal interviews using a semi-structured questionnaire.

Study site: This study was carried out in Maseno division of Kisumu West district, Nyanza Province, Kenya. Maseno division is a rural area with a population of 82, 223 (43, 506 males and 38, 717 females) people accounting for approximately 14 % of the Kisumu West district population (6, 7). There are eight health facilities and 30 community based organizations involved with HBC for PLWHAs. In Kisumu district there was a prevalence of 11.2% HIV and AIDS and an average of 3, 500 PLWHAs were under HBC services (8).

Study Population: The study included 248 caregivers, sampled from a sampling frame that included 420 home-based caregivers who were involved in HBC activities and registered in Maseno division. The inclusion criteria comprised of consenting persons of either gender, above 18 years of age, residing in the study area who were providing HBC service to people living with HIV and AIDS, (PLWHAs). Also required them to be registered members of a community based AIDS support groups and consented to participate in the study.

Sampling Technique: Purposive sampling was used to identify the study area and support groups which were involved in HIV and AIDS care and support. Maseno division was purposely selected because it had a high prevalence of HIV positive people, 8% in comparison with the national 7.8% (UNAIDS 2009). The location and current activities was used as major dimensions to select the functioning support groups. Thereafter simple random sampling was used to select the actual participants. Simple random sampling was considered adequate as each caregiver had chance of being selected. Sampling was done by numbering all 420 caregivers in each support group by using a table of random numbers. The starting point in the table was determined by randomly picking a page and dropping a finger on the page with eyes closed. Then numbers were chosen up and down, until the 248 required sample size was obtained. Once a number was chosen, it was not chosen again. A list of all HIV and AIDS care givers in Maseno division was obtained from the Ministry of Health office, Kisumu.

To get the required sample size that was involved in the study, individual caregivers were selected proportionately across the 14 functioning support groups during their meeting (Table 1), using the following formula:

$$\frac{n_i}{n} \times N$$

Where; n_i = Number of group members in the support group.

n = Total number of group members in all the support groups.

N = Required sample size

Table 1
Distribution of respondents by community based organizations (support groups)

Name of support group	Number of Caregivers	Desired sample size per group Proportion(percentage)
1. Ampath support group	49	29 (12.69)
2. Zingatia post test club	46	27 (10.88)
3. Positive men against Stigma	44	26 (10.48)
4. Grail COFFIDO support group	37	22 (8.87)
5. Mercy drop women group	34	20 (8.06)
6. Rise talk post test club	32	19 (7.66)
7. Wings of love	30	18 (7.25)
8. Bongu women group	29	17 (6.85)
9. Baraka support group	25	15 (6.05)
10. Misiani women group	24	14 (5.65)
11. Kakamu self help	22	13 (5.24)
12. Oloo women group	19	11 (4.43)
13. Nema support group	17	10 (4.03)
14. Kakamun Group	12	7 (2.82)
Totals	420	248

A semi-structured questionnaire was administered by two research assistants to consenting participants, at the meeting venue of the support groups. The questionnaire was developed to include level of male involvement, demographic, social and cultural variables. The items on attitude and opinion included Likert-type scales with responses ranging from one (strongly agree) to five (strongly disagree). To measure the level of male involvement, we asked 13 questions on aspects of home-based care (counselling, accompanying patient to clinic, bed bathing, following up patients) and the response was measured on a five-item Likert scale (ranging from not at all=1, to completely involved=5). We then computed the mean level of involvement for each activity and also ranked the mean values to identify the most and least preferred care activities. The instrument also included open-ended questions to identify specific socio-cultural factors and views on how to tackle them to involve men in HBC activities. The interview lasted for an average of 20 minutes. We had a male and female research assistant who had completed secondary education, spoke the local Dholuo language and were residents of Maseno division.

We pre-tested the questionnaire with 20 formal caregivers from Maseno division who were not included in the study, to refine it and identify any potential errors. The pre-test sample was similar as possible to the study sample and the interviews took place in conditions similar to those of the actual questionnaire administration. The consent form and semi-structured questionnaire were translated into the local Luo language.

Ethical consideration: The permission to carry out the research was obtained from Maseno University, School of Graduate Studies, Medical Officer of Health of Kisumu West District, Commissioner of Kisumu District and the area Chief. The permission was sought to interview members of a support group through their contact persons to whom we explained the aims and purpose of the study. Meetings were held with members of the support groups to explain the study aims and procedures. Thereafter, individual members volunteered to participate in the study after providing written consent.

Data management and Data Analysis: Quantitative data ware cleaned, coded, entered and analysed using SPSS version 12.0 for Windows (SPSS Inc., Chicago, IL) computer software. We performed descriptive (frequencies, percentages, means and standard deviations) and inferential analyses to determine the association between socio-cultural constraints and level of male involvement in HBC activities.

From the Likert scale, mean scores were used to create the rank as recommended by Guberman *et al*., (9). Interpretation of the descriptive statistics was used to identify the significant constraints. We treated the five point Likert scales as if it is interval and computed the mean statistic. Mean values of 2.50 and above were considered negative attitude while

a mean below 2.49 was considered positive attitude. The mean score that was above 2.50 was considered presence of socio-cultural constraints, while below 2.49 was considered no presence of socio-cultural constraints. Attitude with mean above 2.50 was considered positive attitude while mean below 2.49 was considered negative attitude. We performed correlation analysis to compute the strength of association and cross tabulation to measure the statistical significance (from Pearson's chi-square). Subsequently multiple regression analysis was used to investigate the trends in the significant relationships. The confidence level chosen for this study was 95%.

A three stage thematic approach was used to analyse the qualitative data: In the first stage, transcribed document were read and re-read in order to generate explanation addressing the basic research open-ended questions; during the second stage, these were sorted into specific themes; lastly the third stage was the systematic organization (coding) of the entire data and matching it with the relevant research questions. This allowed for an understanding of the extent to which the qualitative data generated information directly related to the primary aim of the study and provided explanations for the keys findings from quantitative analysis.

RESULTS

The study was done in the month of May, 2008. The overall response rate was 224 (90%) out of 248 potential participants invited. Some of the reasons for non-response included inability to attend interviews due to bad weather (heavy rains), refusal and incomplete data.

Socio Demographic Characteristics: Majority of the caregivers, 161(71%) were female while 63(29%) who were male. This showed that male involvement was low. The mean age of the participants was 38.24. Most of the respondents, 79 (37.4%) were aged between 30-39 years. Nearly half, 105 (47.9%) had secondary level of education while only 22 (10%) had no formal education. More than half, 123 (56.2%), of the respondents were married and 105 (49.3%) had no formal employment. The majority of the respondents, 130 (59.7%) had not been formally trained on home-based care while only 88 (40.4%) were trained.

The gender of the care recipients was variable: 144 (68.2%) were attended to both male and female, 38 (18%) were female and 29 (13.7%) were male. Most of the patients, 61 (31.3%) were aged below 19 years while six (3.1%) were 50 years and above. About three quarters of the respondents were taking care of other relatives 164 (74.9%) followed by grandchildren 17 (7.8%) and spouses 15 (6.8%). The number of patients taken care of by the respondents ranged from 1-20 with a mean of four (SD = 3.1). Table 2 is a summary of the demographic characteristics of the participants.

Male involvement: The overall reported level of male involvement was established per respondent and the frequency categorised into the respective category. Majority (42.9%) of the males felt that males were involved to a little extent, while majority (44.9%) of females felt that the males were involved to some extent (Figure 1). On open-ended respondent in the study said, "*Fathers can't take care of the sick. They only help out with money once in a while*". Another woman remarked, "*You know males they are not that sensitive. Mothers can take care of so many things. Most males don't like taking care of sick people… women are patient and caring. Men can't be like that*". There was a feeling that men do not want to work with women and if they do, they want to assume leadership and command the women.

Table 2
Socio-demographic caracteristics of the Respondents

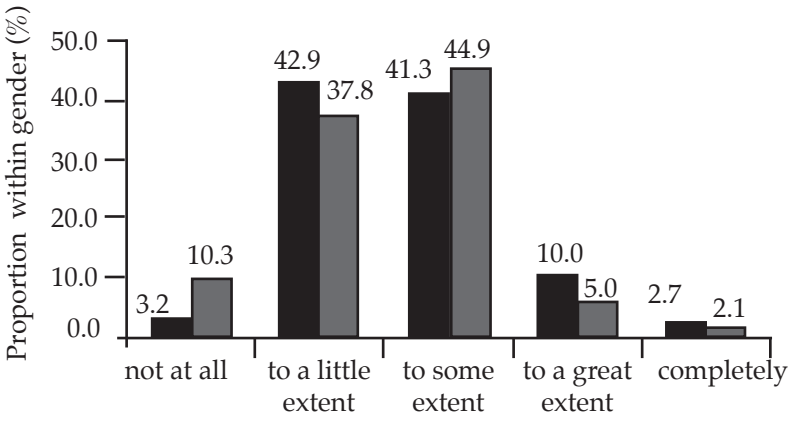
		Gender		
		Male N(%)	Female N(%)	Total N(%)
Age(Years)	19-29	5(8.2)	39(26.0)	44(20.9)
	30-39	29(47.5)	50(33.3)	79(37.4)
	40-49	18(29.5)	38(25.3)	56(26.5)
	50-59	3(4.9)	15(10.0)	18(8.5)
	60 and above	6(9.8)	8(5.3)	14(6.6)
Education	None	1(1.6)	21(13.5)	22(10.0)
	Primary	2(17.5)	39(25.0)	50(28.8)
	Secondary	33(52.4)	72(46.3)	105(47.9)
	Tertiary	18(28.6)	24(15.4)	42(19.2)
Marital status	Married	48(76.2)	75(48.1)	123(56.2)
	Single	2(3.2)	9(5.8)	11(5.0)
	widow or widower	11(17.5)	70(44.9)	81(37.0)
	Divorced/separated	2(3.2)	2(1.3)	4(1.9)
Occupation	salary employment	7(11.5)	6(3.9)	13(6.1)
	self employment	31(50.8)	53(34.9)	84(39.4)
	casual employment	6(9.8)	5(3.3)	11(5.2)
	None	17(27.9)	88(57.9)	105(49.3)
gender of the patients				
the respondent has	Males	6(10.3)	23(15.0)	29(13.7)
	Females	12(20.7)	26(17.0)	38(18.0)
	both sexes	40(69.0)	104(68.0)	144(68.2)
Age(Years) of the patients				
the respondent has	19 and below	6(11.5)	55(38.5)	61(31.3)
	20 to 29	15(28.8)	42(29.4)	57(29.2)
	30 to 39	18(34.6)	21(14.7)	39(20.0)
	40 to 49	11(21.2)	21(14.7)	32(16.4)
	50 and above	2(3.8)	4(2.8)	6(3.1)
Relationship with				
the patient	Partner	8(12.7)	7(4.5)	15(6.8)
	Parent	4(6.3)	3(1.9)	7(3.2)
	Child	4(6.3)	12(7.7)	16(7.3)
	Other Relative	45(71.4)	119(76.3)	164(74.9)
	Grand Child	2(3.2)	15(9.6)	17(7.8)
formal training of the				
respondents in HBC	Yes	24(38.7)	64(41.0)	88(40.4)
	No	38(61.3)	91(58.9)	130(59.7)

Further analysis indicated the following ranked mean scores ascending in terms of level of male involvement per activity in Table 3. Overall, most score for individual activities were low involved from nursing to general activities on level of male involvement except for buying and taking food home (μ=2.95, SD=1.15) and making referral to healthcare centres (μ=2.72, SD=1.18) for which there mean scores were higher than 2.50 in Table 3.

Table 3
Total ranking of the level of involvement by mean scores (N= 224)

Involvement activities	Mean score (Standard deviation)
Nursing activities	
Change soiled beddings	1.33 (0.61)
Bed bath HIV and AIDS patients	1.61 (1.42)
Support lift and physical therapy	1.68 (0.74)
Provide first aid for burns and wounds	1.71 (0.71)
Monitoring the health of the HIV patients	1.80 (0.87)
Follow up drug prescribed to patients	1.81 (0.96)
General activities	
Attending home-based care trainings	1.86 (0.83)
Cook and feed HIV and AIDS patients	1.91 (0.99)
Fetch water and make cleanliness	1.98 (0.88)
Counselling and giving spiritual support	2.03 (0.80)
Attending home-basedcare trainings	2.22 (1.17)
Make referral to the health care centres	2.72 (1.18)
Buy and carry food home	2.95 (1.15)
Total mean score	1.97 (0.95)

Figure 1
Reported Level of Male Involvement in Home-Based Care



Association of male involvement with socio-demographic factors: On cross tabulation socio-demographic variables of the respondents with the overall reported level of male involvement, there was statistically significant relationship with occupation and number of patients being taken off by the respondents. Those respondents who had high number of patients were statistically more likely to report lower levels of male involvement than those who had lower number of patients (χ^2 =61.69, p= 0.025). Also those respondents who reported to have no employment were statistically more likely to report lower levels of male involvement than those who had employment (χ^2=17.18, p=0.046). Similarly response from open-ended questions indicated that males found it difficult to work as volunteers as they were breadwinners. Even though they were unemployed they were given some stipends. However, they felt the stipends they received were too low and not able to satisfy their societal role of being a breadwinner. *"Men cannot work for volunteer in HBC because they are breadwinners; who should provide for the family, maybe, if they are paid"*. Another respondent indicated that: "*even if they are free men don't like working where they are not paid, even at home they ignore helping domestic work*". An increase in the stipends may help enhance recruitments of males to care-giving. Men are ignorant when it comes to some work at home, such that they are left for their wives.

Community Opinions on socio-cultural practices related to male involvement in home-based care: The respondents were asked to gauge, on a Likert scale, their communities' opinions on various practices and beliefs as regards to HBC. The responses were further categorised into "Agreed" and "Disagreed". All of the socialcultural practices had high frequencies reported to be agreed presence of socio-cultural constraints in Table 4.

Ranking of the Socio-cultural practices and beliefs: The mean scores for the various socio-cultural practices ranged from highest (4.11) to lowest (2.95). The following descending order of negative practices and beliefs, based on the computed mean scores, was observed: HIV positive men should marry another wife to take care of him (mean =4.11, SD=0.79), men always doing household activities is a sign of wife laziness (mean =4.08, SD=0.75), men should accompany their wives to clinic (μ=4.03, SD=0.80), men are embarrassed when associated with HBC (μ=4.01, SD=0.61), care giving is meant for women (μ=3.96, SD=0.70), it is a taboo to cook when married (μ=3.96,SD=0.90), men doing general cleanliness are bewitched (μ=3.90, SD=0.83), Cooking and fetching water are meant for women (μ=3.83, SD=0.84), HIV positive women should be divorced (μ=3.74, SD=0.99) and lastly men accompanying their wives are controlled by their wives (μ=2.95, SD=1.30). Overall, all the scores for socio-cultural factors were positive with mean score higher than 2.50.

Table 4
Community Opinions on social cultural aspects of Home-based care

Variable	Opinion	N(%)
Taboo to cook when married	Agree	118(55.9)
	Neither	49(23.2)
	Disagree	44(20.9)
Cooking and fetching water are for women	Agree	105(50.5)
	Neither	39(18.8)
	Disagree	64(30.8)
Men who do general cleanliness are bewitched	Agree	162(76.4)
	Neither	29(13.7)
	Disagree	21(9.9)
Woman found HIV positive to be divorced		
	Agree	162(75.0)
	Neither	47(21.8)
	Disagree	7(3.2)
HIV positive man should marry another wife to take care of him	Agree	111(51.9)
	Neither	65(30.4)
	Disagree	38(17.8)
Care giving is for women		
	Agree	91(44.4)
	Neither	28(13.7)
	Disagree	86(42.0)
Men involved in HBC are discriminated by society	Agree	94(44.3)
	Neither	42(19.8)
	Disagree	76(35.8)
Men embarrassed with HBC		
	Agree	141(65.6)
	Neither	38(17.7)
	Disagree	36(16.7)
Men increased HBC involvement is a sign of wife laziness	Agree	125(57.9)
	Neither	41(19.0)
	Disagree	50(23.1)

Other socio-cultural practices and beliefs that hinder male involvement in HBC activities: The other reason relates to men's reluctance to perform care activities was brought up in open-ended questions; that bringing them in close contact with female patients for example: *"Men may be perceived to be engaged in wife inheritance when giving HBC services to the opposite sex"*. Despite the general reluctance of men in care-giving as care givers, there were handful of men in support groups who indicated that although other men discouraged them by making jest of them, they were undeterred. Another male respondent indicated, *'The community, the majority being men say that care giving in HBC for PLWHAS is the work of women and men should do other jobs that women cannot do. I tell them that any work a man can do'*. This was strongly supported by the fact that women are the ones who give birth and knows the pain hence this makes women more compassionate than men as indicated below; *"I think men do not have the heart of caring that can induce them to the HBC activities for the sick and others. They only take care of the sick when there is no female and once female comes home they excuse themselves"*. The assertion was that men provide care only when there are no woman around to do it and that they look for every opportunity to abdicate the responsibility.

On further analysis of open-ended questions, other reported beliefs which hinder male involvement in HBC activities were identified: majority of the respondents 102(56%) indicated that in their community HBC activities are believed to be the work of women; 50 (27.6%) respondents indicated that men fear getting infected with HIV, while 43 (22.4%) said that they should be paid for any HBC activities they do. Additionally, 57 (31.5%) respondents said that men feared being associated with HIV and AIDS in home-based care activities, 49 (27.2%) indicated that the men felt they may be perceived to conduct wife inheritance when giving HBC services to the opposite sex, while 36 (19.9%) indicated that men did not have the heart of caring that can induce them the HBC activities for the sick and others. Lastly 20 (11%) indicated that men are ignorant when it comes to some work at home, such that they are left for their wives (Table 5).

Table 5
Socio-cultural factors hindering male involvement

Factor	Number (%)
Fear of HIV infection	50(27.6)
HBC work for women	102(56)
HBC activities not paid	43(22.4)
Fear of being associated with AIDS patients	57(31.5)
Perceived to conduct wife inheritance	49(27.2)
Men lack heart of caring	36(19.9)
Men's ignorance	20(11)

Respondents' views on solving socio-cultural constraints: Majority of the respondents, 88 (48.6%) said that men should be counselled on the importance of involvement in HBC; 63 (34.8%) that seminars should be given on the importance of HBC, 54 (29.8%) suggested the formation of male involvement campaign groups, 62 (34.9%) stated mobilisation in the community to deal with issues related to socio-cultural beliefs while 45 (25.9%) outlined the need for sensitising the community on the socio-cultural issues that can constraint men's involvement in HBC.

When we performed correlation between the socio-cultural factors variables and the level of male involvement, we found almost all the variables to have a significance relationship. Pearson's correlation co-efficient was used to estimate the strengths of associations between observed variables of measuring level of involvement and the socio-cultural constraints. The result indicated a negative relationship between socio-cultural constraints and level of male involvement in HBC for PLWHAs (Table 5). There was significant strong negative relationships in the following: between taboo for married man to cook with men cook and feed HIV patients ($r = -0.69$, $P=0.01$); between ($r = -0.50$, $P=0.01$) attend HBC trainings and men involved in HBC are discriminated as well with ($r = -0.37$, $P=0.01$) men are afraid / embarrassed to become associated with HBC; between ($r= -0.48$, $P=0.01$) care giving is believed to be the work of women and bed bath AIDS patients; between ($r= -0.43$, $P=0.01$) men are afraid / embarrassed to become associated with HIV and AIDS; between ($r = -0.67$, $P = 0.01$) care giving is believed to be the work of women and change soiled beddings for AIDS patients and between ($r = -0.55$, $P= 0.01$) care giving is believed to be the work of women and fetch water with general cleanliness at home.

It also revealed significant weak negative relationships in the following: between ($r = -0.31$, $P=0.05$) buy and take food home and care giving is believed to be the work of women; between ($r = -0.27$, $P= 0.05$) counselling and giving spiritual support and HIV positive man marry another wife; between ($r = -0.28$, $P= 0.05$) bed bath HIV and AIDS patients and HIV positive man marry another wife and between ($r=-0.26$, $P=0.05$) make referral to the healthcare centres and HIV positive wife are divorced.

DISCUSSIONS

Gender disparity in terms of roles was observed to exist in the studied population. The results from the random selection of the caregivers showed that the majority of respondents were females compared to males. This gave evidence that there was low male involvement in HBC programmes and activities in the study area. The result concurred with other

studies by; Kenya NGOs Consortium Kavuma *et al.*, who mentioned low male involvement in HBC interventions being reported by health workers and service providers both at institutional and community grassroots levels (4, 10). Further review of literature indicates that males did not volunteer to become caregivers; often they had no choice because the females were not available (11).

Additionally, the majority of the age category of the caregivers was 30-39 years; followed by 40- 49 years on both genders that were in the younger and middle age group, although a difference was noted on age category of 19-29 years where more women were involved to care than men. Since HIV and AIDS mainly affect the population between 15 to 45 years (12), this study results also showed that between 19 to 49 years had more patient taken care of by the respondents due to HIV epidemic affecting the age group.

In this study majority of the respondents had not been formally trained on home-based care. This concurred with a study done in Kiambu, Kenya which indicated very few caregivers had appropriate training and were worried about their lack of knowledge and yet they were to care for patients. It was evident that they lacked a framework that would provide the capacity to facilitate home-based care. Such a framework would bridge the gap between the noble concept of HBC and the reality of HBC (12). Similarly, in Botswana family care giving was poor because family caregivers were not trained to provide basic care (13).

Further analysis identified the gender of the caregiver as well as the relationship to the patients as significant contributing social-cultural factor to the level of male involvement. Males were highest when the spouse and parents were care recipients than the females, but lowest when a child and other relatives were care recipients. It also agrees with another study (5) that responsibilities towards the family have the highest priority and precede loyalty towards other parties such as employer, neighbours and friends. Additionally, those respondents who had lower number of patients were significantly more likely to report lower levels of male involvement than those who had more number of patients. This might be due to the amount of workload involved in HBC activities. Also those respondents who were not employed were significantly more likely to report lower levels of male involvement ($\chi^2 = 17.180$, $p = 0.05$) than those who had more number of patients. This suggests that they might lack resources for providing the services in HBC for PLWHAs. It agrees with a study in South Africa the high level of unemployment was explained to be the general lack of skills among volunteers in care giving (14).

From this study, results revealed a generally low level of male involvement. However, on specific elements of involvement, males were seen to be slightly more involved in buying and taking food home compared to the other HBC activities. Some activities were much lower like the nursing activities; feeding, bathing, and wound care. This concurred with a study done in eastern Zimbabwe which found that voluntary caregivers, had difficulties to provide certain nursing activities (15). It also agreed with a study done in South Africa which indicated that men rarely assisted with care giving. When men do assist like bathing patients, cleaning and treating pressure sores, women caregivers often feel uncomfortable as opposed to when men assist with hospital visit and arranging transport for the sick (16).

The result of this study identified socio-cultural constraints on male involvement in HBC for PLWHAs. The respondents indicated presence of taboos, norms and beliefs that hinder male involvement in HBC for PLWHAs. The statement used as care giving is meant for women indicated that norm was positive in the study. It concurred with a study done in South Africa described the impact of community norms that deter men from becoming involved in HBC activities regarded as women's work (14). Also, the study agreed with a study done in South Africa that; men identified being afraid of embarrassed to become associated with HIV and AIDS as well as HBC for PLWHAs, partners were worried others would accuse them of being lazy, incompetent or even of bewitching their husbands (17). It also concurred with documentation that those men who do not conform to societal expectations face stigma and discrimination (18). While women provide care, they themselves are denied this when they need it. They are stigmatised too and would be dispossessed and chased from their matrimonial homes especially when they cannot take in cultural rites. Indeed, it is seen to be easy to replace a wife as men can be polygamous, it agrees with a study done Western Kenya (19).

On using Pearson's correlation to determine the relationship between socio-cultural factors and level of male involvement in HBC activities, the study found a negative relationship between some socio-cultural factors, like gender discussed above, on the level of male involvement in HBC for PLWHAs. The results indicated that socio-cultural constraints can significantly predict the level of male involvement in HBC for PLWHAs. It agrees with a study done in China, cultural values as predictors of caregiver's behaviour was emphasised by Zhan, described how Chinese caregivers are influenced by the Confucian norms where obedience provision and care towards the parents and/or other close relatives has always been emphasised (20). The relationship implies that as the socio-cultural constraints increases and the level of male involvement decreases. This study also agrees with a study done in South Africa that revealed a negative association between socio-cultural factors

and the level of male involvement in PMTCT (21) which suggested that so long as the socio- cultural factors exist then the low level of male involvement still will be indicated.

In conclusion, The study indicated low male involvement and the presence of socio-cultural factors having a negative influence on the level on male involvement in HBC for people living with HIV and AIDS. There is need to make the involvement of men in the care of sick family / community members more culturally acceptable to alleviate some of the women's high work load. Therefore, context-specific and cultural sensitive massages should be formulated and disseminated through health education.

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