



Innovative Approaches for Eliminating Mother-to-Child Transmission of HIV

Engaging Men as Change Agents
to Prevent Mother-to-Child
Transmission of HIV: Experiences
from Côte d'Ivoire, Democratic
Republic of the Congo, Malawi,
and Uganda

Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women (OHTA), a UNICEF-supported initiative with funding from the Governments of Norway and Sweden, aimed to accelerate access to Option B+ for the elimination of mother-to-child transmission in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi, and Uganda. Option B+ is an approach recommended by the World Health Organization in which all pregnant and breastfeeding women living with HIV are offered treatment with antiretrovirals for life regardless of their CD4 count.¹

The OHTA Initiative's primary focus was to strengthen the capacity of the primary health care system to deliver lifelong HIV treatment to pregnant and breastfeeding women; create demand for programmes aimed at preventing mother-to-child transmission (PMTCT), increasing uptake and timely utilization of PMTCT programmes by women, and retaining women in care; and strengthen monitoring and evaluation for decision making to improve service delivery.² The OHTA Initiative was implemented between 2012 and 2017 through in-country implementing partners.

“This male involvement I think is helping us in the PMTCT outcomes, because once they [the couple] test together, and they know what their status is, then it helps us as health workers to talk to them and see how they can have their treatment done according to schedule.”

— District Health Official, Uganda



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Between 2010 and 2016, crucial progress was made in scaling up treatment and PMTCT in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi, and Uganda. Since 2010, AIDS-related deaths in these four countries have decreased by 14 per cent, 46 per cent, 47 per cent, and 56 per cent, respectively. Additionally, between 70 and 95 per cent of pregnant women living with HIV received ART in each country – 73 per cent in Côte d'Ivoire, 70 per cent in the Democratic Republic of the Congo, 84 per cent in Malawi, and 95 per cent in Uganda. All four countries also experienced a 40 per cent or higher decrease in the number of children acquiring HIV between 2010 and 2016. Despite these accomplishments, challenges remain. For example, in 2016 alone the number of AIDS-related deaths among children 0 to 14 years old ranged from 2,600 to 2,800 deaths in Côte d'Ivoire and the Democratic Republic of the Congo, to 4,100 in Malawi, and 5,800 in Uganda. In addition, less than half of children living with HIV were on treatment in the four countries, ranging from 25 per cent in Côte d'Ivoire to 49 per cent in Malawi.³

Better service delivery and improved uptake, adherence and retention in care are essential to achieving universal access to lifelong antiretroviral therapy (ART) for people living with HIV, and innovative approaches are often required. Programmes that engage men as fathers, partners, change agents, and clients of health information and services are an important part of the solution. However, in sub-Saharan Africa, male partner involvement in PMTCT is generally low, and the majority of pregnant mothers across these countries attend maternal health services unaccompanied by their spouses.⁴ Positive male partner involvement has been shown to increase factors such as attendance at antenatal care (ANC) visits, ART initiation, and retention of pregnant women living with HIV on ART.⁵ Male partner involvement has also been shown to reduce the number of pregnant women who acquire HIV.⁵ For these reasons, male partner involvement programmes were implemented through the OHTA Initiative in all four countries. Based on the collective programme experience in the four countries, male partner involvement programmes have been identified as a promising practice to support PMTCT outcomes.⁶

“Before the project, there were no men accompanying their partners, but now we are at close to 30 per cent. Men have also requested more counselling, more services, and have become more interested and involved in the health of their wife and how to make sure she eats and is healthy.”

– Health care provider, the Democratic Republic of the Congo

Country Approaches to Male Partner Involvement

The OHTA Initiative supported the Ministry of Health (MOH) and implementing partners to facilitate male partner involvement programmes that were adapted to each country’s specific context. For example, the Mon Mari, Mon Visa (“My Husband, My Visa”) programme in Côte d’Ivoire and the CPN Papa (“ANC Dad”) programme in the Democratic Republic of the Congo encouraged male engagement in ANC by providing women a personalized invitation to give to their male partners to attend ANC with them. Malawi used a different approach to promote use of ANC and PMTCT while improving community-facility linkages – male study circles were created to educate men about sexual and reproductive health and the importance of male partner involvement. In Uganda, male champions encouraged men to accompany their spouses to ANC visits and receive HIV testing, and they also increased men’s knowledge about the importance of their involvement in ANC and PMTCT and in supporting facility delivery. Lessons learned from the implementation of these male partner involvement programmes under the OHTA Initiative can be used to inform future PMTCT programming, global efforts to achieve universal access to lifelong ART, and broader sexual and reproductive health programming for men and women.



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Mon Mari, Mon Visa: Côte d’Ivoire

Côte d’Ivoire’s Mon Mari, Mon Visa programme aimed to encourage male partner involvement in ANC and thereby increase ANC retention and postnatal follow-up, as well as increase the number of men tested for HIV and improve ART coverage for men. The programme advertised its approach of using personalized invitations to encourage men to accompany their partners to ANC visits in the community via local radio and TV advertising. Couples who attended together received group education facilitated by CHWs on a variety of topics including ART adherence, disclosure of HIV status, breastfeeding, and the importance of male partner involvement in ANC and HIV testing and counselling. Additionally, couples who were tested for HIV together received a formal certificate and couples who attended together were prioritized in line at the facility. All CHWs who implemented the group education sessions received an initial training and were supervised by nurses.

CPN Papa: The Democratic Republic of the Congo

The CPN Papa programme in the Democratic Republic of the Congo, like the Mon Mari, Mon Visa programme in Côte d’Ivoire, provided each woman who attended ANC a personalized invitation to deliver to her male partner encouraging him to accompany her to future ANC visits. Some health facilities modified the hours they provided ANC care to accommodate men’s work schedules, for example, by offering ANC appointments early in the morning or later in the evening. Couples who attended ANC together received group education sessions at the facility about the importance of HIV testing and counselling. These couples also received

a travel reimbursement, a mosquito net, or a birth kit as an incentive. Additionally, in some sites, couples who attended ANC together received priority in line. The programme was advertised by local community leaders and district-level authorities during community events. Local religious and community leaders also received training on HIV testing, prevention and treatment, as well as the importance of male partner involvement and techniques for engaging men in the CPN Papa programme.

Male Study Circles: Malawi

In Malawi, male study circles consisted of approximately 10 to 25 men who were husbands and fathers and one circle facilitator. Study circles met once a week for approximately one to two hours. During these meetings, participants discussed health indicators in the community, challenges they had encountered, and priorities for supporting male partner involvement and PMTCT. Health facility staff provided study circle participants a roster of all pregnant women in the community. Male study circle participants then conducted home visits to speak with their male partners to promote their support and participation in early ANC, facility deliveries, family planning, and HIV partner testing and adherence to ART. They also provided clinic referral slips as needed and distributed condoms. In addition to reaching pregnant couples, male study circle participants leveraged community events such as football games, funerals, and market days to facilitate health talks. Local village chiefs played a large role in recruiting study circle facilitators and sensitizing the community, and they often attended the meetings.



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Study circle participants were also tasked with various reporting activities. For example, every month study circle participants and a Health Surveillance Assistant (HSA) participated in facility data review sessions where they

reviewed indicators on topics such as facility deliveries, family planning, ART, early ANC, postnatal care, HIV testing and counselling, couple counselling, PMTCT counselling, and ART adherence. Additionally, several study circle representatives participated in quarterly data review meetings with an HSA and community members to review ART adherence information for the community, assess progress, and determine topics for future health talks in the community. The HSA then shared the information discussed with other relevant stakeholders at the health facility.

Male study circle facilitators were recommended and recruited by health facility staff and the village chief. The circle facilitators in turn recruited additional study circle participants. All male study circle facilitators received a three-day training on HIV prevention and transmission, partner testing, ART adherence, safe motherhood, and other sexual and reproductive health topics.

Male Champions: Uganda

In Uganda, male champions conducted home visits with men and couples and followed up with men who did not accompany their partners to ANC. These male champions provided health information and encouraged men to attend community dialogue meetings. Each male champion was equipped with a bicycle to facilitate follow-up visits in the community and a manual to implement individual and group education sessions on the importance of ANC, facility deliveries, HIV testing, male partner involvement in maternal, newborn, and child health (MNCH)/PMTCT care, nutrition, and birth spacing. They also worked with village health teams (VHTs), health facility workers, and community leaders to facilitate community dialogue meetings that provided information on various topics including the importance of ANC, facility deliveries, HIV testing, and breastfeeding. Basic services such as HIV testing and counselling, blood pressure testing, and weight management were also provided during dialogue meetings.

Under the OHTA Initiative, health facilities also implemented a male health service package in order to encourage men's sustained health care-seeking behaviour and participation in ANC. The package included basic services such as health education, couple HIV counselling and testing, screening for non-communicable diseases and sexually transmitted infections, and referrals for medical male circumcision. It was provided by facility health workers, VHTs, and male champions at the facility. It was advertised through community awareness campaigns, utilizing radio and posters. Additionally, men who accompanied their spouse to ANC, and were tested with their spouse, received a certificate, and in some sites couples who attended services together were given priority in line.

VHT members and facility health workers identified and recruited the male champions. To be considered for the role of male champion, men had to be able to read and write; be fathers themselves; have no criminal record; and be in good standing with the community. Male champions were existing users of basic health care services, including participating in MNCH services. All male champions in Uganda received a four-day training on various health topics such as ANC, HIV testing, nutrition, and birth planning. The trainings also included instructions on engaging male clients, community mobilization, and integrating elements of gender into maternal, newborn, and child health. In Uganda, male champions were supervised by health workers during dialogue meetings to ensure that accurate health information was provided, and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) provided supervision support in the form of monthly review meetings between VHTs, health workers, and male champions to ensure community-facility linkages.

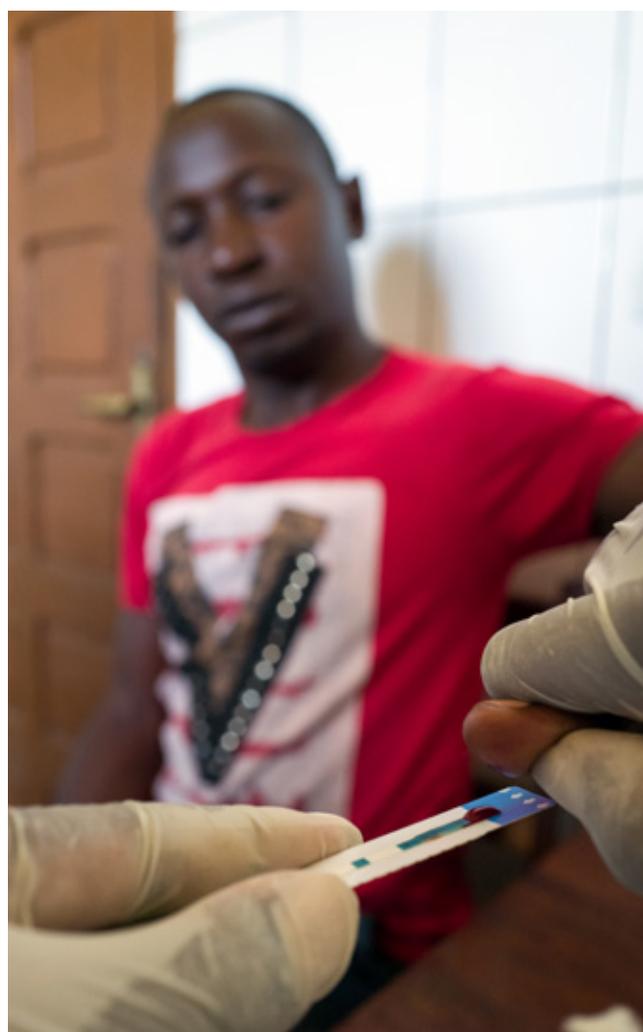
Locations

Male partner involvement programme under the OHTA Initiative were implemented in various districts throughout the four countries.

- Côte d'Ivoire: The Mon Mari, Mon Visa programme was implemented in four districts – Bouake, Daloa, Portboue Vridi Koumassito, and Treichville.
- Democratic Republic of the Congo: CPN Papa was implemented in six health zones in the Katanga province and six health zones in the Nord-Kivu province.
- Malawi: The 188 active male study circles operated in 81 sites in three districts – Dedza, Mzimba North, and Mzimba South.
- Uganda: Male champions were deployed in eight districts comprising Bushenyi, Ibanda, Isingiro, Kabale, Kanungu, Kiruhura, Mitooma, and Rukungiri.

“Men are the leaders, they have the money, we want them to be involved so that needs are met for the woman. It increases the amount of visits that the mother goes to.”

– District Health Official, Côte d'Ivoire



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Role of the OHTA Initiative and Implementing Partners

The OHTA Initiative provided critical financial resources and support for researching, implementing, and documenting each country's male partner involvement programme. In addition to the financial resources, the OHTA Initiative provided training and logistics support and monitoring and evaluation technical assistance. When applicable, the OHTA Initiative also facilitated knowledge exchange and learning among sites implementing the programme within the country. The MOH worked with a number of implementing partners in each country to implement the male partner involvement programmes.

Implementing Partners	Role
MOH, National Programme to Fight AIDS	In all four countries, the MOH and respective national HIV/AIDS programmes supported the design, training, implementation, and monitoring and evaluation of each programme.
District Health Office	Across the four countries, District Health Offices aided in the development of strategic plans, identification of site locations, and collection and analysis of data from the health centres. The District Health Office also provided monitoring and evaluation reports to UNICEF country office staff and the MOH and met on a regular basis with implementers to discuss progress and findings.
Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)	EGPAF provided implementation support, training, financial incentives, and supervision for male study circles in Malawi and male champions in Uganda. EGPAF was also involved in the monitoring and evaluation efforts in both countries.
Femmes Actives	In Côte d'Ivoire, Femmes Actives implemented the Mon Mari, Mon Visa programme by providing training, logistical support, and monitoring and evaluation support to community health workers (CHWs).

Promising Practice Outcomes

Overall, the male partner involvement programmes in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi, and Uganda:

- Encouraged male partner involvement in ANC, family planning, and facility delivery
- Strengthened men's knowledge about HIV and the importance of their role in PMTCT
- Nurtured a supportive community environment for PMTCT
- Strengthened community-facility linkages
- Strengthened male support networks through peer-to-peer education
- Increased demand for services among men

Other country-specific outcomes:

- Democratic Republic of the Congo: Improved men's access to services by changing ANC hours to accommodate work schedules
- Malawi: Provided men with a safe and informal environment to discuss health information
- Uganda: Encouraged male partner participation in ANC by providing a free male health service package at the health facility level
- Uganda: Increased access to health services for men at the community level by directly providing basic health services during dialogue meetings

The Democratic Republic of the Congo Spotlight

From 2013 to 2016, more than **52,000** pregnant women were screened for HIV in the Katanga province and over **790** tested positive for HIV.² More than **3,750** of their male partners were tested and counselled for HIV, of whom approximately **120** tested positive for HIV.² Over a one-year period in the Nord Kivu province, more than **66,000** pregnant women were tested for HIV including more than **21,600** male partners – **417** pregnant women and **180** of the male partners tested positive for HIV.² Additionally, more than **1,160** ANC kits were distributed to couples who attended an ANC visit in the first trimester of pregnancy.²

Côte d'Ivoire Spotlight

In 2016, in one district alone – Treichville – **10,900** women were tested for HIV and more than **1,600** men received HIV counselling at the facility.⁷ Of these men, **73** per cent agreed to be tested for HIV.⁸

Malawi Spotlight

Male study circle participants distributed more than **17,000** condoms and provided more than **7,220** referrals to health facilities for services related to HIV testing, ART adherence, ANC, and family planning.²

Uganda Spotlight

In all eight districts, male partner HIV testing and knowledge and support for ANC and PMTCT increased.² Additionally, male champions provided individual and group education to approximately **800** households.⁹

“I felt I needed to help other men whose families were not performing in the same way as mine. I am using my life and family as an example.”

– Male champion, Uganda

Essential Components and Factors for Success

Several factors were identified as essential to the success of the male partner involvement programmes including:

Individual:

- Community recognition, peer-to-peer support and education, desire to improve the health of their family and community, small monetary and non-monetary incentives, and personalized invitations motivated male partner involvement

Interpersonal:

- Peer-to-peer interaction, support, and learning through various approaches encouraged men to attend ANC and seek health care

Community:

- Community sensitization through radio and TV advertising was key to ensuring the community was aware and accepting of male partner involvement in PMTCT programmes
- Leveraging existing community structures such as involvement of community leaders to identify male participants and promote the programme helped support sustainability and nurtured a supportive environment for male partner involvement and PMTCT
- Provision of male health services and male-led community education offered men convenient and informal places to receive health information and encouraged men to seek health care and attend ANC
- Tailoring approaches to the individual needs and context of the community increased relevance for community members, supported sustainability, and nurtured a supportive environment for PMTCT

Facility:

- Collaboration with existing health facility structures and staff in the provision of community and facility education sessions, including rescheduling facility ANC hours as needed, supported quality education in PMTCT and men's involvement in ANC

Structural:

- Strong communication and support among implementing partners, the MOH, community members, and health facility workers allowed for the coordinated use of data for decision making and strengthened community-facility linkages

“Since we started giving messages about PMTCT we haven't heard about a child getting HIV from their parents and no deaths from HIV. Our programme is helping people.”

– Male study circle participant, Malawi

Cross-Country Learning

Community Leader Involvement

Community leaders, including village chiefs, played an important role in the implementation of the male partner involvement programmes in the Democratic Republic of the Congo and Malawi. Community leaders in the Democratic Republic of the Congo received trainings on the importance of the programme, PMTCT, and general HIV testing and prevention, encouraging them to be advocates for PMTCT at the community level and nurturing a supportive environment for PMTCT. In addition, in Malawi community leaders recruited men for study circles and often participated themselves in study circle meetings to stay informed on community-level indicators. The participation of community leaders, in turn, motivated other men because they felt it was their duty to actively engage in the study circles since they had been recruited by the village chief.



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Community Sensitization

All four of the male partner involvement programmes included a community sensitization approach. The Democratic Republic of the Congo and Uganda used traditional media channels such as radio, TV, and print materials to promote the programme and educate the community about PMTCT and the importance of male partner involvement. In addition, the Democratic Republic of the Congo and Malawi leveraged community events, and village chiefs in Malawi, to promote the programme. Although community sensitization was implemented in various ways, it was an essential component of success for each programme to create awareness, dispel misconceptions, and promote male partner involvement.

Community, Facility, and Structural Approaches

Several countries implemented structural approaches to encourage male partner involvement. For instance, health facilities involved in the CPN Papa programme in the Democratic Republic of Congo modified the ANC schedule at the health facility level to accommodate men's working schedules and enable them to accompany their female partner. Such structural approaches can be helpful in ensuring a supportive and accessible environment for behaviour change and do not always require additional funds. Similarly, Uganda leveraged existing resources and structures to provide an additional facility-level incentive to men free of cost – the provision of a male health service package. The provision of male-friendly services at the health facility, including testing for non-communicable diseases and sexually transmitted infections, and providing referrals for male circumcision was felt to be one of the essential components for success of the male champion programme in Uganda. It encouraged men to participate in ANC and supported men's health care-seeking behaviour. The male health service package leveraged already available resources including facility, equipment, and staff. Similar approaches could be considered as additional motivation for men who are visiting the health facility under the CPN Papa and Mon Mari, Mon Visa programmes. Finally, the male champion programme in Uganda was the only one that brought male-friendly health services to the community during community dialogue meetings. The provision of services at the community level increased not only accessibility but also knowledge about HIV testing and counselling and PMTCT and encouraged male partner involvement.

Demand Creation

Male study circle participants in Malawi and male champions in Uganda both conducted home visits as part of their strategies to reach and engage men in ANC and PMTCT. This peer-to-peer interaction and individualized support encouraged men to support PMTCT and seek health care services. When feasible, outreach approaches such as these could also be considered as part of demand generation activities in countries such as Côte d'Ivoire and the Democratic Republic of the Congo to promote male partner involvement in ANC.

Community-Facility Linkages

While all of the programmes supported and strengthened community-facility linkages through different approaches, facility data review sessions in Malawi directly supported the use of community-level data for decision making and ensured relevant information was fed back to the facility. This type of collaboration and coordination between the health facility and community can support transparency and trust in the facilities and services they provide.

Supervision

Supervision played an important role in the implementation of each male involvement programme. Despite some programmes only partially occurring in the health facility, such as the male study circles and the male champion programme, all of the programmes relied on existing facility-level structures for supervision. While conducted at varying levels and by varying cadres of health facility staff, supervision in all four countries was an essential component for success, supporting sustained programme quality.

Potential Negative Consequences

Although couples who attended ANC together were given priority in line as an incentive in some sites implementing the programme in Côte d'Ivoire, the Democratic Republic of the Congo, and Uganda, this practice was not recommended by the OHTA Initiative. Practices such as prioritizing couples who attend services together or providing an incentive for women to attend with male partners, can negatively impact those who are not able to attend with male partners. A woman who is already stigmatized because she is living with HIV could be further stigmatized if she does not have a male partner and may be motivated to ask a man who is not her partner to accompany her to the facility to receive the incentive.¹⁰ Male partner involvement should not be a requirement for women to receive care.

“We have seen that the idea of a community dialogue works and does well. We have seen the idea of a male champion works very well.”

— Health facility staff member, Uganda

Considerations for Scale-Up and Sustainability

The various male partner involvement programmes implemented under the OHTA Initiative engaged male partners to attend ANC visits, strengthened community-facility linkages, and supported PMTCT activities. Several factors should be weighed when considering replicating or scaling up these programmes nationally or in other settings.

- **Unintended consequences:** Practices such as prioritizing couples who attend services together or providing an incentive for a woman to attend with a male partner can negatively impact and further stigmatize women who are not able to attend with male partners. Unintended consequences such as these need to be carefully monitored alongside intended results in order to continue improving the implementation and impact of male partner involvement programmes.
- **Adaptability:** Male partner involvement programmes should be modified to fit the context of each specific community. For example, programmes that offer invitations for men to accompany their female partners to ANC visits may not be effective or welcome in areas where men have historically not been allowed to attend ANC visits or where women do not want their male partners to be involved in their matters at the health facility. Similarly, in some communities it may not be appropriate for male study circle participants to conduct home visits if a man is not at the home. Other innovative approaches to reaching men can be used in such contexts, such as looking for men at their place of work. Finally, differences between urban and rural areas should also be considered. For example, men in rural areas might have to travel longer distances than in urban areas to participate in the programme.
- **Supply chain:** If specific health services are being promoted, such as a male health service package and ART retention, the programme should ensure availability of consistent stocks of ART treatment, HIV test kits, and basic health supplies to meet demand and strengthen community-facility linkages.
- **Incentives:** All of these programmes included an incentive to encourage male partner involvement. Some incentives were monetary, such as bicycles for male champions, while other were non-monetary, such as certificates for couples who attended ANC together. Although the incentives varied, all of them played a key role in encouraging male partner involvement and should thus be maintained or considered in order to sustain motivation and participation.
- **Capacity building of community actors:** Programmes should leverage the role of community leaders and involve them in education, training, and promotion of the programme to increase sustainability and community participation.

“We used the chiefs as gatekeepers. The chiefs were responsible to assemble their men. This may be why the circles are still strong, because the chiefs are always there.”

– EGPAF staff member, Malawi

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Methodology for Documenting Male Partner Involvement as a Promising Practice

The Johns Hopkins Center for Communication Programs (CCP) supported the documentation of this promising practice. Information and data were collected through a desk review of existing OHTA Initiative documents, including annual reports, partner reports, and presentations. Site visits by CCP and project staff were also conducted, including interviews and focus group discussions among implementing organizations, Ministries of Health, and programme implementers.

For more information about the OHTA Initiative, visit <http://childrenandaids.org/optimizing%20HIV%20treatment%20access>.

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This paper is published by the HIV and AIDS Section, United Nations Children’s Fund, 3 United Nations Plaza, New York, NY 10017, USA.

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October 2018.

Front cover image: © UNICEF/Batumike