AIDSRelief Ethiopia

Male involvement in prevention of mother-to-child HIV transmission (PMTCT) program in Southwest Shoa Zone, Oromia Region, Ethiopia

Background

Prevention of mother-to-child HIV transmission (PMTCT) is still the most effective intervention in combating new HIV infections. The Ethiopian national PMTCT guidelines were revised in 2007 to address partner testing. Partner testing and involvement in PMTCT are intended to increase partner disclosure, to facilitate women to cope with their test results, and ultimately, to support women to adhere to PMTCT recommendations. Moreover, this approach provides an opportunity for male partners to know their HIV status and obtain necessary treatment. It also helps health providers to identify and manage discordant couples. However, the potential benefits of partner testing in PMTCT settings, including for the prevention of vertical transmission of HIV, are often not realized due to poor uptake of partner testing services. AIDSRelief undertook an intervention as part of its Continuous Quality Improvement (CQI) initiative to increase the uptake and involvement of male partners in its PMTCT program in Ethiopia.

Approach

At the beginning of the PMTCT program in September 2010, partner testing had low figures of 20.7% at Antenatal Care (ANC) clinics and 0% at Labor and Delivery (L&D) units in AIDSRelief supported health facilities. To address this gap, AIDSRelief instituted an intervention to increase male partner testing. Since CQI is a core component of AIDSRelief model of care, the program supported its health facilities to form CQI teams to take ownership of all quality improvement activities at their facility including implementation of the small test of change (STOC) interventions; in this case partner testing was taken as one of the priorities to be addressed through this approach. As a result, focus group discussions (FGD) were organized with all Maternal Neonatal and Child Health (MNCH) staff of St. Luke hospital, Gurura and Dilela health centers. Discussions focused on the rationale for partner testing, brainstormed on reasons for underachievement in partner testing and strategies to improve partner testing and developed facility specific plans for partner testing to be overseen by the health facilities' CQI team to address the identified gaps in partner testing.

The main reason identified for low partner testing was the fact that women came to seek antenatal care services to the health facilities without their partners, and providers thought of male partners testing at MNCH as an additional responsibility. Based on the FGD findings, strategies implemented as part of the STOC approach included: 1) Educating providers of the importance of male partner involvement and its impacts on the mothers' wellbeing and babies' outcomes, 2) Intensified use of partners "invitation cards" and 3) Repeated requests for male partner testing at each health providers' encounter with the mothers.

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To complement the health facility level interventions, a community sensitization workshop was conducted in September to encourage women to bring their partners to the health facilities for testing. During the implementation of the STOC intervention, AIDSRelief provided targeted technical assistance focused on the follow-up action items highlighted as gaps during the FGDs, and supported and encouraged the CQI teams at the health facilities to oversee these activities related to partner testing in order to ensure ownership, close follow-up and the use of data for decision making.

Outcomes

The graph and the table below summarize the data on partner testing obtained from the three health facilities from June 2010 to April 2011.

Figure I. Partner Testing Trends at ANC and L&D

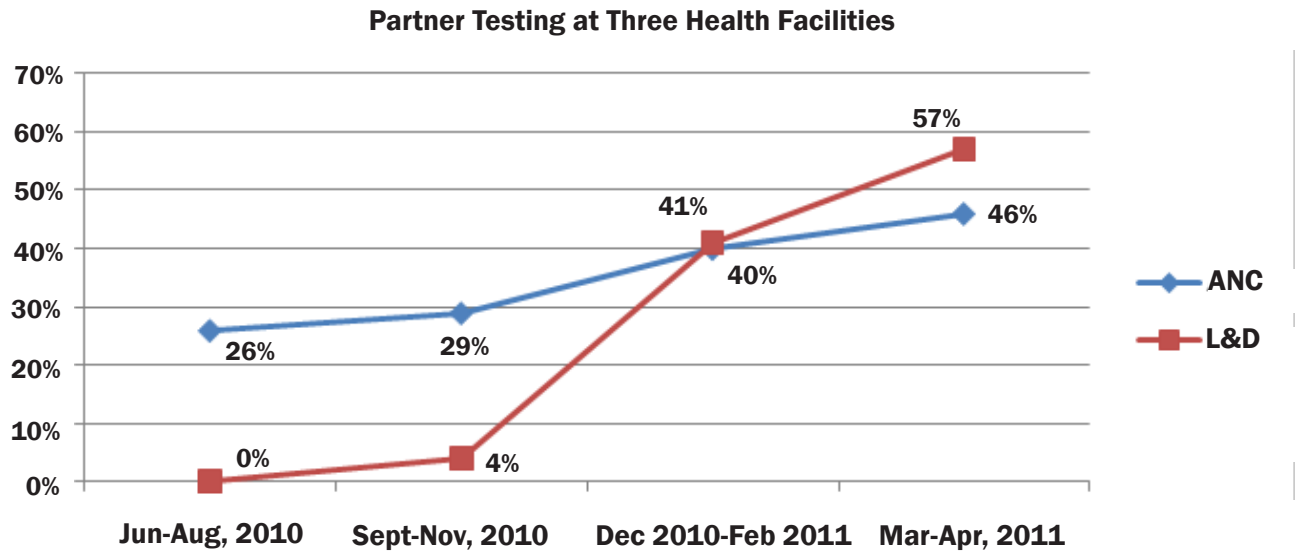

Table I. Partner Testing Trends at ANC and L&D

Unit	Jun-Aug 2010			Sep-Nov 2010			Dec 2010- Feb 2011			Mar-Apr 2011		
	Mother tested	Partner tested	%	Mother tested		%	Mother tested	Partner tested	%	Mother tested	Partner tested	%
ANC	576	149	26%	948	274	29%	951	382	40%	550	254	46%
L&D	225	0	0%	332	13	4%	433	178	41%	309	176	57%

* Note that the results of actual number tested decrease in the last quarter results in data for two months only compared to quarterly data.

As reflected above, partner testing significantly increased from 26% [95%=22.4%-29.6%] to 46% [95%=41.8-50.2] and from 0% to 57%[95%=53.2-61.8] at the ANC and L&D respectively showing a consistent and dramatic raise in uptake as a result of the intervention.

Challenges

Despite this effort, staff at health facilities still considers that partner testing is a new task and an additional burden. Additionally, there is persistently low community awareness and acceptance of the importance of partner testing arising from the misconception that PMTCT is meant only for females.

Lessons Learned

Partner testing increased dramatically after the application of STOC strategies suggesting that STOC is a promising change tool for program performance improvement in PMTCT. Data on increased uptake for partner testing will be used to encourage health facilities' staff to improve their efforts. Intensive community based campaigns using the community volunteers as adherence supporters to promote the uptake of PMTCT is crucial to increase the utilization of these services by those who need them. Hence, using various approaches, from tools for performance improvement plans at the facility level to community level interventions, provide complementary activities leading improved service outcomes in partner testing. Most importantly, this type of intervention is one that is easily replicable at other health facilities to address the challenges of partner testing.