CASE STUDY

Increasing male partner participation in PMTCT in Burundi

Summary

USAID and PEPFAR, through the USAID ASSIST Project, support Burundi’s Ministry of Public Health and the Fight against AIDS (MSPLS) to improve the quality of PMTCT services in Burundi. The project helped form quality improvement (QI) teams in 70 demonstration sites in Northern Burundi and trained the teams and coaches from the district health management teams on QI techniques. Following the analysis of the PMTCT process, teams identified and tested change ideas in their health facilities to improve the participation of pregnant women’s male partners in PMTCT. These change ideas led to improvement in the proportion of women enrolled in antenatal care (ANC) and tested for HIV and whose male partners were also tested: there was an increase from 2% in January 2013 to 70% in March 2016.

This case study describes and shares the experience of QI teams in Burundi improving the participation pregnant women’s male partners in PMTCT to increase the use of PMTCT services in four northern provinces of the country.

Background

In Burundi, the HIV/AIDS epidemic is a growing concern and a major public health challenge. According to the 2010 Demographic and Health Survey (DHS 2010), it is a generalized epidemic with low prevalence, estimated at 1.4% in the general adult population 15-49 years old. Burundi is one of PEPFAR’s 22 priority countries for the elimination of mother-to-child transmission of HIV (eMTCT) and is in the process of implementing the National eMTCT Plan with support from implementing partners.

Studies have shown that male partner involvement in the continuum of care for preventing mother-to-child transmission of HIV (PMTCT) promotes spousal communication on HIV infection and sexual risks, use of contraceptives, and use of PMTCT services. In addition, as supportive partners, men can influence the social environment of the family, especially within the extended family, to create an environment that is more conducive to treatment, adherence, consultation, and retention in care both during pregnancy and after childbirth. Thus, the involvement of male partners has been identified as a strategy to improve PMTCT programs under PEPFAR.

In 2012, PEPFAR Burundi requested technical assistance from the USAID Health Care Improvement (HCI) Project, the precursor to the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project to improve the quality of PMTCT services in Burundi. A 2012 baseline assessment of the quality of HIV and AIDS services served as the basis for the design of an improvement program. Among the main quality gaps identified in the assessment was the low participation of pregnant women’s male partners in antenatal care (ANC) services and HIV counseling and testing. In fact, only 6% of pregnant women enrolled in ANC and tested for HIV also had a partner who tested for HIV.

MAY 2017

This case study was authored by Claude François Niyomwungere, Bede Matituye, and Mayssa el Khazen of University Research Co., LLC (URC) and Julia Holtemeyer of WI-HER, LLC and produced by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, funded by the American people through USAID’s Bureau for Global Health, Office of Health Systems. The work described was supported by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). The project is managed by URC under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. URC’s global partners for USAID ASSIST include: EnCompass LLC; FHI 360; Harvard University School of Public Health; HEALTHQUAL International; Initiatives Inc.; Institute for Healthcare Improvement; Johns Hopkins Center for Communication Programs; and WI-HER, LLC. For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.
ASSIST studied the reasons male partner involvement was so low and found that stigmatizing community attitudes towards partners who accompany their wives to ANC and factors related to satisfaction with the quality of ANC services were the main barriers inhibiting the involvement of male partners of pregnant women (both HIV negative and HIV positive) enrolled in ANC. These stigmatizing attitudes, for example, were that women in the community believed these partners were under a spell and bewitched by their wives, dominated by their wives, or that the couple was HIV-positive. Men in the community also believed that these partners were bewitched or dominated by their wives and mocked such partners.

To overcome these barriers, ASSIST, with USAID and PEPFAR funding, partnered with the Ministry of Public Health’s National AIDS Control Program (PNLS) in Burundi to improve the involvement of male partners in PMTCT care. The involvement of male partners is an issue across health areas (including reproductive health, family planning, ANC, and HIV and AIDS), but since ASSIST started with PMTCT, we decided to start with involving male partners in HIV care for pregnant women.

**Improvement Strategy and Process for Identifying Best Practices**

Based on the initial assessment carried out in 2012, a set of potentially effective changes (known as a change package) was developed to address the issues identified. This change package was validated at a workshop with key players in the fight against HIV and AIDS in Burundi. ASSIST started to work with 70 demonstration health facilities, including health centers and hospitals, in four provinces in the north of the country: Kirundo, Muyinga, Karusi, and Kayanza. The work was organized as an improvement collaborative where all the teams were focused on PMTCT aims.

Provincial orientation workshops on quality improvement (QI) principles were held for providers and managers of HIV and AIDS activities in all four provinces. Coaches selected from the PNLS, the Provincial Health Offices (BPS), and the District Health Offices (BDS) were trained on QI techniques and follow-up to support help site-level teams apply QI methods. This ensured the transfer of skills to local actors. In January 2013, QI teams were set up in the 70 demonstration sites. Coaching visits were conducted monthly by coaches from the BDS, BPS, PNLS, and ASSIST staff to provide strong support for site-level QI teams.

At the site level, each team followed this basic improvement approach:

1. Analyzed the PMTCT process from ANC to follow-up after delivery by using a process diagram (flow chart);
2. Developed change ideas to bridge the quality gap or issue identified by brainstorming or using the initial package of changes developed by experts at the beginning of the collaborative; and
3. Test small-scale change ideas using the Plan-Do-Study-Act (PDSA) cycle and scale-up those that are effective.

The work carried out by the QI teams (ideas implemented, results, lessons learned) were then shared and discussed periodically during learning sessions with the other teams, which include representatives of each team and the support team or coaches from BDS, BPS, PNLS/IST, and ASSIST staff. These learning sessions offered the representatives of the different QI teams a framework for exchanging experiences on the implementation of the collaborative activities, particularly the change ideas developed and tested, as well as the results obtained.

This first demonstration phase of a QI collaborative resulted not only in improvement in the data, but also a list of changes tested and implemented to increase the level of performance.

**Results**

During the initial demonstration phase, the 70 sites identified a number of effective changes that could be applied in other health facilities. These change ideas were gathered into a best practices’ change package that synthesized the work of multiple QI teams to increase the proportion of pregnant women whose partners are tested for HIV.
Five key change ideas were identified:

1. Visit each sub-colline in a mixed team (providers, health committee members, community health workers, Collines/Sub-collines and other opinion leaders) to conduct information, education, and communication sessions for men on the importance of accompanying pregnant women to ANC and couples’ HIV testing
2. Make announcements and post statements via churches and other gathering venues on the importance of male partners accompanying women to ANC
3. Conduct a weekly health education session on the importance of HIV testing for pregnant women who come for ANC at the health center
4. Give a written invitation to unaccompanied women at ANC to give to their male partners
5. Provide incentives to couples who come to ANC (e.g., ambulance reimbursement, blood glucose test, systematic blood pressure measurement to all partners who come to the health facility, hand soap, notebooks and pens, etc.)

Among these best practices is to “give a written invitation to unaccompanied women at ANC to give to their male partners.” This was and should always done by respecting the confidentiality of the woman’s HIV status. After the ANC session and delivery of the HIV test result to the woman, the provider informs the woman about the importance of also testing her partner (e.g., the possibility of serodiscordance). If the woman agrees to assistance in bringing her partner to come for testing, the invitation letter is given to her in a sealed envelope, making sure to explain to the woman the contents of the invitation. It is therefore the woman who decides whether she wishes to give this invitation to her partner, and not the provider.

During the baseline data collection in the 70 demonstration sites, participation of pregnant women’s male partners in ANC services and HIV testing and counselling among partners of pregnant women was very low—around zero. After three years of improvement activities, male partner involvement reached 70% in March 2016 (Figure 1).

**Figure 1:** % of women enrolled in ANC and tested for HIV whose partners were tested in HIV, 69 demonstration sites, 4 provinces (Kayanza, Kirundo, Karusi, Muyinga), (Jul 2012 – Mar 2016)
Dissemination of Best Practices

At the end of the demonstration phase, the results and identified best practices were encouraging, and PEPFAR and the Ministry of Health decided they should be scaled up to other sites. The second phase of the collaborative effort consisted of extending this package of "best practice" changes to new health facilities. To do this, a meeting of PMTCT experts was organized to validate the updated change package and adopt a dissemination strategy. The provinces of Bujumbura Mairie, Bujumbura Rural, Gitega, and Ngozi, as well as the original four provinces, were chosen for the scale-up of the phase 1 change package. In total, 309 new sites (103 sites in the former 4 provinces and 206 sites in 4 new provinces) participated in the scale-up phase.

During the implementation phase, the coaches, providers, supervisors, and health officials who had demonstrated mastery, interest, and enthusiasm for QI during the demonstration phase were tasked with being "scale-up supporters", responsible for supporting the coaches in the new scale-up activities.

Currently, following a modification in the geographical area covered by USAID and PEPFAR in Burundi, 234 sites in five provinces (Bujumbura Mairie, Bujumbura Rural, Kayanza, Kirundo, and Ngozi) are implementing QI activities using the updated change package to improve the involvement of pregnant women’s male partners in ANC services and HIV testing and counseling.

Lessons Learned and Next Steps

The collaborative effort to improve the quality of PMTCT services improved the involvement of pregnant women’s male partners in ANC services and HIV counseling and testing and proved to be a good strategy to improve the PMTCT program. In close collaboration with the Ministry of Health, ASSIST will continue to disseminate this best practice package in other health districts in the five provinces to improve HIV testing among pregnant women attending ANC services and enrollment in antiretroviral treatment for HIV-positive pregnant women. The project is also working to strengthen the links between communities and health facilities. This is being done by strengthening the community health system to improve the performance of the community health worker and delivering quality PMTCT services at the community level. To ensure the sustainability of these QI activities, ASSIST is building the capacity of a pool of coaches to support this work at the national and provincial levels.

Finally, these best practices constitute evidence that can be used in subsequent efforts to improve adherence to HIV treatment and retention in the cascade of PMTCT care and can also be used to promote the participation of men in maternal and child care programs in general.

This case study was made possible by the support of the American people through USAID. The contents of this case study are the sole responsibility of URC and do not necessarily reflect the views of USAID or United States Government.