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**The RESPOND Project Study Series:  
Contributions to Global Knowledge**

Report No. 10

**Encouraging Men's Participation in  
HIV and AIDS Prevention and HIV  
Testing Services: Evaluation of the  
Men As Partners® (MAP) Approach in  
Côte d'Ivoire**

**Dr. Sarah Castle, Consultant**  
**Dr. Yvonne Tano-Kamelan, The RESPOND Project/Côte d'Ivoire**  
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**Pamela B. Harper, The RESPOND Project/EngenderHealth**

*July 2013*



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# Acronyms and Abbreviations

AIDS	acquired immune deficiency syndrome
FP	family planning
GBV	gender-based violence
HIV	human immunodeficiency virus
IEC	information, education, and communication
INS	Institut National de la Statistique
JHU•CCP	Johns Hopkins Bloomberg School of Public Health Center for Communication Programs
MAP	Men As Partners®
MEN	Ministère de l'Éducation Nationale [Ministry of Education]
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMI	protection maternelle et infantile [maternal and child health services]
PMTCT	prevention of mother-to-child transmission
PNPEC	Programme National de la Prise en Charge des Personnes Vivant avec le VIH [National Program for People Living with HIV]
PNSR	Programme National de la Santé de la Reproduction [National Reproductive Health Program]
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing [for HIV]



## Executive Summary

Côte d'Ivoire has the highest rates of HIV in West Africa, with an estimated prevalence rate in 2005 of 4.7% among adults ages 15–49 (Institut National de la Statistique, Ministère de la Lutte Contre le Sida & ORC Macro, 2006). As in many developing countries, women bear a greater share of the disease burden related to HIV and AIDS than men, even though women engage in less risky sexual behavior.

In Côte d'Ivoire, women are routinely tested for HIV during antenatal consultations in the context of prevention of mother-to-child transmission (PMTCT). They can also access testing through family planning (FP) services and through voluntary counseling and testing (VCT) services. Men are often reluctant to access such services, which they view as being highly feminized—designed for and used by women, not men.

Since 2008, The RESPOND Project has provided technical assistance in Côte d'Ivoire to build the capacity of local and international organizations (partners in the U.S. President's Emergency Plan for AIDS Relief [PEPFAR]) to use the Men As Partners® (MAP) approach, which was developed by EngenderHealth. The MAP approach, applied in more than 15 countries worldwide, stimulates dialogue around gender norms, encouraging men and women to reject harmful norms and to promote those that protect the health of men and their families. The current objectives of the project in Côte d'Ivoire are as follows:

- To build the capacity of PEPFAR partners to incorporate gender-transformative messages in ongoing prevention efforts
- To build the capacity of facilities to engage male partners in HIV services, including testing and PMTCT
- To build the capacity of facilities to respond to the needs of survivors of gender-based violence with sensitivity

EngenderHealth initiated its MAP work in Côte d'Ivoire in 2008 through The ACQUIRE Project, and activities will end in 2014. This midcourse process evaluation was conducted in March 2013.

The objectives of the evaluation were to:

- Describe the reasons behind the lack of male involvement in PMTCT and VCT for HIV before the MAP approach was implemented
- Assess knowledge and attitudes about the MAP approach and services for men among facility and PEPFAR partner staff
- Assess service delivery, including HIV testing, and community engagement after facility trainings in the MAP approach
- Describe the capacity of facilities and PEPFAR partners to include gender-transformative messages in ongoing HIV prevention work

The evaluation team conducted in-depth interviews with PEPFAR partners, health care providers, and community educators. In addition, a checklist of materials, services, and activities was administered at each facility. Results of the checklist were compared with baseline findings from 2011. Evaluators also analyzed service statistics from the seven facilities that have implemented the MAP approach.

Key findings from the evaluation include the following:

- All providers and PEPFAR partners interviewed said they would recommend the MAP approach to other organizations.
- Health facilities are highly feminized and medicalized in Côte d'Ivoire, factors that discourage men from visiting them. Facilities must address these factors if they are to attract men.
- The total number of men tested at the seven facilities increased dramatically, from 244 at the program's inception to 1,435 during the last quarter of 2012—over a five-fold increase.
- Most men received testing through combined FP-VCT services rather than through couples' PMTCT.
- The number of couples tested remained low, even though six of the seven pilot facilities had increased the number of couples tested.
- Providers and PEPFAR partners found that MAP training was innovative and practical.
- The seven facilities often lacked sufficient supplies of materials developed for information, education, and communication (IEC).
- The strategy of encouraging men to use PMTCT services during their partner's antenatal care has not worked well. Few men were tested through PMTCT services. Antenatal care settings are highly feminized and medicalized, factors that may discourage men from visiting them.
- Condom promotion was not well integrated into the MAP initiative.
- Because of men's work commitments and because of their reluctance to visit health centers, community outreach may be a more effective means of reaching men for testing than facility-based efforts.

The evaluation team made several recommendations regarding training, service provision, community outreach, management, supervision, monitoring, and evaluation. Highlights of those recommendations are as follows:

- Increase the duration of training related to gender-based violence
- Defeminize and demedicalize service delivery settings
- Put condom education and provision at the heart of MAP activities
- Make more IEC materials available
- Increase outreach activities, especially in the workplace
- Create a task force for best practices and supervision

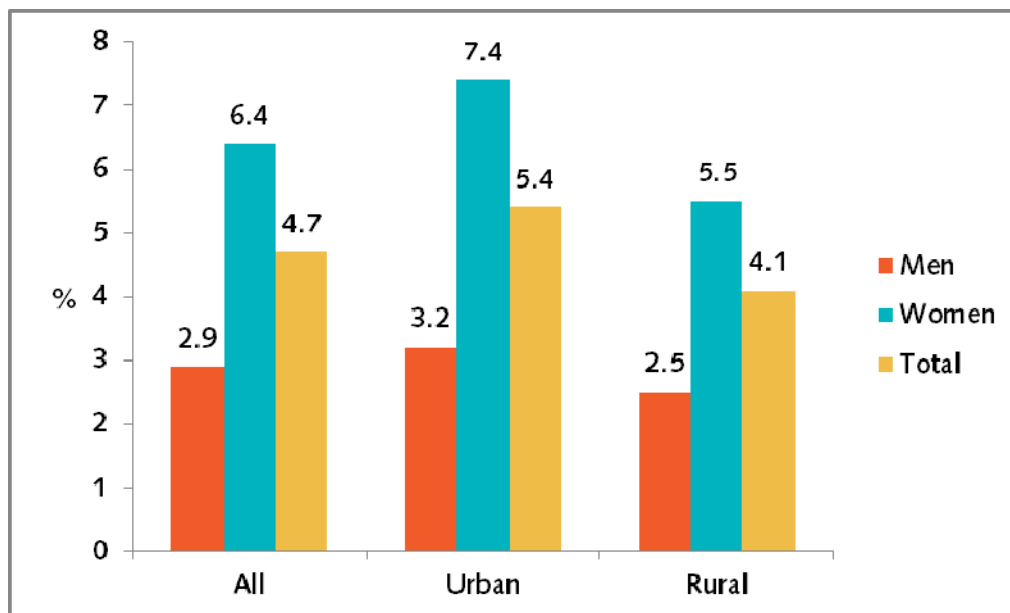
# Introduction

## Background

Côte d'Ivoire has the highest rates of HIV in West Africa, with an estimated prevalence rate in 2005 of 4.7% among adults ages 15–49 (INS, Ministère de la Lutte Contre le Sida, & ORC Macro, 2006). In Côte d'Ivoire, as in many developing countries, women bear a greater share of the disease burden associated with HIV and AIDS than do men, even though women engage in less risky sexual behavior. In 2012, for example, 3.5% of Ivoirian women reported having two or more sexual partners in the previous 12 months, compared with 28.6% of Ivoirian men. Ivoirian women ages 15–49 report a lifetime average of 2.5 sexual partners, while men report an average of 10.1 sexual partners (Ministère de la Lutte Contre le Sida, Institut Nationale de la Statistique, MEASURE DHS, and ICF International, 2012). In 2005, HIV prevalence among adult women in Côte d'Ivoire was 6.4%, compared with a prevalence of 2.9% among adult men (Figure 1).

Women are routinely tested for HIV during antenatal consultations in the context of services for the prevention of mother-to-child transmission of HIV (PMTCT). They can also access testing through family planning (FP) and voluntary counseling and testing (VCT) services. HIV testing services are also available to men, but men's testing rates are much lower than women's.

**Figure 1. HIV prevalence in Côte d'Ivoire, by sex and place of residence, 2006**



*Source:* INS, Ministère de la Lutte Contre le Sida & ORC Macro, 2006

An increasing body of evidence suggests that socially constructed expectations about men's and women's responsibilities, roles, and attitudes are a root cause of men's and women's differential risk of infection. Harmful norms about masculinity (e.g., men's dominance over women,

multiple sexual partners) and about femininity (e.g., women’s submissiveness, their “innocence” about sexuality) are associated with high-risk sexual behavior. These traits are compounded by gender-based violence (GBV), alcohol abuse, and unprotected sex in Côte d’Ivoire and elsewhere in Africa (Dunkle et al., 2004). In 2005, about 12% of women in Côte d’Ivoire had been victims of some form of GBV; about one in three knew a man who had perpetrated such violence (INS, Ministère de la Lutte Contre le Sida & ORC Macro, 2006). GBV can occur in the context of HIV (e.g., when a husband blames his wife for bringing HIV into their marriage). Gender-transformative programs can raise awareness about harmful gender norms and seek to question and redefine them; such programs have effectively engaged men in challenging social constructs of masculinity to reduce HIV risk (Dunkle & Jewkes, 2007).

### **The Men As Partners® Approach**

EngenderHealth has applied its Men As Partners® (MAP) approach in more than 15 countries to improve the health of men, women, and their families. MAP uses provider training, information, education, and communication (IEC) materials, and peer education to reduce men’s high-risk behaviors, promote fidelity, reduce the number of sexual partners, reduce GBV, and increase men’s participation in health services. MAP programs stimulate dialogue around gender norms, encouraging men and women to reject harmful practices and to adopt those that protect the health of men, women, and their families.

### **The RESPOND Project in Côte d’Ivoire**

Since 2008, The RESPOND Project has provided technical assistance in Côte d’Ivoire to build the capacity of local and international organizations (U.S. President’s Emergency Plan for AIDS Relief [PEPFAR] partners) to use the MAP approach. The RESPOND Project is a five-year cooperative agreement funded by the U.S. Agency for International Development (USAID). It is managed by EngenderHealth and includes five PEPFAR partners: the Population Council, FHI 360, the Futures Institute, Meridian Group International, and the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU•CCP).

The objectives of RESPOND in Côte d’Ivoire are as follows:

- To build the capacity of PEPFAR partners to incorporate gender-transformative messages into ongoing prevention efforts
- To build the capacity of facilities to engage male partners in HIV services, including HIV testing and PMTCT
- To build the capacity of facilities to respond to the needs of GBV survivors with sensitivity

To implement the MAP approach in Côte d’Ivoire, RESPOND works at seven pilot sites in and around Abidjan: six public-sector facilities and one faith-based facility. At each facility, a staff member designated as the MAP *point focal* (focal point) coordinates MAP activities, liaises with RESPOND about the approach, and collates monthly service statistics. One PEPFAR partner provides technical support to each of these sites.

In implementing the MAP approach, RESPOND works with the PEPFAR partners Ministère de l’Éducation Nationale (MEN), the Programme National de la Santé de la Reproduction (PNSR), the Programme National de la Prise en Charge des Personnes Vivant avec le VIH

(PNPEC), and the Elizabeth Glaser Pediatric AIDS Foundation and its local affiliate Fondation Ariel Glaser. RESPOND also works with local HIV organizations such as ACONDA-VS.

RESPOND has undertaken a number of MAP activities, including:

- Training trainers to build the capacity of PEPFAR partner organizations to include gender-transformative messages and to engage men in their HIV prevention work
- Collaborating with JHU•CCP to develop messages and materials that challenge harmful gender norms and encourage men to participate in HIV and PMTCT services
- Training staff at seven pilot facilities to provide male-friendly services and to respond to GBV survivors with sensitivity (This work complements trainings on the medical response to GBV led by the United Nations Population Fund.)
- Supporting the development and implementation of action plans to make facilities more friendly to male clients and to encourage men to participate in HIV testing
- Training and supporting facility-based community educators to include gender-transformative messages in their work and to engage men and couples

This combination of activities is known locally as “The MAP Approach.” After the current Country Operational Plan finishes in 2014, RESPOND hopes to leave the MAP approach as a sustainable legacy in Côte d’Ivoire’s public health services.

## Study Methodology

The study objectives were to:

- Describe the reasons behind the lack of male involvement in PMTCT and in VCT for HIV before the MAP approach was implemented
- Assess knowledge and attitudes about the MAP approach and services for men among facility and PEPFAR partner staff
- Assess service delivery, including HIV testing, and community engagement after facility trainings in the MAP approach
- Describe the capacity of facilities and PEPFAR partners to include gender-transformative messages in ongoing HIV prevention work

The study did not explore newer elements of the project, such as the GBV work, as activities had not been completed at the time of data collection.

### In-Depth Interviews

The study methodology used qualitative, individual in-depth interviews with selected respondents (10 PEPFAR partners, 10 health care providers working in PMTCT or VCT, and 10 facility-based community educators). Interviewers also visited the seven supported facilities. The interviews, conducted in March 2013, explored:

- Respondents’ perceptions of the reasons behind the lack of male involvement in VCT and PMTCT before the MAP approach was implemented

- Level of satisfaction of PEPFAR partners, providers, and community educators with the training and materials developed by RESPOND to be used in MAP activities
- Planning and implementation of activities involving men, with a particular focus on VCT and PMTCT
- The impact of MAP on respondents' perceptions of GBV
- The long-term sustainability and community impact of the approach

The interviewer began by explaining informed consent; after this explanation, each interviewee signed a form (a) granting permission to be interviewed and (b) confirming his/her understanding of his/her rights and the potential risks associated with the interview. The interviewer also completed a form that collected relevant information about the interviewee, such as his/her facility or PEPFAR partner affiliation.

The interview guides were pretested with two PEPFAR partners, two providers, and two community educators. Subsequently, minor revisions were made to the instruments. Two local consultants and one international consultant conducted all interviews in French. The interviews were tape-recorded; the most revealing and pertinent quotations were transcribed word for word.<sup>1</sup> The transcribed quotations were analyzed using The Ethnograph software, which allows for coding of useful themes and subthemes and facilitates analysis. This report includes illustrative quotations from those transcriptions.

### **Facility Checklist**

Interviewers administered a checklist of materials, services, and activities essential to male-friendly service provision to a health care provider in each service facility. Most items on the checklist were asked directly to the provider and verified by observation, as appropriate. The checklist and findings are presented in the appendix. The same checklist had been administered in 2011 as a baseline measure.

### **Analysis of Service Statistics**

At each facility, health care staff regularly collect and report to the Ministry of Health service statistics disaggregated by sex. Using these data, RESPOND's quarterly and annual reports show the numbers of men, women, and couples undergoing HIV testing via PMTCT, VCT, and FP services. Selected data are analyzed here to give a picture of testing trends and to inform programmatic recommendations.

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<sup>1</sup> In the interests of time, the interviews were not fully transcribed.



### Barriers to Men's Participation in VCT and PMTCT

The qualitative research explored gender norms and structural barriers that have contributed to low male participation in HIV-related services, as well as the progress made by RESPOND and PEPFAR partners in addressing these norms and barriers.

#### “Feminization” of Health Services

According to the respondents, one of the main barriers to male participation in VCT and PMTCT is the “feminization” of health care services in Côte d'Ivoire. Health centers tend to focus on maternal and child health services, which include immunizations and antenatal care—both of which men and women view as largely female domains. In a male-dominated society where men and women often function separately, using services embedded in such a setting is stigmatizing for many men; the feminized environment can deter them from coming to be tested.

Many men find that the structure is oriented toward women; it is not conceptualized as being adapted for men. It is stigmatizing for men to come here. They don't sit down; they pace back and forth, and then they finish up by asking us, “Can you see me quickly? There are too many women.”

—*Social worker (community educator)*

Men consider that coming to the health center is women's business.

—*Medical doctor (provider)*

For the most part, stakeholders reported that women liked the idea of being accompanied by their husbands for PMTCT or VCT.

[Women] have a desire to be accompanied by their husbands to the health center. There are fewer interrogations on the part of husbands when women use the health services and in the follow-up after they have been tested. [If they are accompanied], the women are better supported, and there is better harmony within the couple.

—*MAP focal point (provider)*

However, this sentiment was not universal; many women questioned the presence of men in PMTCT. This finding suggests that women need to be sensitized about the importance of male participation.

Certain women are surprised when we ask them to involve their husbands in following their pregnancy or to accompany them to hospital. They don't see the point of that.

—*General practitioner (provider)*

#### The Cultural Context of Testing and Disclosure

Respondents described Côte d'Ivoire as a patriarchal society. This tradition plays a role in GBV:

African and Ivorian culture places men above women in that he is the head of the family. A man is not in the habit of treating his wife as a partner and

accompanying her to hospital. When a man goes with his partner to the hospital, his peers will say, “Have you become a woman or what?”

—PEPFAR *partner*

Cultural norms around masculinity also mean that men are likely to expose themselves to risk factors for HIV.

Real men show their physical force and have lots of girlfriends; they dominate everything. They don’t use condoms, as they think that the illness will never get them.

—*Community counselor (community educator)*

Out of a fear of appearing “weak,” men often wait until the last minute before accessing treatment for HIV and AIDS. According to respondents, many men are reluctant to come for HIV testing, even when their partner(s) have tested positive. Men often wait until they have full-blown AIDS before they seek health care services; this behavior puts their lives and the well-being of their families in grave danger.

Men don’t feel concerned by health problems, and they prefer to endure illnesses like “real men,” instead of going to the hospital, where they will be seen as being weak by people in the community. This means that they often show up at the health center in the advanced stages of the illness.

—*MAP focal point (provider)*

During the interviews, providers identified one subgroup that was particularly reluctant to use testing services: Muslim men in polygamous marriages.

The men who are most reluctant to accompany their wives for PMTCT and to get tested themselves are adults aged around 40 who are Muslim and who want to control their wives. For example, a man came here with his young wife, who was HIV-positive. The man himself was HIV-negative. We asked him to bring his other wives, because he was polygamous, but he didn’t agree and blamed the wife we saw for her infection.

—*Community counselor (community educator)*

The same community educator noted that such men are more likely than other men to accompany their wives for testing; however, they do not come to provide support or to get tested themselves. Rather, they want to monitor the spouse to make sure she is really going to the clinic and to hear her test results directly. According to the educator, such men appear to have complete control over their wives, even possessing their identity cards. It is important for health care staff to understand the motivations of a man who accompanies a woman for testing and to determine whether he is coming to provide support or to monitor and control.

In Côte d’Ivoire, open communication between men and women is not the norm. Disclosure after HIV testing can be problematic for couples, particularly if they are discordant or if only one of them has been tested. Men tend to blame women who test HIV-positive for bringing HIV into the partnership, regardless of whether the man knows his status. The consequences can be severe; such women may be beaten, abandoned, divorced, thrown out of the marital home, or denied access to their children. Thus, when a woman tests HIV-positive, she often

prefers to keep her status to herself, fearing the social and physical consequences if she informs her spouse.

Women have a lot of problems explaining their status to their partner. They are afraid of being blamed, and that is a problem we have to solve. There are lots of problems related to compliance because a woman who is seropositive hides her status from her partner and conceals the fact she takes medicine.

—*MAP focal point (provider)*

Women often resort to ruses to keep their HIV status secret.

Often women refuse to tell their husbands about their serological status. They empty other medicine bottles and put the [antiretrovirals] in them.

—*MAP focal point (provider)*

In a climate of noncommunication, children's lives are also at risk. Mothers often feel obliged to keep their children's HIV status secret from their husbands.

A child who is taking antiretrovirals is given them in secret by his/her mother because she has not told her husband about the child's status.... We had a case where the father found the bottles and broke them. The child wasn't followed regularly, and the mother and the child missed a lot of appointments. We got the husband to come in with the woman, and we redid their tests; they were both HIV-positive. The situation was sorted out, and now they all take antiretrovirals, including the child.

—*PEPFAR partner*

These testimonies point to the fact that a large part of the “problem” of male participation is rooted in the difficulties that men and women have with communication, particularly about sensitive and life-threatening issues, such as HIV. These difficulties are exacerbated because most testing is done in medicalized clinical settings—that is, the medical aspects may be discussed in detail, but there may not be enough emphasis on the need for mutual communication and support.

### **Men's Employment Obligations and Time Constraints**

During the interviews, one of the most frequently given reasons for men's low use of testing services was that they are frequently at work or seeking ways to provide for their families.

The man is the head of the family; he has to go and find whatever he can to feed his family. He goes out early and comes back late. Coming to the health center is not in his schedule.

—*Social worker (community educator)*

When men do come, they do not have time to wait to see a provider; at many health care facilities in Côte d'Ivoire, waiting times can be several hours, and there is no appointment system. Long waits become even more difficult when men are surrounded by women in the waiting room. In addition, facility hours do not often coincide with men's availability. Facilities are usually open during the day from Monday to Friday but are closed except for emergencies during evenings and on weekends.

Men are always in a hurry, and they don't like the long waiting lines in the hospital.

—*Community counselor (community educator)*

The hours during which men do not have to work do not coincide with the hours when consultations are available. —*MAP focal point (provider)*

Men are not available on weekdays and so they cannot come to get tested. —*Community counselor (community educator)*

### **Sex and Attitudes of Health Personnel**

The sex of health care personnel and their attitudes may contribute to a lack of men's participation. Although all seven facilities reviewed during the evaluation reported having male providers, they were not in evidence when the study was conducted.

Female providers, as well as their male counterparts, often take on the cultural values that are ingrained in the communities they serve; many may feel that a man's place is not in maternal and child health services, even for the purposes of PMTCT.

There is a problem with the way in which men are welcomed, the layout of the services, an insufficient number of qualified personnel, and the attitudes of the providers. —*MAP focal point (provider)*

There is a problem with the attitudes of the providers who live in the same cultural environment as the community and who are bound by the same social norms, which do not allow them to access men. Changing these norms will take a long time. —*PEPFAR partner*

### **Lack of Appropriate Waiting Areas**



An additional problem is the lack of appropriate waiting areas for men. At some facilities, the waiting area was very cramped and usually full of women. At one facility, VCT services had no waiting area at all except for a bench outside in the hot sun.

**A waiting area for VCT services**

Some providers said that men are put off because they view the waiting area as a women's space, and they consequently feel uncomfortable there.

When a stranger comes to the health center, he is struck by the number of women and children. So men are embarrassed to come here because they will find themselves in the middle of a load of women.

—*General practitioner (provider)*

### **Lack of Privacy and Confidentiality**

A pressing concern at many facilities is the lack of privacy and confidentiality. Counseling settings are often cramped, and the doors do not close properly. Because the same small room is used for pretest counseling, posttest counseling, and medical consultations, clients cannot be assured of privacy in any of these sessions.

The space is small, and there is no confidentiality. The VCT and the PMTCT case management take place in the same room.

—*Community counselor (community educator)*

The space doesn't protect patients' confidentiality and doesn't contribute to combatting stigma.

—*MAP focal point (provider)*

At one facility, clients receiving pretest and posttest counseling were seated a matter of feet from each other; the main door did not close, and two "private" booths were divided by partitions that did not reach the ceiling.

At another facility, which had fairly low rates of male participation, one provider noted that many of the staff were from the same small rural community as the clients. To protect confidentiality, he put staff who lived in other communities in charge of testing; he believed that this change had improved attendance rates.

When outreach workers perform tests in the community (e.g., in people's homes and in public spaces such as bars), ensuring confidentiality can present a challenge.

We ask ourselves if we go into the community, "Is patients' confidentiality really respected?"

—*Social worker (community educator)*

Another issue related to confidentiality is the fact that men sometimes divulge their spouse's HIV status to others.

There is a fear that the husband will disclose her status. There was a woman who took her courage in her hands to tell her husband, and to her great surprise, he called a meeting of the extended family and told everyone.

—*MAP focal point (provider)*

## **Effectiveness and Use of Messages and Materials**

RESPOND worked with JHU•CCP to develop information, education, and communication (IEC) messages and materials. Findings from focus group discussions about gender and HIV conducted by RESPOND in Abidjan in 2011 guided the work. Radio spots, posters, and other printed materials were produced in local Ivorian languages (Figure 2, page 10).

In general, health care providers liked the posters and other materials. However, some facilities had run out of materials, and most had no flipcharts. On the facility checklist, two sites reported that they did not have any signs or posters on display to show that services are available for men; only three facilities said they had materials for clients about men's sexual and reproductive health.

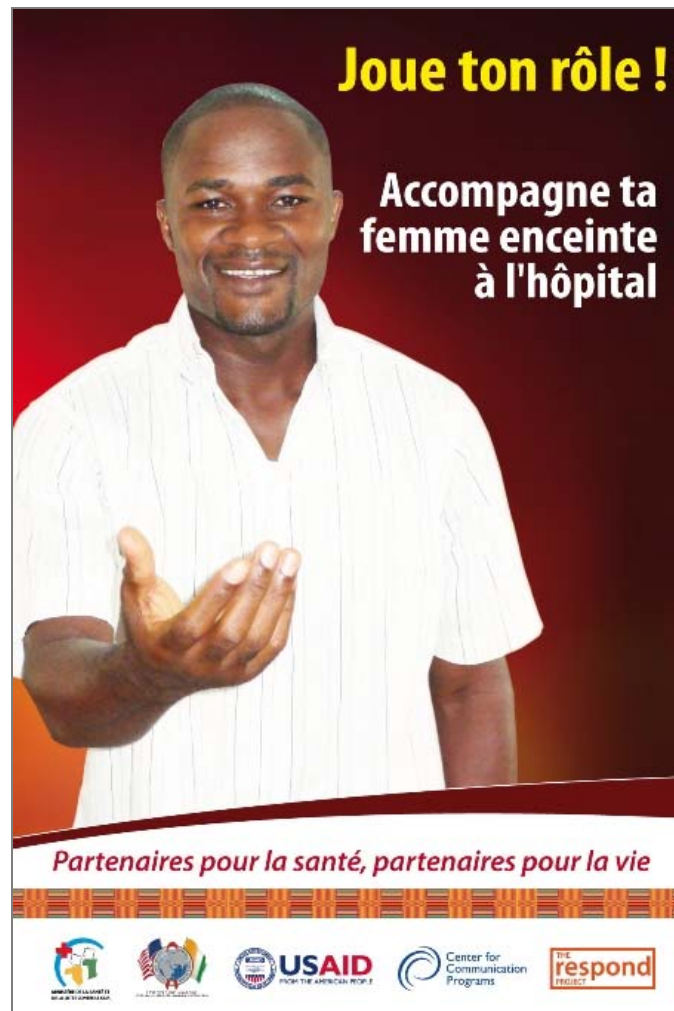
The posters and the leaflet are appropriate, and the messages are clear. However, there are not sufficient quantities of either, and there is no flipchart.

—*MAP focal point (provider)*

The posters are beautiful and contain pertinent messages. They are useful instruments for sensitization. They are attractive to people, and they are innovative. The image on the poster of the man with his pregnant wife is a model to which each couple should aspire.

—MAP focal point (provider)

**Figure 2. Poster to encourage male participation in PMTCT**



During visits to health care facilities, members of the evaluation team noticed that MAP posters were usually hanging inside, or on the door of, the chief medical officer’s office or in the office of another senior staff member. This placement does not target potential clients, who are likely to congregate in waiting areas and other public places at the facility.

Although radio spots can be important in disseminating the MAP approach, they are broadcast nationally in Côte d’Ivoire, even in regions where no work has been done to make testing services male-friendly. Before the introduction of the MAP approach, most testing services in Côte d’Ivoire were not designed to appeal to men. If radio spots encourage men to go for testing and the services are not male-friendly, men may be deterred from ever being tested.

## Effectiveness of Training

RESPOND trained staff from PEPFAR partner organizations and health facilities in the MAP approach through separate trainings. Four-day trainings for all staff of supported facilities were conducted between September and November 2011. These sessions focused on:

- Exploration of gender norms related to HIV prevention and health care-seeking
- The rationale for engaging men in HIV testing and PMTCT services
- Development of action plans to make facilities more male-friendly

In July 2012, RESPOND trained staff of PEPFAR partners and the Ministry of Health to build their capacity to address gender norms and engage male partners in HIV prevention activities.

In general, evaluation respondents reported that the trainings were well received and that they were practical, innovative, and relevant.

The training was well liked by the members of [organization]. It allowed us to acquire new knowledge about gender and, above all, to get to know this innovative approach known as MAP. The methodology and the trainers were very good.  
—PEPFAR partner

Personally, I liked the training very much. The approach was innovative and very participatory. It taught us a lot about gender and the involvement of men. The themes chosen were very pertinent. The participants really liked the MAP training and were open to applying the things they had learned. One participant told me that the training had taught him a lot and that he applies what he learned in his family life.  
—PEPFAR partner

In particular, we liked the MAP training. The approach to training the providers and community health workers was innovative and participatory and practical [using role plays, focus groups etc.]. The partners want the training to be rolled out to all the training sites. The providers were open to the messages and activities because they already saw their importance, and so you could say that EngenderHealth just reinforced a door that was already open.  
—PEPFAR partner

Health personnel appreciated the training and said they had learned new facts and skills, mostly about gender relations.

The training helped me learn how to address men in the fight against HIV and AIDS. I learned certain strategies about how to get through to men efficiently and easily and how to involve them in combating HIV and AIDS.  
—Community counselor (community educator)

I learned that involving men in PMTCT improves follow-up and can help sort out a lot of problems for couples in which the woman finds herself HIV-positive.  
—MAP focal point (provider)

One area of training that could be improved was that covering GBV, which was given only half a day in the curriculum.

On the facility checklist (see appendix), all seven sites indicated that providers had been trained in couples counseling for PMTCT, VCT, prenatal consultations, and FP. One site gave a “partial” response to the question, indicating that providers had been trained in some of these elements, while the other six indicated “yes.” The sites were also asked if providers had been specifically trained in the last two years to work with men and boys. Two said “yes”; four gave “partial” responses; one said “no.” These findings may reflect the frequent transfer of providers and other facility staff; some providers who were trained in the initial trainings of late 2011 are no longer affiliated with the RESPOND-supported facilities.

## Implementation of Action Plans

After training, each health care facility developed an action plan identifying steps to take to make the site more male-friendly. Each plan was created in collaboration with the facility’s PEPFAR partner organization and RESPOND; it was designed to fit in with Côte d’Ivoire’s national strategic plan for HIV and AIDS (Conseil National de Lutte Contre le SIDA, 2011). However, two facilities had difficulty implementing their plans because of a lack of resources. In addition, Côte d’Ivoire introduced free health care for women and children in January 2012; this development taxed the resources and capabilities of health facilities.

There were five main points to the plan and these were (1) the promotion of PMTCT, (2) improving the signage and posters, (3) improving the way men are welcomed, (4) sensitizing health care workers, and (5) sensitizing the community with regard to couple counseling. However, the plan was not completely executed, because we did not have enough financial resources in the hospital or from our partner. We did not have any IEC materials, and we were overworked with the extra tasks that the MAP approach required of certain doctors. The fact that the implementation of MAP coincided with the introduction of free health care for women and children lowered cost recovery and reduced the hospital’s financial resources.

—MAP focal point (provider)

One facility had trouble implementing its plan because of civil unrest in 2010–2011; the unrest probably also contributed to the low numbers of men coming for testing.

First of all, the war and the fact that the population was displaced [affected implementation of the action plan]. Secondly, there was a lack of revenue for the health center because health care was made free in 2012 for pregnant women and children under 5—so we did not have any financial resources to implement the activities.

—Medical doctor (provider)

One facility was not able to implement its action plan because construction closed its services for much of 2012.

One of the more successful centers included targets for testing in its action plan. Targets are important because they provide goals to aim for. Even though the site had financial problems implementing the plan, it had a way of quantifying progress. The facility seemed more aware than other centers of how many clients and couples it was serving and the degree to which the numbers had increased.



The action plan... had a number of different aims. These included increasing the number of male clients from 15% to 20%, providing a warm welcome to men accompanying their wives for PMTCT, and increasing the percentage of men seen in PMTCT services from 0% to 15%.  
—*MAP focal point (provider)*

## Creating a Male-Friendly Environment

Interview responses indicated how important it is for facilities to become less “feminine” and to create settings that appeal to men and make them comfortable. Changing the service environment appears to be particularly challenging, although two facilities had taken steps by ensuring that images of men were displayed. In interviews, one provider described the effort that a facility had made to “defeminize” the area where men were seen.

The hall used to be used for vaccination. But now [when] men come to the center, they don’t see a lot of women because the vaccination services have been moved elsewhere.  
—*General practitioner (provider)*

The facility checklist (see the appendix) asked several questions about the environment within sites. While all seven facilities indicated they had male providers on staff, other responses indicated that the sites could do more to create a welcoming environment for men.

None of the facilities said they had consulted with men and boys about clinic hours. Only two of the facilities responded “yes” to the question “Are there signs and posters on display that show that services are available for men?” Three sites responded “partial” to this question, while two responded “no.” Four facilities said that photographs of men were in evidence; one responded “partial,” and two said “no” to this question. All of these responses indicate a need to do more to make the clinic settings more welcoming to men. However, findings did show an improvement over baseline, when no facilities answered “yes” to any questions other than having both male and female staff members.

A community educator recognized the value of the MAP approach, but noted the continued need to improve the environment for men:

The MAP approach has had a positive impact on men’s use of testing and treatment services, but there remains a lot more to be done in terms of improving the way they are received.  
—*Community counselor (community educator)*

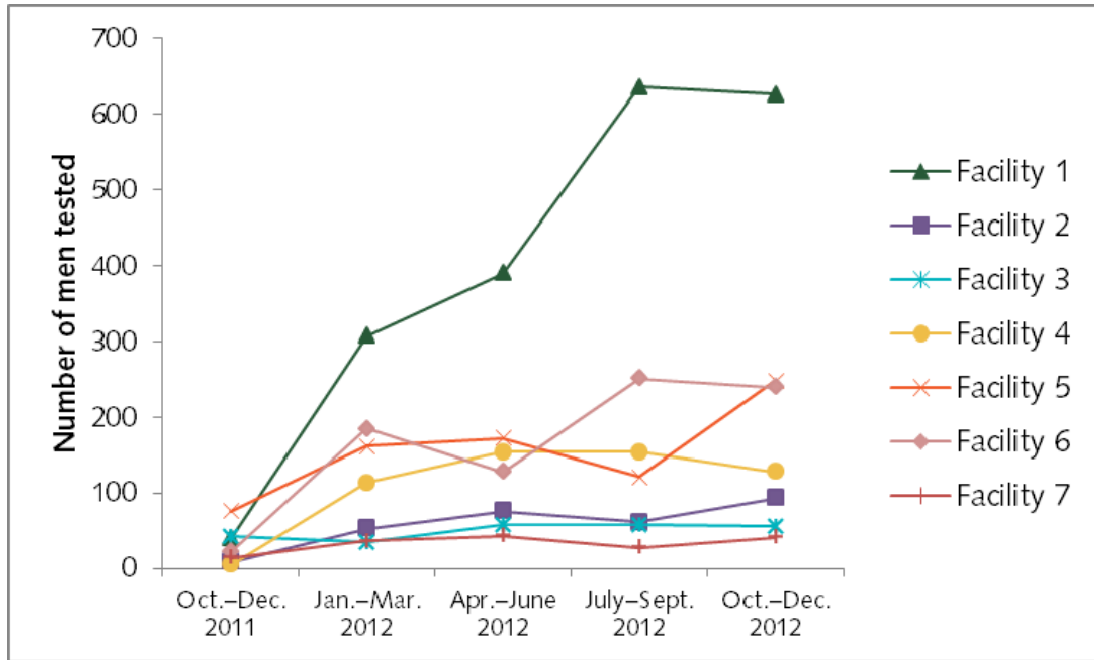
## Service Delivery Statistics

### Trends in Testing among Men and Couples

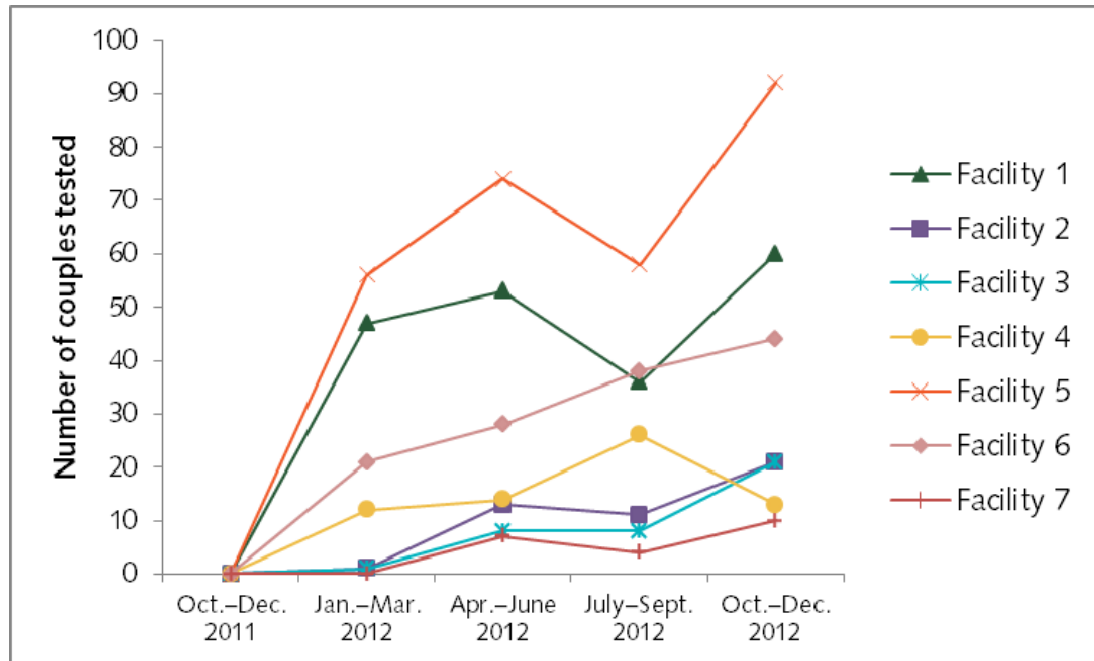
RESPOND began to collect service statistics from supported facilities on a quarterly basis beginning in late 2011, when the male-friendly services and community educator trainings were complete. Figures 3 and 4 show considerable heterogeneity in the numbers of men and couples tested at the seven centers supported by RESPOND. Facility 1 tested significantly more men than the other centers. In the second half of 2012, this site had tested more than 600 men per quarter. This may be because staff at Facility 1 had already identified a need to engage men in HIV testing and thus were eager to begin to make changes to attract male clients. At four facilities, the number of men tested increased less dramatically, reflecting

transfers of RESPOND-trained providers, incomplete implementation of action plans, and stock-outs of essential testing supplies.

**Figure 3. Number of men tested, Oct. 2011–Dec. 2012**

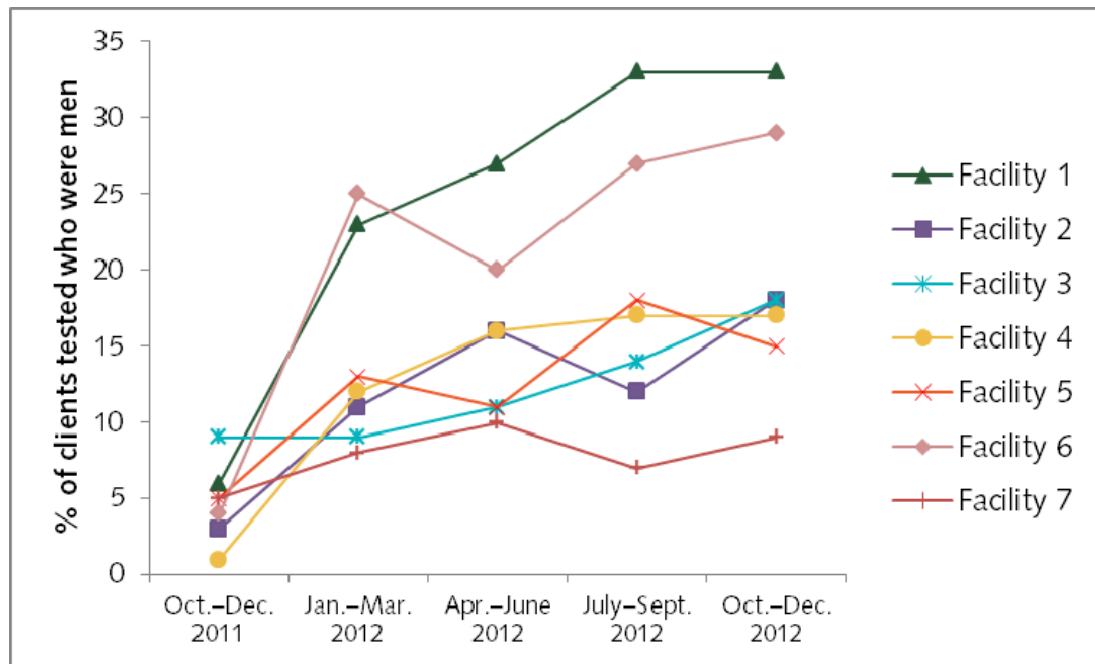


**Figure 4. Number of couples tested, Oct. 2011–Dec. 2012**



By October–December 2012, while the numbers remained low, each of the seven centers had increased the numbers of couples tested together since their staff had been trained in male-friendly services.

**Figure 5. Percentage of clients tested who were men, Oct. 2011–Dec. 2012**



In terms of the percentage of clients tested who were male, all facilities showed upward trends (Figure 5). Supported facilities increased the percentage of male clients from an average of 5% to an average of 20%.

Some centers appear to have fundamental problems attracting men in significant numbers, although they did consistently test sizable numbers of female clients. This may be due to the barriers to men’s participation described earlier in this report, rather than to practical issues related to commodities, staff turnover, or infrastructure.

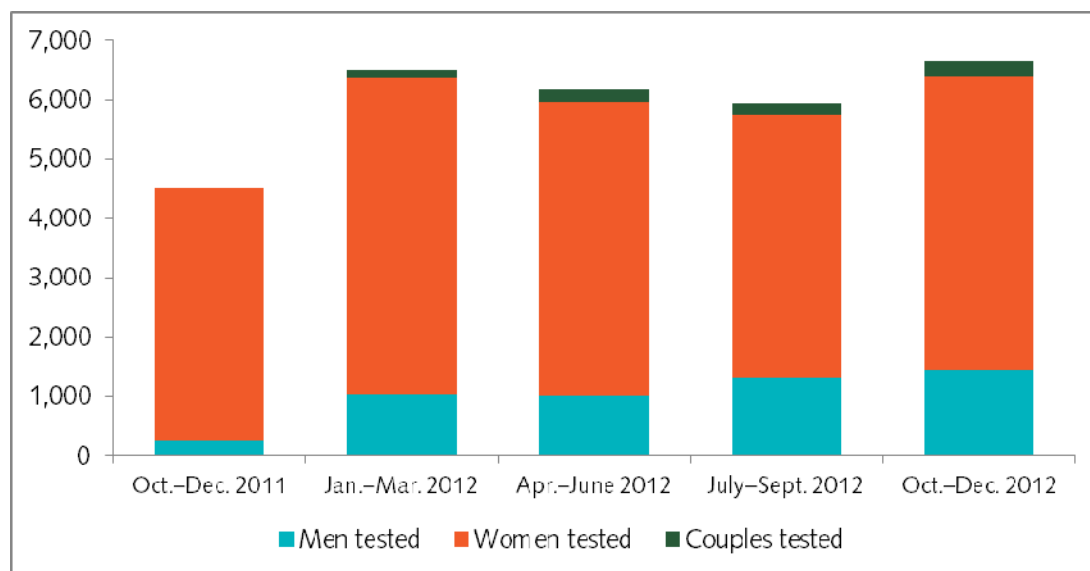
### Numbers of Men, Women, and Couples Tested

After receiving training in male-friendly services, facilities dramatically increased the total number of men tested, from 244 at the program’s inception to 1,435 during the last quarter of 2012—over a five-fold increase.

In the last quarter, the sites tested 4,962 women—more than three times the number of men tested during the same period (Figure 6, page 16). However, in the first quarter of 2012, the numbers of women tested was even higher, totaling 5,347. The decline may be due to lower numbers at Facility 5, which contributed a large number of cases to the total number of women tested. This facility frequently has stock-outs of testing reagents.

The numbers of couples tested rose from 138 in January–March 2012 to 261 in October–December 2012. Although the numbers almost doubled, the total is relatively low, averaging 37 per health center in the last quarter. However, this number ranged from 92 per quarter at Facility 5 to just 10 at Facility 7. Couple testing reflects only the men and women who came for testing together; men who came for testing after their female partners were encouraged in the PMTCT setting to send them are recorded separately.

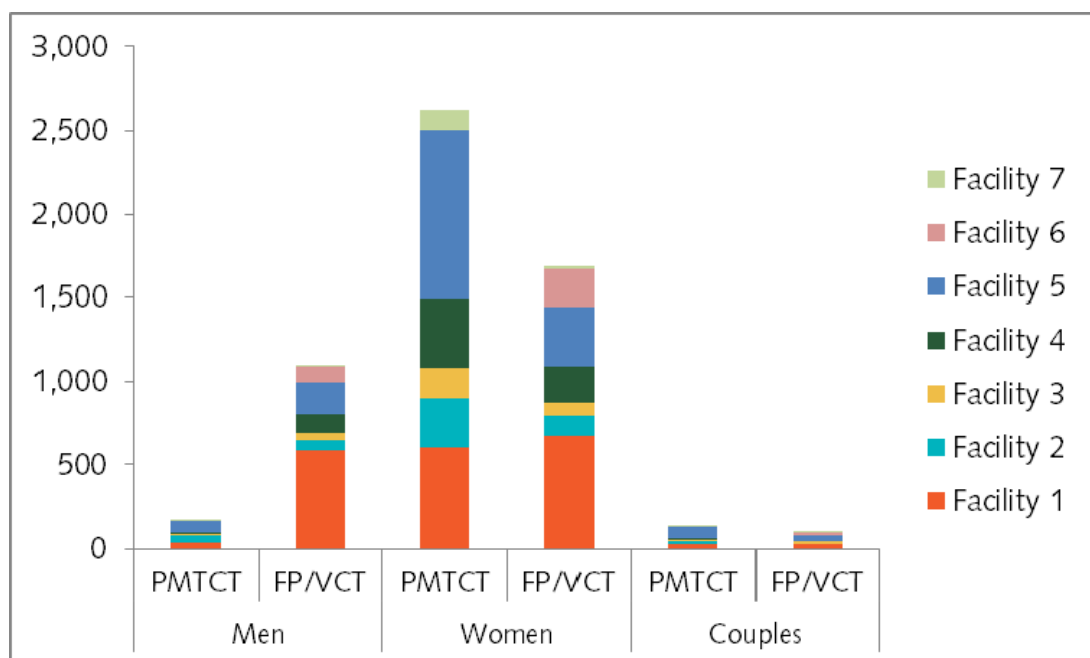
**Figure 6. Total number of individuals and couples tested at supported facilities**



**Numbers of Men, Women, and Couples Tested, by Type of Consultation**

According to data presented in Figure 7, the strategy of encouraging men to use PMTCT services during the partner’s antenatal care is not yet working effectively, even in centers such as Facility 1, where testing rates are high. Very few men are being tested as part of PMTCT services. The facilities have sent out letters of invitation to men and have conducted other outreach strategies; however, the PMTCT environment may be so feminized and medicalized that men may be put off.

**Figure 7. Number of men, women, and couples tested, by type of consultation**



At all facilities, most men were tested via FP or VCT services. With the exception of one facility (which closed its PMTCT services for a good part of 2012), slightly more couples were tested through PMTCT services than through VCT services (123 versus 120). However, as noted earlier, the overall numbers tested were small, ranging from two to 54 at the various facilities in the last quarter of 2012.

Most women seeking testing used PMTCT services, as opposed to FP or VCT. The exceptions were Facility 6, where PMTCT services were closed during much of 2012, and Facility 1.

Unlike other centers, Facility 1 tested more women through FP-VCT consultations than through PMTCT visits. This may indicate that VCT for women is integrated and routine across services and not limited to antenatal care; to maximize points of contact for clients, facilities may want to aspire to such a model. Testing via FP services will probably continue to attract primarily women because women are more likely than men to seek contraceptive services, but such services could still reach out to men.

## Commodities

Low numbers of tests were sometimes related to a lack of commodities. For example, Facility 5 had no reagents for a period of several months.

## Staffing

At some facilities, staff were not paid regularly. At one facility, a community educator sometimes went several months without being paid by the partner nongovernmental organization.

I don't do any other activity [apart from peer education]. I would like to continue doing this work, but I have to be paid properly. They can wait two or three months before giving us our salary.

—*Community counselor (community educator)*

We are not paid regularly. It was only in February 2013 that we received our salary from October to December 2012.

—*Community counselor (community educator)*

Failure to pay salaries may contribute to the high turnover of staff, which was noted by several respondents.

The MAP approach has allowed men to be involved in the services, but the impact has been limited as all the community counselors who were trained have moved on.

—*MAP focal point (provider)*

## Community Engagement

### Community Outreach

In the facility checklist, six out of seven sites said they had systems in place to encourage men and boys in the community to use health services. Given men's reluctance to use health care facilities, outreach work in the community may be a better strategy to encourage them to get

tested than facility-based approaches. One provider saw the MAP approach as being especially pertinent to a community strategy.

I was a bit skeptical when I saw that the [MAP] training was aimed at health personnel because it is not sure that we will obtain the required results. The health care workers are doing all they can. If we are going to act, then it needs to be in the community.  
—*MAP focal point (provider)*

Community locations where men congregate, such as small businesses and sports venues, can be especially appropriate for male outreach.

The best places to sensitize are in the heart of the community—for example, in garages and barbers.  
—*Community counselor (community educator)*

The best places to sensitize are in people's homes and in businesses—for example, in mechanics' or welders' workshops. You can also go to where people play sports, but it is no good sensitizing those who are watching football matches, as they can't concentrate on anything else!  
—*Community counselor (community educator)*

Some community educators appear to be successfully using this outreach tactic.

I sensitize people in the public transport minibuses [woro-woro]. I give people a rendezvous at the hospital, and then the men come and do their test. I convince them by saying that a man needs to know his status and that of his wife, no matter what he has done in the past, so that they can start a new life after having been tested.  
—*Community counselor (community educator)*

Community educators sometimes focused on the financial aspects of being tested and knowing one's status.

I explain to men the advantages of knowing one's status, together with the status of their wives and children. I use the fact that each man needs to know his status so he can start a new life, and I make him understand that one third of his revenue could be spent on illnesses each month. However, if you know your HIV status early, you will get free treatment.  
—*Community counselor (community educator)*

Because gender issues can play a role in the success or failure of community-based work, program planners must carefully consider them. For instance, depending on the community, it may not be wise to use female educators for such work.

### **Communication and Referral between Community Workers and Facility-Based Providers**

Communication between community-based workers and health care facilities was patchy, irregular, and unstructured. Compared with other sites, health centers that tested more men had better referral systems and more communication between community educators and providers.

After we have sensitized clients, we give them a pink card for PMTCT and a white card for VCT. They go and see the health workers, and then they come back and tell us if they were satisfied with the services. Each month we share the good and bad points with the health care providers. The doctors are very open, and we feel supported knowing that we do a good job. We can quantify the number of people referred to services, and if there are people who have not been seen, we can follow them up via our contact with the clients.

—*Community counselor (community educator)*

The above quote demonstrates that this facility embraces the concepts of service quality and client satisfaction; these will in all likelihood encourage men to come for testing. In addition, community educators at this site apparently can identify clients who drop out and can thus follow up with them appropriately.

In principle, there is a system whereby educators supported by RESPOND provide a card to men and couples counseled in the community; those clients are asked to bring the card with them when they arrive at the health facility. Husbands of women attending PMTCT are invited to come and be tested; however, they rarely come, and if they do, they do not bring cards.

Feedback isn't very frequent, as the counselors refer cases to us, but I never receive any cards from [clients].

—*MAP focal point (provider)*

In order to get feedback after the community visit, we give out cards... However, for example, if 90 cards are given out, only about two come back to us. Those who come and see us say, "Your colleague gave me a card."

—*Medical doctor (provider)*

In addition, there was little evidence that providers at facilities offered feedback to community workers once a client had presented at the health center. Furthermore, collaboration between the MAP focal points within the facilities and the community educators was poor.

There is no feedback between the health provider and us, as she does not work with us. When we all met together just now, she didn't even recognize me as the outreach worker, even though we are supposed to work together.

—*Community counselor (community educator)*

## Addressing Gender-Based Violence

About 12% of women in Côte d'Ivoire have been victims of some form of GBV (INS, Ministère de la Lutte Contre le Sida, & ORC Macro, 2006). Community educators who were interviewed believed that the solution lies in working with communities and traditional leaders to emphasize gender-transformative messages.

Men are not open to countering this violence because they feel that they have paid bride-price and the woman belongs to them. They say, "I paid the bride-price and I can do what I want!" Women are reluctant to talk about gender-based violence. Traditional customs favor violence against women. We need to do more sensitization in communities.

—*Community counselor (community educator)*

The problem is people's mentalities, and this is cultural. For me, you have to involve everyone and sensitize the communities and involve the religious leaders and the traditional chiefs to change people's mentalities.

—*Community counselor (community educator)*

According to respondents, some Ivoirians view violence as an expected and acceptable part of marriage. For example, some families of Malinké origin give a newly married man a whip with which he can beat his wife if, in his eyes, she misbehaves.

In certain traditions, in the marital kit, there is a whip for the husband to beat the wife. In these cases, a woman can never complain.

—*Medical doctor (provider)*

In certain Muslim families, the husband is given a whip to make sure that his wife respects him.

—*MAP focal point (provider)*

Despite the alarming frequency of GBV, women are often reluctant to report it.

The barriers are at the level of the woman herself. She is afraid to talk about it. Often they say they were hit but don't say that it was their husband who did it. They want it to get sorted out, but they won't talk about it openly.

—*General practitioner (provider)*

The evaluation found that while some providers had referred cases of GBV to social workers, facilities did not record the number of battered women seen; they also did not have a systematic approach to deal with cases of violence.

The MAP training apparently focused on the fact that women can be at increased risk of violence if they are part of a serodiscordant couple or if the man has not been tested. According to evidence from the interviews, a common scenario in Côte d'Ivoire is for the woman to be blamed for the infection (even when the man does not know his status) and consequently thrown out of the marital home, often having to leave her children behind. There are few services to help abandoned women find shelter and food.

We see more cases of HIV-positive women being chased out of their homes and abandoned than cases of gender-based violence.

—*Community counselor (community educator)*

A woman came to ask us for help after having gone to the police. She had been thrown out by her husband, who had told everyone in their neighborhood that she was HIV-positive. We tried to reason with the husband, but he refused to do a test and to take his wife back. There wasn't a single structure that could help the woman.

—*Community counselor (community educator)*

Many women do not realize their rights when it comes to GBV. However, respondents indicated that an increasing number are engaging lawyers, sometimes with the help of social



workers at social centers,<sup>2</sup> such as the one affiliated with Facilities 4 and 5, which is actively addressing GBV. This center has good relations with the police and legal professionals, who can prosecute perpetrators (see Castle, 2011, for a discussion of legal services provided to GBV victims through social centers in Côte d'Ivoire). The MAP training could integrate a rights-based approach into the curriculum so that providers learn how to inform women of their rights and refer them to appropriate legal services.

Women are behind combating gender-based violence, but they don't always know of the solutions. Now they have lawyers to help them, and they can go for help at the social services in the hospital, which manages cases of gender-based violence in collaboration with the social center of the commune. The women are not sensitized [as to what options are available].

—MAP focal point (provider)

## Management and Supervision

### Involvement of Senior Health Officials

Interview findings suggest that senior health officials have not been sufficiently involved in the MAP initiative. Several respondents (both within and outside the Ministry of Health) believed that the Ministry of Health had not participated enough in the planning and implementation of the approach.

There was no national seminar to talk about the MAP approach. It was done in an isolated manner. The Ministry of Health and the program to fight against AIDS need to be properly involved in the approach, and this requires advocacy.

—PEPFAR partner

In particular, respondents said that departmental and regional health directors and other senior health personnel needed to be more involved, both to win their buy-in and commitment and to increase the likelihood of sustainability.

You need to involve and train the departmental directors, the regional directors, the chief medical officers, and the hospital directors in the MAP approach.

—PEPFAR partner

The departmental directors are not involved enough; [the initiative] should not just be aimed at providers and community health workers. We really want the regional and departmental directors to participate in EngenderHealth's trainings. From the outset, they need to better understand the project.

—PEPFAR partner

Côte d'Ivoire may also need to designate someone to serve as the MAP focal point for departmental and regional levels (a focal point for HIV and AIDS already exists). Alternatively, the person serving as the HIV focal point could be trained in the MAP approach and be responsible for integrating it into regional and departmental efforts.

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<sup>2</sup> In Côte d'Ivoire, a network of social centers provides food and nutritional support, health care, shelter, education and training, psychosocial support, protection, and economic support to community members. Social centers are staffed by social workers and affiliated with one or more public-sector health care facilities.

## Supervision

In the course of its work, the evaluation team observed that RESPOND and other MAP stakeholders do not have a joint supervision system. There is little coordination between RESPOND and other stakeholders with regard to issues that come to light in their separate supervision activities. For example, there seems to be no attempt to address common problems, such as nonpayment of salaries, referral issues, or lack of reagents and condoms.

## Coordination among Stakeholders

To date, meetings between MAP stakeholders have been ad hoc; there is no regular meeting schedule, structure, or coordinating body.

We got involved on the basis that it is a pilot project that should show results before going on to other stages [scaling up]. That is why there is no task force to address strategic problems, governance, and relations between partners.

—PEPFAR partner

During the last year of the project, RESPOND will establish a task force to coordinate as well as to ensure sustainability of efforts. Several stakeholders emphasized the need for greater collaboration with social workers, as they can best address certain problems, such as GBV.

There needs to be a coordination structure put in place and a formal way of following all the partners, reinforcing the collaboration between them and also between the health care providers and the social workers.

—PEPFAR partner

RESPOND has already started to train social workers, and the project will train additional social workers and will continue to support those already trained during its final year.

## The MAP Approach

### Stakeholder Opinions of the MAP Approach

In interviews, partners and providers expressed general satisfaction with the aims and implementation of the MAP approach. Some noted that MAP was cost-effective.

It was easy to integrate the MAP approach into our existing activities, as it does not require a great deal of financial investment. It just requires a reorientation of programs and activities.

—PEPFAR partner

Providers and partners were asked if they would recommend the MAP approach to other organizations. All said that they would, noting that MAP helps to increase men's participation, improves several aspects of health care services, and increases the number of people being tested, thus facilitating cost recovery as individuals either pay for services out-of-pocket or facilities seek reimbursement via insurance schemes.

We would recommend the MAP approach because it has increased the rates of attendance by men and women and has improved cost recovery. The approach has made the hospital more attractive and has reinforced the capacity of the personnel, leading to a better quality of health care.

—MAP focal point (provider)

I would recommend it, as it enables us to increase the rates of male attendance. It makes the work more attractive and enables the personnel to understand the local population. It helps us to go further with our vision.

—*General practitioner (provider)*

Respondents noted that the MAP approach works with the couple as a unit and addresses barriers to men's participation. Partners said that they would recommend the approach because it addresses gender norms and the sociocultural context of health-seeking behavior.

I would recommend the MAP approach because it allows for a family-centered approach and helps us to retain clients. It improves the follow-up of HIV-positive pregnant women in PMTCT and improves harmony among couples. It also enables the provider to clearly inform the community and to get rid of their prejudgments and taboos.

—*MAP focal point (provider)*

Providers and community educators felt that if a man is involved in his wife's testing and the couple can communicate openly, he can help her manage her infection and even improve her adherence. Further, they believed that a couple who communicate openly are likely to accept each other's status; this can help the provider better manage the woman's health, including during pregnancy.

The involvement of men has an extremely important effect on the way in which the woman is followed up. If the two spouses are informed and tested as a couple, they accept each other's status, and then the follow-up of the woman is easy. That is why the MAP approach is important for us.

—*MAP focal point (provider)*

When a man is involved in testing, he can tell his wife to take her medicines regularly.

—*Community counselor (community educator)*

Respondents would also recommend the MAP approach because it can be applied to other areas of health care besides HIV and AIDS.

I would heartily recommend the approach. It needs to be scaled up and used in all health programs; I am especially thinking of nutrition.... It could be used in family planning because you have to get men to adhere to the idea of contraception.

—*PEPFAR partner*

### **Perceptions of MAP's Impact on Service Delivery**

Facilities testing the largest number of men recognized that the MAP approach had added value to their services, helped to increase the number of men seen, and promoted change in provider attitudes.

There has been an increase in the number of couples being tested during PMTCT, and the management of couples' cases has been improved. The attitude of the providers has changed, as now they ask after the husband every time a woman shows up for PMTCT. —*MAP focal point (provider)*

The program has had a positive impact with regard to the testing of men. The rates have increased from 0% to 10% or 20% in PMTCT settings, according to

our partners. Since the training, the quality of consultations has improved. Couples are now tested, and the way men are welcomed has improved.

—PEPFAR partner

The rates of testing among men have increased from 30% to 60% in all services considered together.... Men accompany their wives, and they become like “father hens.” The men go to the chats and IEC sessions and ask a lot of questions.

—Community counselor (community educator)

There are fewer and fewer losses to follow-up. Thanks to MAP, the husbands now understand the serological status of their wives.

—MAP focal point (provider)

We have noted that there are more men who come in for VCT and who are under our care.

—General practitioner (provider)

A community educator at a center that had increased the number of men tested noted a change in men’s attitudes to wives who had tested positive for HIV.

There has been a greater involvement of men in pregnant women’s antenatal care and the treatment of HIV-positive women with [antiretrovirals]. For example, some men phone to come to get the treatment for their wives if they are HIV-positive and unable to come in.

—Community counselor (community educator)

Some providers noted that, after the initiation of the MAP approach, women were more likely to come forward and talk about GBV. They also reported that the numbers of cases of GBV had diminished, but these claims cannot be verified because no records are kept and because many women are too ashamed to report GBV.

*Women are reticent about expressing themselves when it comes to gender-based violence, but with the MAP approach, they are becoming more open about talking about it. A framework has been created so they can express themselves, and a psychologist does consultations once a week in the hospital.*

—MAP focal point (provider)

## Discussion

### Limitations of Checklist Findings

The checklist used in this evaluation study (see appendix) addressed some aspects of service delivery (e.g., availability of trained staff, the physical environment of service facilities, IEC materials). Interestingly, and perhaps paradoxically, the health facilities that tested the most men met fewer of the checklist’s criteria than those that saw fewer clients. For example, the site that tested the largest number of men did not have IEC materials, had not consulted men about opening hours, had not trained first-line providers to work with men, and did not specifically offer men sexual and reproductive health services. The site that tested the second largest number of men also lacked materials and had not consulted men about opening hours. By contrast, one site reported that it had all the materials and training specified on the checklist, yet this facility had tested few men.

These findings suggest that factors other than those described in the checklist play an important role in encouraging men to be tested. How staff welcome or refer male clients and the effort they make to make men feel at ease may be more important than material resources or training. In many cases, these factors depend on the personality of the health care provider and his/her social and communication skills, which cannot be easily measured via a checklist. For example, one facility lacked photographs of men and IEC materials, but the social skills of the empathetic staff were evident. In addition, the site made great efforts to conduct community outreach. Staff personally encouraged members of their own families, churches, and other community members, such as market traders and bus drivers, to get tested. At other centers, community outreach programs did not attract a large number of clients for a number of reasons; for instance, community educators reported that the reimbursement for transportation costs given by RESPOND was insufficient.

Other issues may also play a role in site performance. In Côte d'Ivoire, as in many African countries, staff turnover is often high, and many of those trained by RESPOND have left. At one site, for example, only two of the four current staff had been trained in the MAP approach. In addition, although most facilities claimed to have IEC materials, in reality these were often only MAP calendars or posters, which provide minimal educational content.

### **Meeting the Needs of Other At-Risk Populations**

The MAP initiative focuses on men and links testing for both men and women to reproductive health events in a woman's life (e.g., pregnancy, FP use). Consequently, it does not reach out to other at-risk groups; it is important that such groups are not ignored. For instance, the initiative does not reach men whose partners are neither pregnant nor seeking FP services.

In Côte d'Ivoire, older men, older women, and younger women are at increased risk of HIV infection (INS, Ministère de la Lutte Contre le Sida, & ORC Macro, 2006). For instance, in 2005, 4.7% of men aged 45–49 were infected, compared with 0.3% of young men aged 20–24; 10.2% of women aged 45–49 were infected, compared with 4.5% of young women aged 20–24. The current MAP approach is not designed to reach these populations.

“Know your epidemic, know your response” has become a rallying cry for HIV prevention (Wilson & Halperin, 2008). It stresses the fact that HIV is a risk for a variety of different populations. Because of age and sex differentials, opportunities for HIV testing should be offered to both sexes through all types of health care services (e.g., adolescent health care, consultations for menopausal problems). Male partners of younger and older women seeking health services could be asked to come in for testing. Such a broad approach could provide access to older husbands (e.g., men over 50) or to older male partners of young women (who may be “sugar daddies” of girls under 20).



# Recommendations for RESPOND

## Training

**Increase the duration of training related to GBV, and include a component about abandonment:** In the current training, GBV is given only half a day. During the evaluation, it was clear that many providers did not have a good grasp of what *gender* meant and did not know what to do when they encountered cases of GBV. Many providers reported encountering more cases of abandonment than violence; thus, training needs to address this topic. Interaction with social workers should also be incorporated into training.

## Service Provision

**Defeminize service delivery settings:** The overwhelming presence of women in waiting areas, particularly for PMTCT, puts many men off. Facilities need to provide special areas reserved for male clients and/or particular days or hours reserved for male services.

Better branding of the MAP approach could help attract men into services that are traditionally viewed as being for women. While the phrase *protection maternelle et infantile* and its corresponding abbreviation PMI cannot be changed, as they are well known among both clients and providers, male-focused branding could help. In the 1990s, the Baby-Friendly Hospital Initiative used a slogan and logo to promote breastfeeding in maternal and child health settings around the world (WHO & UNICEF, 2009); similarly, a slogan and logo for MAP could be displayed, advertising the fact that FP, PMI, VCT, and PMTCT services are “male-friendly.”

**Demedicalize counseling and testing settings:** HIV infection has important social dimensions, including disclosure and couple communication, which are embedded in gender relations. A medicalized setting that focuses primarily on the clinical aspects of infection is unlikely to attract men, particularly via their female partners. Facilities need to create a relaxed physical and social environment that will facilitate communication with health providers and within the couple.

**Make more IEC materials available:** Health care providers reported that they had insufficient numbers of posters and other materials and that these were late in arriving at the facility or ran out quickly and were not replaced. None of the facilities appeared to have flipcharts. In addition, posters need to be displayed where clients can see them and not in the offices of senior staff, whom they are unlikely to visit. To attract male clients, posters should also be hung in community locations, such as bars and barber shops.

**Provide information about HIV counseling and testing to men seeking health care services unrelated to sexual and reproductive health:** To increase male uptake and decrease stigma, men seeking all types of health care should be invited to participate in VTC (inreach). For example, men coming for cardiac care, for malaria diagnosis and treatment, or because of accidents should all be offered VCT. Furthermore, men targeted in this way should be asked to refer their wives or female partners.

**Organize site visits and exchanges between high- and low-performing centers:** MAP-trained staff should visit each other's sites. In this way, they can learn from each other about what works and what does not and how to overcome barriers, particularly those related to lack of resources, poor communication between different levels of health care personnel, and problems associated with feminized service delivery environments. The exchange visits should involve the facility focal points, community educators, and outreach workers; they should also include visits to community outreach sessions. A checklist could help facility staff identify structural, logistical, and attitudinal factors that distinguish high- and low-performing settings.

## Community Outreach

**Increase outreach activities, especially in the workplace:** Because men are reluctant to come to health centers, which they perceive to be for women, community outreach is likely to be a more successful strategy to enroll them in VCT than are facility-based efforts. Furthermore, a major reason why men do not come to health care facilities is that they are too busy working and finding food for their families. For these reason, the evaluation team recommends that RESPOND and its partners take outreach work into the workplace. For example, mobile testing could be done at factories, workshops, offices, and industrial sites. MAP could work with employers' associations to persuade them to give male (and female) workers permission to be tested, in the same way that workers receive permission to take time off if they are sick. However, measures must be put in place to ensure that workers do not lose their jobs or suffer from workplace discrimination if they test HIV-positive. For all types of workers, outreach needs to go to the workplace and encourage testing (e.g., construction sites to reach manual laborers, market locations to reach vendors, transportation hubs to reach truck drivers).

**Extend community outreach to women outside of the reproductive ages, with an emphasis on attracting younger and older women and their partners:** In Côte d'Ivoire, the highest HIV risk is among older men, older women who have often finished their reproductive careers, and younger women who may not have started them. These individuals are unlikely to be attracted to PMTCT or to FP services, but they should be included in community outreach for VCT. In the context of the MAP approach, both older women and younger women need to be asked to refer their partners, as both groups tend to be in long-term or temporary unions with older men.

**Strengthen communication and referrals between community educators and facility staff:** Communication between community-based workers and health care facilities was generally irregular and unstructured. Furthermore, health centers that tested more men than other sites had better referral systems and more communication between community educators and providers. RESPOND can promote an improved communication system, perhaps through monthly meetings of facility staff and affiliated educators.

## Management and Supervision

**Stress the training and involvement of departmental and regional directors and focal points:** The participation of these key personnel will increase the likelihood that the MAP approach will be sustained. They can also play a role in supervision and follow-up.



**Identify barriers to the implementation of action plans:** When action plans are developed, PEPFAR partners and RESPOND should work with facilities to identify:

- Barriers to implementation of the plans (e.g., lack of financial or human resources) and ways to overcome those obstacles
- Action steps that the facility can undertake right away without new resources
- Action steps that either RESPOND, the Ministry of Health, or local entities can help with

RESPOND should also consider encouraging facilities to incorporate targets into their action plans to clarify expectations and to increase accountability.

**Create a task force for best practices and supervision:** As MAP is a pilot initiative in Côte d'Ivoire, some changes in function and feedback will be needed before it can go to scale. A task force, led by the PNPEC, could be established to share best practices and discuss problems related to the MAP approach. Members should meet monthly. The task force could also act as a coordinating body for supervision, which should be done in an integrated manner involving all stakeholders. Task force members would include service providers and representatives of the implementing partners; in addition, it is essential that departmental and regional directors be part of the task force to secure their buy-in and to increase the likelihood that the MAP approach will be sustained over time. When scale-up occurs, membership would be expanded to include new stakeholders.



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## Appendix

### Summary of Checklist Data from the Seven Health Facilities Using the MAP Approach

	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7	Total Yes
<b>Observed</b>								
Are there signs and posters on display that show that services are available for men?	P	N	Y	N	P	P	Y	2
Are there photographs of men in evidence in the health facility?	Y	Y	Y	P	N	N	Y	4
Does the health facility have IEC materials for clients concerning men's sexual and reproductive health?	N	Y	Y	N	N	N	Y	3
<b>Asked</b>								
Were men and boys consulted as to the clinic's opening hours?	N	P	N	N	N	N	N	0
Does the health facility have male as well as female providers?	Y	Y	Y	Y	Y	Y	Y	7
Have the providers been specifically trained over the last two years to work with men and boys?	P	Y	P	N	P	P	Y	2
Have the providers been specifically trained to do couples' counseling for PMTCT, VCT, prenatal consultations, and family planning, and do they encourage women to get their partners to come for testing?	Y	Y	Y	P	Y	Y	Y	6
Are first-line providers especially trained to work with men and boys?	N	Y	Y	N	P	Y	Y	4
Are sexual and reproductive health services offered to men?	N	Y	Y	N	Y	Y	Y	5
Does the health facility have systems in place to encourage men and boys in the community to use the health services?	Y	Y	Y	N	Y	Y	Y	6
Do the education sessions offered in the health facility include subjects related to men's health and to the participation of men in reproductive health activities?	P	Y	Y	N	Y	Y	Y	5
<b>Total Yes</b>	<b>4</b>	<b>9</b>	<b>9</b>	<b>1</b>	<b>5</b>	<b>6</b>	<b>10</b>	

Y = Yes

N = No

P = Partial (the facility has made progress toward the indicator but has not yet fully achieved it)