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**Sub-Regional Consultation to Discuss Strengthening
Male Involvement in the Elimination of
Mother-to-Child Transmission of HIV**

Kigali, Rwanda

24-26 August 2011

Meeting Report

Final Report

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BACKGROUND

Introduction: Between 24-26 August, 2011, the Government of Rwanda joined with WHO and UNAIDS, with the participation of UNICEF and UNFPA, to co-host a consultation on the engagement of men in PMTCT. This meeting was motivated by the publication of the *Global Plan towards the Elimination of New HIV Infections among Children by 2015, and Keeping their Mothers Alive*, prepared by UNAIDS and partners, and launched by UN Secretary General Ban Ki-Moon in June 2011 at the High Level Meeting on HIV/AIDS. The Global Plan has set two ambitious targets:

Global Target 1: Reduce the number of new HIV child infections by 90%

Global Target 2: Reduce the number of AIDS-related maternal deaths by 50%

Neither of these targets can be achieved by 2015 if services are provided to only mothers and exclude fathers. The literature clearly shows demonstrable benefits in terms of program coverage and improved health when men are involved in PMTCT. Yet few programs are able to meaningfully embrace men in maternal, neonatal and child health services, which remain the domain of women and children. The accelerated pace at which the *Global Plan* will have to be implemented provides an impetus to explore and disseminate strategies that can facilitate more efficient and effective service delivery, including strengthening male involvement.

Kigali was chosen as the site of this consultation both because of Rwanda's leadership in the arena of male involvement in PMTCT and because of the opportunity this represented to learn from the Rwandese experience. Worldwide, the proportion of pregnant women attending antenatal care whose male partner was also tested was 5% in 2008¹ – in Rwanda, by contrast, the proportion is now 84% (GOR 2011).

Meeting Objectives: The goal of the Kigali consultation was to look at the interface between policies and programmes for sexual and reproductive health (SRH), maternal, neonatal and child health (MNCH) and HIV interventions, with a focus on strengthening male involvement in the elimination of MTCT of HIV (see agenda in Appendix I). The meeting examined strategies to:

- Help women and men remain HIV-free
- Increase women's adherence to PMTCT programmes through support from their partners;
- Enhance the quality of services for men and women by addressing stigma and discrimination and potential benefits for maternal and new born health outcomes;
- Reducing violence against women following disclosure of HIV positive status;
- Recognize and respond to the sexual and reproductive health needs of men, including men in key affected populations such as sex workers and young men;
- Provide effective services to discordant couples; and
- Identify strategies to increase awareness of the importance of male involvement among health care providers and in communities.

¹ WHO, UNAIDS and UNICEF: Towards Universal Access – Scaling up priority HIV/AIDS Interventions in the Health Sector. Progress Report, 2009. Geneva, WHO, 2009.

Meeting Participants: Forty-three (43) participants engaged in PMTCT, MNCH/SRH, STI and HIV programs at country, regional and international platforms attended the meeting. They included representatives of the Government of Rwanda, UN agencies, representatives of PEPFAR, representatives of international, regional and national NGOs, members of civil society and representatives of persons living with HIV. The list of participants is found in Appendix II.

MEETING HIGHLIGHTS

Day One: Wednesday, 24 August 2011

Opening the meeting: The meeting was chaired by Professor Hoosen Coovadia, Director, Maternal, Adolescent and Child Health (University of the Witwatersrand), Emeritus Professor of Paediatrics and Child Health, and Emeritus Victor Daitz Professor of HIV/AIDS Research, (University of KwaZulu-Natal). The meeting rapporteur was Eric Ramirez-Ferrero, an independent consultant. The consultation was coordinated by Karusa Kiragu of UNAIDS, Geneva, and Manjula Lusti-Narasimhan, WHO/RHR, Geneva. The consultation was opened by the Minister of Health of the Republic of Rwanda, the Honorable Dr. Agnes Binangwaho. Also present were the Deputy Director General, Institute of HIV/AIDS, Disease Prevention and Control, Rwanda Biomedical Center, Anita Asimwe, and the WHO country representative and acting resident coordinator, Boureima Hama Sambo.

During her opening remarks, Hon. Binangwaho reminded the participants that male involvement was not only a great opportunity for PMTCT, but also for all other areas related to family and community health. She informed the meeting participants that Rwanda has a family-focussed PMTCT program and is committed to the elimination of new HIV infections among children, a campaign that was launched by the First Lady herself. It is an effort that is integrated and discussed even at the local community meetings that are part of the country's governance and development structures, demonstrating the topic's high priority. She discussed Rwanda's integrated MNCH-PMTCT program and its focus on reducing the burden on women. She also discussed the performance-based management system that is used to monitor the progress of programs at the district and sub-district levels, including monitoring male engagement.

Discussion of the Background Paper: The opening ceremony was followed by a review of the background paper that had been prepared for the meeting by Eric Ramirez-Ferrero. The paper outlined the current level and nature of male involvement to identify opportunities for the advancement of constructive men's engagement in PMTCT. It highlighted the benefits of men's engagement, barriers to their engagement, promising strategies to involve men, as well as conceptual and methodological issues that merit further consideration and research. The paper revealed that despite overwhelmingly positive attitudes toward PMTCT programming among men, their engagement remains low. Barriers to men's participation include fear of knowing one's status, stigma and discrimination. Perhaps the most significant obstacles are the conceptual and policy barriers that create a logic that inadvertently supports men's exclusion from PMTCT and other reproductive health services. This historic institutionalization of reproductive health as women's health has contributed to men's perception of clinic spaces as "women's spaces," reproductive health as women's work, and has produced health services that are not welcoming of men and couples.

The Global Plan and SRH Linkages: The overview paper was followed by a presentation on the *Global Plan Towards the Elimination of New HIV Infections among Children by 2015, and Keeping their Mothers Alive*, which has incorporated male engagement as a key pillar of implementation. It was delivered by Karusa Kiragu. This presentation was followed by an assessment of opportunities for male engagement in sexual and reproductive health programs, presented by Manjula Lusti-Narasimhan.

The PMTCT Implementation Framework: Sibili Yelibi of UNFPA and Chewe Luo of UNICEF reviewed the PMTCT programming framework and its implications for male engagement and accelerated action. Luo also presented a country typology that UNICEF is exploring to guide the PMTCT scale-up to eliminate new infections based on current PMTCT coverage (% HIV+ pregnant women who received ARV prophylaxis or treatment). Typology A countries (>80% coverage) now need to scale up to reach the remaining 20%. They also need to accelerate phasing out sdNVP and improve coverage of PMTCT regimens to infants which often lags behind that of their mothers. Countries in Typology B (coverage of 60-80%) face challenges of high attrition along the MCH continuum. Countries in Typology C need to increase coverage of PMTCT by expanding the number of service delivery points where PMTCT is offered. In some of these countries, PMTCT is only available in less than 60% of ANC facilities. The greatest challenge is faced by countries in Typology D, which have less than 30% coverage, and consequently need to greatly improve access, quality and equity of services.

During the discussions, participants debated how to strengthen male engagement in these various country contexts, and the implications for service delivery. For example, what strategies can still be used to promote male engagement in countries where marriage and cohabitation is not the norm? Participants also discussed programming approaches to address gender imbalances, ranging from gender-neutral programs to gender-transformative programs that actively challenge harmful norms and foster greater gender empowerment. Other topics included where and how to locate male partners so as to engage with them, for example in clinical settings. Participants also discussed the Global Plan and sought to ensure that the desired end-points were HIV-free survival of children, not merely avoiding HIV transmission at birth.

Chairman's Address for Day One: Professor Coovadia, who chaired the meeting, presented a paper about the new findings of the HPTN 052 clinical trial, which tested whether treatment of people living with HIV at higher CD4 counts (350-500 cells/mm³), would lower transmission to their uninfected partners. Such persons are not eligible for treatment under the current (2010) WHO guidelines. Referred to as "Test and Treat," the strategy was shown to reduce the risk of HIV transmission by 96%. The results were so dramatic that the clinical trial terminated for ethical reasons. The extremely high success of HPTN 052 has led many implementers to feel that programs should provide immediate treatment especially to discordant couples. The study has great implications for PMTCT and male engagement because it provides men a chance to reduce transmission to their uninfected pregnant partners, and hence reduce the risk of transmission to the baby.

Kim Dickson of WHO presented the recent findings of the pre-exposure prophylaxis (PrEP) clinical trials. PrEP involves the use of ARVs as prophylaxis by the HIV-negative partner in a sero-discordant relationship to reduce his/her risk of acquiring HIV, much like anti-malarial prophylaxis. There have been about 10-15 studies on this topic. The most recent, which was the

basis of news coverage, was a multi-country trial conducted among over 4000 couples and the results showed that PrEP reduced the risk of transmission by as much as 85%. The implications for PMTCT could be that pregnant women in sero-discordant relationships might take PrEP to protect themselves from acquiring HIV. While both HPTN 052 and PrEP clinical trials have some ways to go before their findings change policy, they both provide important avenues for male engagement in PMTCT in the future. Both HPTN-052 and PrEP have significant implications for work on Prong 1 of the PMTCT programmatic framework as well.

Country Presentations: Participants heard how countries were approaching male engagement. Placidie Mugwaneza, PMTCT Specialist with the Government of **Rwanda** discussed their widely acclaimed experience, where 84% of pregnant women who come for HCT are now tested with their partners, the highest rate in the world. This is up from 16% in July 2002. At the same time, HIV prevalence has declined from 11% to 3%. The country's emphasis on couple counselling and testing enables disclosure, improves adherence and identifies discordant couples in order to facilitate services. These achievements are made possible by the involvement of local authorities and community leadership, Rwanda's emphasis on the performance-based management scheme among the country mayors, and the initiative shown by health care facilities (e.g. by sending invitation letters to men). The extensive network of CHWs also mobilizes men, as do male role models in the community.

Participants also heard about **South Africa's** experience from Tim Shand of Sonke Gender Justice in South Africa. He described various initiatives to reach men including the campaigns "One Man Can" and "Brothers for Life." Sonke Gender Justice supports men to advocate for gender equality through gender-transformative programming. It also functions as a watchdog to help monitor abuse of authority by men in positions of power.

The case study of **Niger** was presented by Yacine Diallo of UNFPA, who described the *Ecole de Mari* ("husband schools"). The 137 husband schools, spread around the country, are designed to respond to the poor maternal and new born health in country by providing a chance for men to discuss how they can address those issues. Men meet once a month to discuss family planning, maternal health, and specific reproductive health cases and situations within their communities. In so doing, they also change their behaviours. Results have been impressive, with an increase in contraceptive use and antenatal attendance. There has also been a doubling of immunization rates, post-natal care attendance, and assisted skilled birth utilization. The *Ecole de Mari* are now seeking a role in the Global Plan.

Kekoura Kourouma presented the case study of **DRC**, which is still recovering from the civil war. He reported only limited engagement of men in PMTCT. He noted gender-based violence is a major problem that nullifies the limited efforts of PMTCT programs. On-going guerrilla movements and local military operations have hampered PMTCT.

The **Nigeria** case study was presented by Kwame Ampomah who noted a lack of systematic male engagement activities in country. Instead he discussed several discrete efforts. For example in Jigawa, where the National Union of Transport Workers have agreed to carry pregnant women to health care facilities free of charge, and are reimbursed later by the union. In Kwara state, the traditional ruler has expressed concern about the high rates of maternal mortality and therefore has established a special fund for pregnant women. And in the Millennium Villages, progress is also being made. In Ondo state, the Fathers' Clubs have become a support group for men

affected by HIV. In the Muslim state of Kaduna, discussions with farmers about family planning led them to accept the methods and triggered an avalanche of wives seeking the services. As a farmer noted, it would be easier and more profitable to sub-divide his land if he had fewer children.

During group work, participants discussed other male engagement programs that were not represented at the meeting. Some of the ones mentioned include Mama's Clubs in Uganda, Rwanda National Men's Network, and MMAAK – Men's Movement Against AIDS In Kenya. Groups also discussed Strategies to engage men, including:

- Fast-tracking men/couples who come for ANC (the example of Kenya was given)
- Providing clinical services for men who come (e.g. blood pressure screening, health check-ups, e.g. Tanzania)
- Peer support for men living with HIV.
- Performance-based agreement, with male engagement as one of the reportable indices
- Male champions to encourage other men to act
- Letters to partners encouraging men to come to the clinic
- Providing transport vouchers for couples (Project San Francisco in Rwanda brings couples for PMTCT by hiring a special bus for them)
- Working with CHWs to mobilize men

Day Two: Thursday, 25 August 2011

Cost-Effectiveness of Male Engagement: Day Two of the meeting began with a recap of the previous day. It was then followed by a Chairman's Address on cost-effectiveness of male engagement in PMTCT, presented by **Lorraine Sherr**. She began by noting that the cost-effectiveness of screening for HIV was established a long time ago. As far back as 2000, studies showed that screening pregnant women for HIV could avert lifetime cost for caring for HIV positive child by £178, 300². However, she also noted that the cost of not engaging men can be measured in different ways; there are financial, psychological and biological costs. Regarding financial costs, she gave the commonly-used example of treatment costs when HIV infection is eventually identified at an advanced stage (i.e., when the opportunity for prevention was missed). However she also discussed psychological costs, such as stigma and the mental health burden, as well as the biological costs, such as missed discordance. Programs should work to reduce these costs. Most current MNCH and PMTCT activities exclude – and therefore, alienate – men. This approach attenuates the impact of all four prongs of PMTCT. For example, in Prong 2, data show that men, regardless their HIV status, are more desirous of additional children, than women. Therefore PMTCT discussions about fertility intentions that exclude men, are excluding the dominant decision maker. Sherr discussed the broader engagement of men – not just in the context of PMTCT but also their involvement in pregnancy care and ANC, breastfeeding decision-making, as well as parenting. She noted that men may be excluded in research that could improve service delivery, as in studies that examine psychosocial well-being and paternal depression. Most studies of post-partum depression are focused on mothers.

² Postma M, Beck E, Mandalia S, Sherr L et al (1999 and 2000)

She concluded that engagement of males is cost-effective – providing testing and counseling for fathers and mothers together identifies sero-concordance as well as sero-discordance, and provides a better opportunity to protect partners. If it is the male who is positive, men’s involvement provides a chance to help both the mother and infant remain HIV uninfected. It also provides a chance for early treatment for the father, if indicated. With recent improvements PMTCT service delivery (e.g. commencing ARV prophylaxis at 14 weeks, re-testing during pregnancy etc.), there are important opportunities for male engagement that programs should not miss.

Sherr’s presentation was followed by a perspective from **Felix Ndagije**, CDC Rwanda, presenting the Rwanda case study. Using the definition of cost-effectiveness as a ratio of the cost of the intervention to a relevant measure of its effect, Ndagije noted that cost-effectiveness of male engagement can be assessed in three ways: a) reductions in horizontal transmission; b) reductions in Infant/vertical HIV infections; and c) reaching the men for their own health. Because most HIV transmissions in Rwanda occur among long-term cohabiting partnerships, and because Rwanda, like most countries in sub-Saharan Africa, has a high rate of discordance (54%), strategies that include men and address couples instead of women alone is a highly efficient strategy, dubbed “buy-one-get-one-free.” The average cost of HCT in Rwanda is around \$25. Based on Rwanda’s HIV prevalence and population distribution, nationwide couple HCT (CHCT) would avert 31,691 infections, at a cost of \$1,136 per infection averted. These costs are recouped quickly; the annual cost of ARV therapy in Rwanda is \$675 per patient (OGAC, 2010) and so in two years, the cost of averting an infection in Rwanda would be recouped, and the remaining funds would represent a savings to the country. Rwanda’s current 84% CHCT rate means that the country is on an accelerated path towards the elimination of new HIV infections among children while keeping mothers – and fathers – alive and healthy.

Empirical Research: Participants next turned their attention to recent empirical evidence on the impact of male engagement. The first presentation was by **Adam Aluisio**, who discussed the results of his prospective study³. The research examined the impact of male engagement in PMTCT on two main outcomes: infant HIV acquisition and infant mortality. The study was undertaken between 1999 and 2005 in Nairobi, Kenya. HIV-infected pregnant women were enrolled and followed with their infants for 1 year. Infant HIV DNA testing was conducted at birth and at months 1, 3, 6, 9, and 12 postpartum. Women were also encouraged to invite their male partners for prevention counselling and HIV testing.

Among 456 female participants, 140 partners (31%) attended the antenatal clinic. Eighty-two (19%) of 441 infants tested were HIV-infected by 1 year of age. Adjusting for maternal viral load, vertical transmission risk was lower among women whose partners attended the clinic compared to those whose partners did not attend (adjusted hazard ratio = 0.56, CI: 0.33-0.98; p = 0.042), Vertical transmission was also lower among women reporting versus not reporting previous partner HIV testing (aHR = 0.52, CI 0.32-0.84; p = 0.008). The combined risk of HIV acquisition or infant mortality was lower with male attendance (aHR = 0.55, CI 0.35-0.88; p = 0.012) and report of prior male HIV testing (aHR = 0.58, 0.34-0.88; p = 0.01) when adjusting for

³ Aluisio A., Richardson, B., Bosire, R., John-Stewart, G., Mbori-Ngacha, D., and Farquhar, C.: Male Antenatal Attendance and HIV Testing Are Associated With Decreased Infant HIV Infection and Increased HIV-Free Survival. *J Acquir Immune Defic Syndr* 2011;56:76–82)

maternal viral load and breastfeeding. The findings from this study suggest that including men in antenatal PMTCT services may improve infant health outcomes.

Boshi Mohalala presented a study examining the impact of male engagement on child outcomes. His study in Khayelitsha, South Africa, examined whether increased male participation in ANC and uptake of couple VCT could reduce horizontal and vertical HIV transmission in sub-Saharan Africa. The study was a randomized controlled trial comparing uptake of VCT among male partners' of pregnant women. The intervention arm received written invitations for their partners to receive VCT and the control arm received pregnancy information sessions (PIS).

Mohlala presented findings showing that all women in the study accepted the invitation letters and agreed to invite their pregnancy partners to attend for VCT or PIS as requested. Thirty-five percent (175/500) of pregnant women given VCT invitations for their partners brought their male sexual partners for ANC compared to 26% (129/500) of those given PIS invitations (RR, 1.36; 95% CI, 1.12–1.64; $P=0.002$). Thirty-two percent (161/500) of male sexual partners in the VCT arm underwent HIV testing compared to 11% (57/500) in the PIS arm (RR, 2.82; 95% CI, 2.14–3.72; $P<0.001$). The proportions of women and men reporting unprotected sex during the pregnancy were lower in the MSP VCT arm than in the MSP PIS arm - 25% versus 81% (RR, 0.30; 95% CI, 0.22 to 0.42; $P<0.001$) and 26% versus 76% (RR, 0.34; 95% CI, 0.25–0.47; $P<0.001$), respectively. No differences in intimate partner violence were observed. The study concludes that providing pregnant women with a written invitation for their partners increased male participation in antenatal care and uptake of couple VCT in a township in Cape Town, South Africa, where community sensitization was conducted and antiretroviral therapy was available.

Strategies for Scaling Up - Experiences from Organizations: **Ewa Skowronska** presented the case of mothers2mothers (m2m) and key areas of focus for the organization in relation to male engagement. Those include: encouraging partners of m2m clients to test for HIV, providing education and psychosocial support to couples, supporting active participation of male partners in support groups facilitated by m2m.

Recently analyzed m2m data from 6 countries revealed that among the cohort of HIV-positive clients attending m2m services there was a consistent positive trend between disclosure and number of visits, with 84 percent of clients with four or more visits reporting disclosure compared to only 53 percent with just one m2m visit. At the same time, the positive correlation between number of visits at m2m and specific outcomes observed with key PMTCT interventions, such as knowledge of their CD4 result, ARV uptake (prophylaxis and HAART), uptake of modern family planning and infant testing, suggest that the program interventions improved results and overall PMTCT program impact. Similar patterns were observed in relation to number of m2m visits and clients coming back with their partners and subsequent increase of disclosure rate among this group.

M2m plan to build on existing promising m2m practices to further explore “Couple to Couple” approach as a potential tool to more meaningful and effective way of actively involving male partners in PMTCT.

Phillip Wambua from the Millennium Villages regional office in Nairobi presented data from several sites showing increased male involvement. He showed an increased number of men volunteering to become male champions, growing demand for male condoms and increased demand for couple counselling and testing during door-to-door testing campaigns. He described various strategies being used to reach men across the 10 countries participating in the project, including the use of invitation letters from local government authorities in Tanzania, training male health workers and outreach staff, use of male champions, door-to-door counselling and testing, as well as mobilization of men by community health workers. In Uganda, they are also providing “Baba’s kits,” where they offer “Mama’s kits.”

Elena Ghanotakis of EGPAF presented their work within the region. EGPAF has supported partners in several countries. For example, in Cameroon, they have supported the Baptist Convention Health Services to design and implement an integrated “Men as Partners” Program. The intervention is comprised of educating men on the importance of male involvement, invitation letters, providing incentives for men that attend the clinic with their partners (1000 Francs) making services more male friendly, and counselling all men at clinics. EGPAF’s sites in Uganda and Zambia have the added component of syphilis diagnosis, treatment and care for both partners. The invitation letters to men are well accepted and have not led to any protests. However, the increasing clientele has increased the workload for the facility staff. In addition, keeping men engaged is a challenge, and EGPAF is trying to roll out an attractive package of services as incentive for men to come. In addition, discordant and polygamous relationships present particular challenges. In Lesotho, activities to reach men brought more women for PMTCT. EGPAF is also in the process of preparing a Cochrane review on male engagement.

Ghanotakis raised several issues, including the importance of:

- Defining constructive “male involvement.” (Is it just men showing at the clinic and testing for HIV with their partners?);
- Being more specific about interventions (i.e. couples counselling and male support can encompass a range of things)
- Defining the roles that men can play to protect their partners and children from HIV and help them access and adhere to services and
- Collecting evidence/ using existing evidence to inform our approaches

Chewe Luo of UNICEF focused her discussion on the equity of service delivery, and therefore equity of male engagement. Presently, programs are less likely to reach poorer women – and by extension therefore, would be less likely to reach poorer men. But given the challenges of reaching such marginalized groups, programs to strengthen male engagement among this population may be a higher priority to maximize gains in an accelerated manner.

She noted that male engagement is important in all components of PMTCT but could be strengthened in specific and strategic ones, for example, to ensure institutional delivery, to support ARV adherence and to ensure that children are receiving their prophylaxis or treatment. She noted that Rwanda had made strides in male engagement because they addressed it from an equity-focused platform. In addition, their performance-based management and compensation motivates service providers to reach out to men more effectively. She also noted the importance for countries to also address adolescent males and females, in order to provide equity across age groups. Girls are less informed than boys and are biologically at higher risk of

HIV acquisition. Therefore PMTCT programs should reach out to young women and their partners, in order to provide equity in PMTCT.

Barriers to Male Engagement - Perspectives of Health Care Providers Three speakers presented views on barriers to male engagement from the perspective of health care providers. Several issues emerged including:

- i. Lack of knowledge among men about the services and how to access them; also men may fear disapproval from health care providers
- ii. Lack of knowledge among health care providers, and therefore discomfort in talking with men
- iii. Health care providers' fear of violent male clients
- iv. Cultural barriers and socially-restrictive gender dynamics in discussing sexual matters
- v. Lack of time by health care providers due to the heavy workload (i.e., need additional time is needed to counsel two people instead of one)
- vi. Preference for men to "talk to experts" rather than the local nurse aide
- vii. Reluctance of health care providers to change
- viii. Stereotyping of men
- ix. Pre-service training is largely silent on male engagement
- x. Reluctance of female partner to invite the man for fear of the consequences of disclosure
- xi. Cost – a family may only be able to afford the transport of one person, as well as other expenses
- xii. Work and other livelihoods demands
- xiii. Entrenched social norms which assume a female exclusivity around services and a reluctance to challenge or overcome this.
- xiv. Lack of welcome and provision within the ante-natal care environment, with simplistic provisions such as seating, greeting, toilets and invitation into consultations.

However, many of these barriers can be alleviated with appropriate motivation, resources and staff. For example, the health care facility can adopt policies that facilitate the enhanced involvement of men. For example, invitation letters to men discussed by several programs are effective because they actively solicit the engagement of men. They also remove the burden of inviting men from women; men simply respond based on the importance many attach to such a letter and may see it as standard policy and procedure from the clinic. There is also a need to build the capacity of health care providers to counsel and test couples, and to make health care facilities more male-friendly by institutionalizing a supportive male-friendly environment. Community engagement activities such as peer advocacy and targeted approaches by CHWs can also be important ways to reach men. By integrating PMTCT activities into ANC, and by strengthening referral, programs can increase their services to men, and therefore provider care for women and their male partners.

Role of HIV-Positive Male Networks: A representative of Rwanda RPositive network presented their efforts to reach men, efforts which are still in their infancy.

Small Group Work and Discussion

Participants worked in four groups. What follows is the assignment that each group received along with the results of their work.

Group 1: Conceptual Framework for Male Engagement in PMTCT (Kekoura Kourouma): The meeting’s background paper presented the gender continuum as a way of understanding the range of male engagement. Please develop a draft conceptual framework that can be used for male engagement in PMTCT.

The group drafted a conceptual framework that is now being discussed. The diagram below summarizes the organizational/structural features of the framework, which combines an ecological approach with the four prongs of PMTCT:

UN PMTCT Framework	Individual Level	Relational Level	Facility Level	Community Level	Structural Level
PRONG 1					
PRONG 2					
PRONG 3					
PRONG 4					

The teams filled in the various male engagement activities that would go in each cell. The framework has now been drafted and is being circulated for comments.

Group 2: Research questions (Lorraine Sherr): What are the key research topics and questions that you think are needed in order to inform programming for male engagement? Please identify two-three key research issues to address for each of the four prongs of PPTCT with regards to increasing male involvement.

- Prong 1: Need to also include HIV prevention among men, and therefore examine the research issues associated with this approach
- Prong 2: Research to explore male approaches and behaviours around family planning
- Prong 3: Study to understand the mechanisms associated with enhanced PPTCT interventions with male involvement/couple interaction.
- Prong 4: Research questions to understand the drivers of inequity and to monitor the effect, both biologically and in terms of mental health, of equal provision. Also a study looking at male caretakers and men’s care needs.

Group 3: Key endpoints and indicators (Susan Kiragu): Male engagement can mean many things and the meeting so far has presented a variety of programmatic endpoints. Please discuss and recommend key endpoints that should be considered in assessing and implementing male engagement programs, and suggest key indicators to measure results to achieve these endpoints.

Indicators for Prong 1

- % couples HTC and results together
- % men and women who know about importance of male involvement in PPTCT/MCH

Indicators for Prong 2:

- % couples receiving family planning
- % couples using FP

Indicators for Prong 3 and 4:

- % of women on treatment or prophylaxis
- % of babies on treatment or prophylaxis
- % of eligible fathers/males on treatment
- % of fathers supporting their partners, attending together with their partner and accepting intervention

Endpoints

- Baby born HIV negative at 6wks and 18 months
- Maternal mortality and on treatment
- Fathers HIV positive and on treatment

Group 4: Priority intervention approaches (Landry Tsague): This meeting would like to make preliminary recommendations on program approaches to strengthen male engagement. Eventually we would like to develop programming guidance for male engagement. Please discuss and list emerging priority approaches that can be used to strengthen male engagement.

Other Issues Arising from Group Discussions During Day Two:

- i. Engaging men also brings in psychological benefits for the couple, and benefits are likely to be increased when there is already a good relationship and communication within the couple.
- ii. We should keep the focus on couple counselling and testing and we should promote strategies to reduce the risk that adverse events will occur as a result of HIV disclosure.
- iii. Violence might exist within couples; however, linking it with couple counselling and testing might not always be accurate; violence may have precluded counselling and testing. However, concerns about violence necessitate very high quality service delivery and follow up.
- iv. Identification of male partners for HIV testing should be bi-directional, both from PMTCT and Care and Treatment programs
- v. The importance of cost-effectiveness and making good use of the limited budget available.
- vi. Men's involvement in PMTCT should be considered in a broader framework of couple sexual and reproductive health and maternal and child health. How do we create an environment that is conducive to couple attendance of MCH and SRH services?
- vii. Organizational partners with best practices in the area of male involvement are encouraged to publish them.
- viii. The Tanzanian experience highlighted the importance of promoting a friendly and supporting environment to male partners (health check and HIV testing, education about parenthood).

- ix. Costing and scalability of male involvement and other interventions should be further discussed. Given the current need to scale-up national responses, we should ensure that initiatives are embedded/shared within countries with the national technical working groups.
- x. The group did not reach a consensus whether the term PMTCT or PPTCT was better; just as many favoured PPTCT as preferred PMTCT.

Day Three: Friday 26 August 2011

Day Three – Opening Session: Day three began with a recap of Day Two, and then proceeded with a presentation about PEPFAR’s experience with male engagement, which was presented by **Kristina Grabbe** of CDC. She noted the risk of HIV infection for both men and women, the fact that incident maternal infections continue to increase the number of infected infants, and that stable cohabiting couples account for a large number of transmissions mostly because couple members lack awareness of their own sero-discordant status. She also presented the 5Ws of male engagement: What is it? Who should be engaged? When? Why? Where?

PEPFAR has supported several consultations on male engagement including two in 2007 and one in 2010 in Arusha (the findings are found at the following link: <http://www.womenchildrenhiv.org/wchiv?page=vc-10-08> .

PEPFAR programs aim to mainstream male engagement at all levels of implementation:

- i. National (through policy, advocacy and M/E)
- ii. Community (community mobilization for male engagement, e.g., Men Taking Action in Zambia),
- iii. Facility (making facilities male friendly, providing guidance, practices, outreach, integrated service delivery)
- iv. Provider (training, provider initiatives, e.g., invitation letters for men)
- v. Family/couple level (education, motivation, modification of norms, incentives, continuum of care).

PEPFAR programs see HTC as a beginning point, not an end point, in the engagement of males. Programs strengthen male engagement by integration within the MCH platform, providing a continuum of care for both women and their partners. The programs use the MCH platform to increase number of women involved and as an opportunity to link individuals and couples to appropriate prevention, care, and treatment services. Programs pay particular attention to women who test negative. Given the high rates of discordance, programs provide re-testing during pregnancy per country guidelines. Programs also pay close attention to women who test positive so that they can be assessed for treatment for their own health. The involvement of men and couples has therefore changed the paradigm of HTC.

Appropriate targets and indicators are essential for program monitoring and evaluation. However at present, there is no PMTCT indicator for male involvement. PEPFAR is harmonizing

its indicators with the WHO HTC M&E Guide and PMTCT IATT M&E Guide. There are two new recommended indicators for male involvement/couples HTC:

- % individuals aged 15+ years who received couples/partner HTC and learned the results of their HIV test together with their partner in the past 12 months (WHO HTC)
- % pregnant women attending ANC whose male partner was tested for HIV (WHO HTC & IATT)

There are currently no required PEPFAR indicators to monitor programmatic linkages but WHO HTC M&E Guide includes this proxy indicator, which PEPFAR supports:

- # newly identified HIV positive clients/patients / Total # new enrollees in HIV care

PEPFAR is developing new indicators to monitor linkage/continuum of care.

Panel Discussion - Resources for Scaling Up Best Practices: A panel discussion with three experts examined resources that countries could explore to scale up male engagement.

Francoise Ndishmaniye of the Global Fund discussed Round 11 of the Global Fund, which was launched in August. Proposals are due in December (update: the proposal deadline has been pushed back to March 2012). While countries have included male engagement in the past, their approaches have remained weak, unclear on the targets to be achieved, and often with no indicators to help gauge progress. She also discussed the opportunity to reprogram existing grants for PMTCT. She recommended that the meeting organizers hold a workshop on integration of male involvement in the four prongs of PMTCT for Round 11. Participants to the proposed meeting could include national AIDS authorities, principal recipients for GF grants, technical consultants who help countries prepare their proposals, and other TA providers. She suggested that the meeting focus on countries types C and D. She also suggested that the proposed meeting provide capacity building on integration in the context of male involvement.

Amy Medley of CDC Atlanta discussed resources available from PEPFAR, both financial and technical. She noted that in FY 2010, PEPFAR PMTCT programs directly supported:

- HTC for nearly 8.4 million pregnant women, of whom...
- More than 600,000 HIV-positive pregnant women received antiretroviral prophylaxis to prevent mother-to-child transmission, which led to...
- More than 114,000 children estimated to have been born HIV-free.
- These are the highest PMTCT results of any year in PEPFAR's seven-year history. The 114,000 infants born HIV-free add to the nearly 340,000 HIV-free infants from the previous years of the program

As part of the Global Plan, USG has pledged \$75 million in new PEPFAR PMTCT funding for FY2012, on top of the ~\$300 million in annual PMTCT funding. In addition, there were private sector pledges of \$40 million (Gates Foundation); \$20 million (Chevron), and \$15 million (Johnson & Johnson).

PEPFAR presently does not offer any guidance to countries about how to allocate PMTCT budgets for male involvement; countries make allocations based on programs and country priorities. PEPFAR is also providing \$38M on GBV through bilateral programs, and committed additional \$57M to bring programs to national scale in hard-hit Mozambique, DRC and Tanzania.

PEPFAR also has resources available through the Gender Challenge Fund Round I for country programs. About **\$9.95M of central resources are available to PEPFAR country programs** on a matching basis. Fifteen **countries** have received additional resources through the Gender Challenge Fund to date, and **Round 2** proposals due in September 2011.

Regarding training materials, PEPFAR has several resources:

Couple HTC: <http://www.cdc.gov/globalaids/Resources/prevention/chct.html>

HTC in PMTCT: <http://www.womenchildrehiv.org/wchiv?page=vc-10-00>

CDC is working with two organizations to provide south-to-south TA for couples HTC. This includes assistance in conducting needs assessments for Couples HTC, national planning, implementation, training of providers, policy and advocacy, communication and promotion of CHTC, and M/E. The countries where this will happen include South Africa, Malawi, Mozambique, Tanzania, DRC, Botswana, Kenya, and Swaziland. The contact person for this is Kristina Grabbe.

The final presentation was made by **Anita Asiiimwe**, who discussed the resource needs of Rwanda in order to scale up. She began by noting that Rwanda's male engagement approach is based on a comprehensive and integrated health system. It puts emphasis on gender-transformation and has put in place, policies and frameworks to support this approach.

Some of the ways it is funding its PMTCT services include:

- Community-based health insurance scheme, which targets more than 97% of the population with basic services (e.g. MCH). It was introduced in 1998-2000 and scaled up beginning in 2004. Its coverage is estimated at 91% (2010)
- Decentralization reform: District autonomy, and performance contracts with mayors means that indicators for PMTCT, including male engagement, are monitored and reported. Rwanda has also decentralized CD4 count system at district level, and task-shifted ARV initiation to nurses
- Performance Based Financing (PBF): Through this mechanism, Rwanda is able to improve equity, increase utilization, enhance quality, and increase efficiency of health services.
- Community Health Program roll-out: The extensive network of CHWs is able to increase demand and referral for follow-up and care.

In order to scale up and sustain services, the country needs financial, human and technical resources, including leadership and accountability, funding, integration, and comprehensive community participation.

DISCUSSION

Participants held an open discussion and reflection about what they had learnt. Some of the key points made included:

- i. The success of initiatives to scale up male involvement will depend on the involvement of high level leadership and the level of policy support that is in place
- ii. PMTCT is an important way to extend services and reach men. It is also an important platform to encourage men to become change agents in their communities
- iii. Men can be reached not only as partners but also as members of the community in their leadership roles
- iv. The challenge of providing male engagement services for women who are not in union, where “couples” do not exist, and where cohabitation is low (e.g., in parts of southern Africa)
- v. There is need to recognize that aggregate figures may mask considerable inequities – poorer women are less likely to access PMTCT services, and therefore efforts to reach them and their partners, need to be re-energized.
- vi. Male involvement is a gender inequity challenge that requires a cross-cutting social and political response from the highest levels of governance down to families and individuals
- vii. While research is still needed to better understand male engagement, it was felt that programs should move forward to involve men to maximize the number of lives saved. There is a cost to inaction.
- viii. Some methodological issues still remain, such as: how to define male engagement and identifying appropriate indicators for monitoring male engagement
- ix. There is need for an ecologically-based framework and approach in which to embed male engagement and the 4 prongs of PMTCT

Professor Coovadia reviewed highlights of the meeting. He noted three essential ingredients for male involvement in PMTCT:

1. Committed and supportive leadership;
2. Change in male behavior and the quality of relationships with women; and
3. Quality and integration of health services, including access, availability, facility structure, personnel attitudes and community outreach and engagement.

Male-friendly services are essential and integration across a wide spectrum of services is central to success in getting males involved in PMTCT (e.g. integrating family planning and PMTCT, integrating male and female services and facilities, integrating prevention/PMTCT facilities with treatment /ARV and care for women and men, integrating routine care with gender-sensitive counseling and care and integrating health facility-level care with community-level engagement).

Integration of health services should also address the continuum of conception, pregnancy, termination of unintended pregnancies, deliveries, postnatal care, and longitudinal HIV care and treatment for the woman’s own health after delivery. Integration should also uphold the human right of access to care as well as the right to decide on family size. When strategically implemented, integration leads to synergies and cost-savings.

Moving Towards a Conceptual Framework of Male Involvement in PMTCT: The four prongs of PMTCT provide multiple entry points for male engagement in the reproductive continuum, from prevention of HIV and the antenatal period, through delivery and the postnatal years, as well as for ongoing HIV care and treatment for the infant, mother and father. The impact of gender inequalities on each prong is evident from the data presented in the consultation. PMTCT is an opportunity to address Millennium Development Goals 3, 4, 5 and 6. Male engagement is linked to these goals too, through the promotion of gender equality and empowerment of women, reducing child deaths, improving women's health and effectively confronting some of the major killers of humankind (HIV, TB, malaria, non-communicable disorders and other diseases).

The diversity of material presented, and the relative newness of the subject in international HIV and MTCT discourse, dictated a pressing need for a unifying framework within which the evidence and ideas that emerged could be logically accommodated and arranged along the four prongs of PMTCT. It was felt that a framework based on the key issues of leadership, major epidemiological factors, programmatic interventions and policy implications was needed. These core elements could be applied to different levels of the health system based on the four prongs of PMTCT. Policy implications could involve recommendations to overcome male barriers to participation in PMTCT. The framework drafted at this meeting was an important start.

EMERGING ISSUES AND NEXT STEPS

Emerging areas needing further discussion included the following:

- i. More scientifically rigorous research is still needed. This can guide the weighing and prioritization of the interventions according their suggestive, probable or proven efficacy.
- ii. Measuring the impact of large-scale programs in developing countries. Scaling-up interventions shown to be efficacious.
- iii. Promoting and supporting strong national and global leadership.
- iv. Determining the policy implications of the data and experiences from this consultation. Developing national and global policies based on the available evidence of the likelihood of success with male involvement in PMTCT programs.
- v. Constructing a rational and comprehensive conceptual and strategic framework for issues related to male involvement in PMTCT.

Next Steps: Michael Mbizvo, Director of WHO/RHR, reviewed the key next steps as follows:

- i. Finalization of the background paper incorporating emerging issues and key recommendations – Eric Ramirez-Ferrero
- ii. Update conceptual framework to incorporate key actions from group work – Eric Ramirez-Ferrero and WHO
- i. Two or three page action note summarizing key considerations of the consultation – Prof. Coovadia
- ii. Develop policy briefs which articulate outcomes from Cochrane review which is about to be undertaken – UN agencies
- iii. Production of a case study on Rwanda – WHO/UNAIDS/MoH Rwanda

- iv. Proposal for a satellite session on male involvement at the forthcoming ICASA meeting (Dec 2011) – UNAIDS (in progress)
- v. Proposal for a satellite session on male involvement at the next IAS conference (Jun 2012) – WHO/UNAIDS

Prior to the close of the meeting, the participants were informed of a powerful bomb blast that had destroyed the lower floors of the United Nations building in Abuja, Nigeria that included the offices of UNICEF, UNAIDS and WHO. A moment of silence was held for the number of United Nations personnel and others who we had died or had been injured.

The meeting was closed by Anita Assimwe, Deputy Director General, Institute of HIV/AIDS, Disease Prevention and Control, Rwanda Biomedical Center.

**Sub-regional consultation to discuss strengthening male involvement in the
elimination of mother-to-child transmission of HIV & keeping their mothers alive
Kigali, Rwanda
24-26 August 2011**

A G E N D A

Day 1 – Wednesday, 24 August 2011

Day 1 – Wednesday, 24 August 2011		
Chairperson/Facilitator:	Hoosen Coovadia	
Co - Chair:	Anita Asimwe	
Time	Topic	Presenter
08:30 – 09:00	Registration	
09:00 – 9:30	<p>Introductions, objectives and expected outcomes</p> <p>Welcome and opening remarks</p> <p>Administrative announcements</p>	<p>Manjula Lusti-Narasimhan WHO/RHR and Karusa Kiragu, UNAIDS/ESR</p> <p>Agnes Binagwaho, Minister of Health, Government of Rwanda</p> <p>WHO</p>
Session 1	Overview	
9:30 – 10:00	Where are we? Status of male engagement in PMTCT globally and best practices - overview of background paper	Eric Ramirez-Ferrero
10:00 – 10:30	Discussion	
10:30 – 11:00	Break	
11:00 – 11:30	<p>Global perspectives (10 mins each):</p> <ul style="list-style-type: none"> ▪ The Global Plan for the Elimination of New Infections Among Children and Keeping their Mothers Alive ▪ Male involvement - key gap in SRH/HIV linkages <p>Discussion</p>	<p>Karusa Kiragu, UNAIDS</p> <p>Manjula Lusti-Narasimhan, WHO/RHR</p>
11:30 – 11:45	The prongs of PMTCT and implications for male engagement (7 mins each)	Sibili Yelbi, UNFPA (P1/2)
11:45 – 12:20	<p>Chairman's Address I: Recent Research Findings and Implications for PMTCT:</p> <ul style="list-style-type: none"> ▪ Treatment for Prevention (20 min) ▪ PrEP clinical trials (15 min) <p>Discussion</p>	<p>Hoosen Coovadia, UKZN</p> <p>Kim Dickson, WHO/HIV</p>
12:20—12:45	Discussion	
12:45 – 14:00	Lunch	
Chairperson/Facilitator:	H. Coovadia	
Co - Chair:	Anita Asimwe	
Session 2	National programme perspectives	
14:00 – 14:30	<p>Country experiences (7 mins each):</p> <ol style="list-style-type: none"> 1. Rwanda 2. Ethiopia 3. Niger 4. Zambia 	<p>Placidie Mugwaneza, GoR</p> <p>Adinew Mohammed, EH</p> <p>Yacine Diallo, UNFPA</p> <p>Moses Sinkala, CMMB</p>

14.30-15.00	Discussion	
15.00-15.25	Country experiences (7 mins each): 1. South Africa 2. DRC 3. Nigeria	Tim Shand, SGJ K. Kouroama, UNAIDS K. Ampomah, UNAIDS
15.25-15.45	Discussion	
15:45-16.00	Refreshment Break and Move Into Group Work	
16.00 – 17.00	Group work sessions: Other country experiences and report back (5 groups. Facilitators: Elena Ghanotakis, Helen Jackson, Laurie Gulaid, Francoise Ndishmaniye, Dieudonne Ruturwa)	
17.00—18.00	Report back	
	END OF DAY 1	
19:00	Welcome Reception	

Day 2 – Thursday, 25 August 2011

Chairperson/Facilitator: H. Coovadia
Co – Chair Kwame Ampomah

Time	Topic	Presenter
08:30 – 08:45	Report back of Day 1	Eric Ramirez and Amy Medley
Session 3	Strategies to scale up male engagement: An Ecological Approach	
08.45 – 09:05	Chairman's Address II: Cost Effectiveness of male engagement (20 mins)	Lorraine Sherr, UCL
09.05—9.20	Discussant and commentary	Felix Ndagije, CDC-R
9.20—10.00	Plenary discussion	
10.00 – 10:30	Empirical research (10 mins each) <ul style="list-style-type: none"> ▪ Male involvement in PMTCT and implications for child survival ▪ Engagement of men and service utilization 	Adam Aluisio, SUNY Boshishi Mohlala, ICL
10:30 – 11:00	Break	
11.00-11.20	Discussion of empirical research	
11.20 – 11.50	Strategies to scale up: Experiences from Organizations (10 mins each) <ul style="list-style-type: none"> ▪ mothers2mothers ▪ EngenderHealth ▪ Millennium Villages 	Ewa Skowronska Adinew Mohammed Phillip Wambua
11.50-12.10	Discussion	

12.10-12.40	Strategies to scale up: Experiences from Organizations (cont) <ul style="list-style-type: none"> ▪ EGPAF ▪ UNICEF ▪ UNFPA 	Elena Ghanotakis Chewe Luo Sibili Yelbi
12.40-13.00	Discussion	
13.00 – 14:00	Lunch	

Chairperson/Facilitator: Co – Chair	H. Coovadia Kim Dickson	
14.00—14.30	Barriers to male engagement: perspectives from health care providers (10 mins each)	Boshishi Mohlala, ICL Adam Aluisio, SUNY Muhadili Shemsanga, MVP
14.30—15.00	Discussion	
15.00 – 15.15	Role of HIV-positive male networks (15 mins)	Joseph Gumuyire, RRP+
15.15—15.30	Discussion	
15:30—16.00	Break	
16:00 – 17:30	Group work on the next steps (ICASA, Global Fund, Indicators, Policy Recommendations), and report back (6 groups. Facilitators: Kekoura Kourouma, Lorraine Sherr, Sibili Yelbi, Nyiramasarabwe Laurence, Landry Tsague, Susan Kiragu)	
	END OF DAY 2	

Day 3 – Friday, 26 August 2011		
Chairperson/Facilitator: Co – Chair	H. Coovadia Yacine Diallo	
08:30 – 08:45	Report back of Day 2	Eric Ramirez and Joseph Gumuyire
Session 4	Evidence and gaps	
08.45 – 9.15	Chairman’s Address: II Programming for male involvement – Lessons from PEPFAR	Kristina Grabbe, CDC
9.15—9.30	Discussant and commentary	Chewe Luo, UNICEF
10.00-10.30	Plenary discussion	
10:30 – 11:00	Break	
Session 5	Resources	
11.00 – 11:30	Panel Discussion: Resources for scaling up best practices (10 mins each)	Francoise Ndishimaniye, Global Fund Amy Medley, CDC Anita Asiiimwe, GoR
11.30-12.00	Discussion	
Session 6	Next steps	

12:00 – 13:00	<ul style="list-style-type: none"> ▪ Rappoteurs report: Emerging lessons and opportunities ▪ Key messages from the consultation ▪ Recommendations and next steps <p>Close of meeting</p>	<p>Eric Ramirez Hoosen Coovadia, MatCH Mike Mbizvo, WHO/RHR</p> <p>Minister of Health</p>
13:00+	Lunch and departure	

Sub-regional consultation to discuss strengthening male involvement in the elimination of mother-to-child transmission of HIV and keeping mothers alive

**Kigali, Rwanda
24-26 August 2011**

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Sub-regional consultation to discuss strengthening male involvement in the elimination of mother-to-child transmission of HIV

The World Health Organization, in collaboration with UNAIDS, UNFPA, UNICEF and the Ministry of Health of Rwanda, organizes at Kigali, Rwanda, a three days workshop, from 24th to 26th August 2011, on the strengthening male involvement in the elimination of mother-to-child transmission of HIV. The participants are experts from national Programmes of Mother-To-Child-Transmission (PMTCT) focal points of 6 selected countries in sub-Saharan Africa (Nigeria, Niger, Tanzania, Kenya, Senegal, Rwanda), managers of national programmes, international Programmes of Mother-To-Child-Transmission experts, policy-makers, representatives of national and international nongovernmental and civil society organizations including people living with HIV, representatives of UN agencies other partners and donor organizations.



Group photo: Male Involvement in MTCT/HIV Workshop, Kigali, 24/08/11

The general objective of the consultation is to look at the interface between policies and programmes for Sexual and Reproductive Health, maternal, neonatal and child health and HIV interventions, with a focus on strengthening male involvement in the elimination of Mother-To-Child-Transmission of HIV.

The focus of the training is a response and a way forward to these specific areas:

- help women and men remain HIV-free
- increase women's adherence to PMTCT programmes through support from her male partners;
- enhance the quality of services for men and women by addressing stigma and discrimination and potential benefits for maternal and newborn health outcomes;
- reducing violence against women following disclosure of HIV positive status;
- recognize and respond to the sexual and reproductive health needs of men, including men in key affected populations such as sex workers and young men;
- provide effective services to discordant couples; and
- strategies to increase awareness among health care providers and in communities.



Opening Ceremony: Minister of Health (right) and WHO Representative (left)



A view of participants

The opening ceremony of the workshop has been presided by the Minister of Health of Rwanda, Dr Agnes BINAGWAHO, in presence of the acting WHO Representative, Dr Boureima Hama SAMBO. In their speeches, they expressed that Rwanda has been honoured to host this meeting and the country's leadership role in the fight against HIV and especially male involvement with male testing in antenatal care services being among the highest at 84% in June 2011. During the workshop, participants will have the opportunity to exchange experiences from countries on the prevention and fight against HIV/AIDS and the involvement of men in the prevention of transmission from mother to child at national level.

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