

MALE ENGAGEMENT IN HIV TESTING, TREATMENT AND PREVENTION IN EASTERN AND SOUTHERN AFRICA

A framework for action



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FOREWORD



Reaching the Sustainable Development Goal target to end AIDS as a public health threat by 2030 requires focusing on and prioritizing people who are not yet accessing lifesaving HIV services. Women are still disproportionately affected than men by HIV, especially in terms of HIV transmission, but men in Eastern and Southern Africa are less likely to access services. They use HIV testing services less, and are less likely to initiate antiretroviral therapy and to remain engaged in care than their female counterparts. Men who are in antiretroviral therapy programmes are 70% more likely to die than women because of their poor health seeking behaviour.

Prevailing harmful norms of masculinity are a key factor contributing to this disparity. Toxic gender norms that equate “illness” with “weakness”, and that consider sexual and reproductive health a foremost female issue, lead to poor health seeking behaviour and lower health service uptake among men in their diversity. Programmes that challenge these norms are far and few between, but are urgent and necessary to achieve the targets to end AIDs. However, norms are only one among many factors.

In the discourse of “men and HIV”, the architecture of the health system and health service delivery ought to be interrogated. Are health institutions organised in ways that promote access to services for men and boys in their diversity? Do HIV-related health system policies and strategies include men, especially men at high risk of HIV? How can services be reconfigured to increase uptake by men and boys across the board? How do stakeholders reconfigure service delivery effectively within resource-constrained settings without causing an unintended negative impact on other service users?

This framework provides insights into some of these questions. It categorises existing research, knowledge and best practices and outlines the necessary building blocks for planning, implementing, and monitoring improvement in the HIV response among men and boys within a broader gender equality framework. The framework is an evidence-based action road map to guide the development of national strategies; when contextualized to local and national contexts and epidemiological situations, the framework provides a foundation for country-led movements to achieve the globally agreed HIV goals in the Global AIDS Strategy 2021–2026 and work towards achieving gender equality.

The road ahead is clear. The urgent and hard work of implementation with the close engagement with men needs to begin now.

A handwritten signature in black ink, appearing to read 'Anne Githuku-Shongwe'.

Anne Githuku-Shongwe
Regional Director, UNAIDS East and Southern Africa

EXECUTIVE SUMMARY

Overview

Over the past decade, it has become increasingly clear that men and boys are less likely than their female counterparts to test for HIV, to initiate antiretroviral therapy, and to remain engaged in care. They are also dying from AIDS-related causes at disproportionately higher rates. Globally, knowledge of HIV status is lower among men and boys, and antiretroviral therapy coverage of men lags behind that of women (1).

In many countries in eastern and southern Africa, the region with the highest HIV burden globally, more than half of men aged 24–35 years living with HIV are unaware of their HIV-positive status and are not on treatment (2). This imperils their own health and increases the risk of transmission. The identification and diagnosis of men who do not know their HIV-positive status is essential in promoting men's health and breaking the cycle of HIV transmission (3).

Since 2009, a growing number of studies have raised the alarm about men's and boys' low involvement in HIV services and urged action on two fronts: to challenge the social, cultural and gender norms about manhood that encourage men to take excessive risks, be overcontrolling, and view health-seeking behaviours as a sign of weakness (4, 5); and improve health system policies, programmes and service delivery strategies to ensure better provision of HIV services for men and boys (6).

A significant body of research and experience shows that a range of complex, multilevel factors contribute to men's and boys' low uptake of HIV-related services (7–10). Although some barriers are the product of prevailing harmful gender norms—such as equating illness with “weakness” and viewing clinical settings as “female spaces”—there are many other factors that contribute to the status quo. Men and boys lack the universal entry points to health systems that women and girls generally have. Limited opening hours and facility-based service delivery models further restrict access for men who work outside their communities during the day. Health-system constraints go beyond the service delivery level. In most countries, men are largely missing from public health strategies, and there is little or no mention of strategies or activities to improve their access to health and HIV services. A broader enabling environment needs to be intentionally created, including laws, policies and health strategies.

The health and lives of men and boys intertwine with those of women and girls. Gender inequalities and associated harmful gender norms about femininities and masculinities disproportionately affect women's and girls' sexual and reproductive health and rights, with only 55% of women having autonomy in reproductive health decision-making and being empowered to exercise their reproductive rights (11, 12). This contributes in clear and direct ways to women's and girls' vulnerabilities to HIV infection (13–16).



Transforming harmful gender norms among men and boys will decrease vulnerability for men, their partners and their children. Working to improve access to health services for men and boys—such as extending clinic operating hours or improving community- or work-based service provision—alongside other health system interventions will go a long way to improving access to health services for communities. Enabling men to stay free from HIV, get tested regularly, and start and stay on treatment will not only improve male health outcomes but also contribute to declines in new HIV infections among women and girls. We must implement far more ambitious interventions aimed at advancing gender equality and improving men’s and boys’ access to sexual and reproductive health and rights and HIV education and services.

In the era of the Sustainable Development Goals, it is recognized that HIV does not operate in a silo. As part of universal health coverage, HIV policies, programmes and services need to be integrated into existing primary health services, systems and budgets. To succeed in “getting to zero” and ending AIDS as a public health threat by 2030, there needs to be accelerated action at multiple levels to reach men with HIV services by addressing existing barriers to men’s and boys’ use of HIV services and scaling up what has been proven to work.

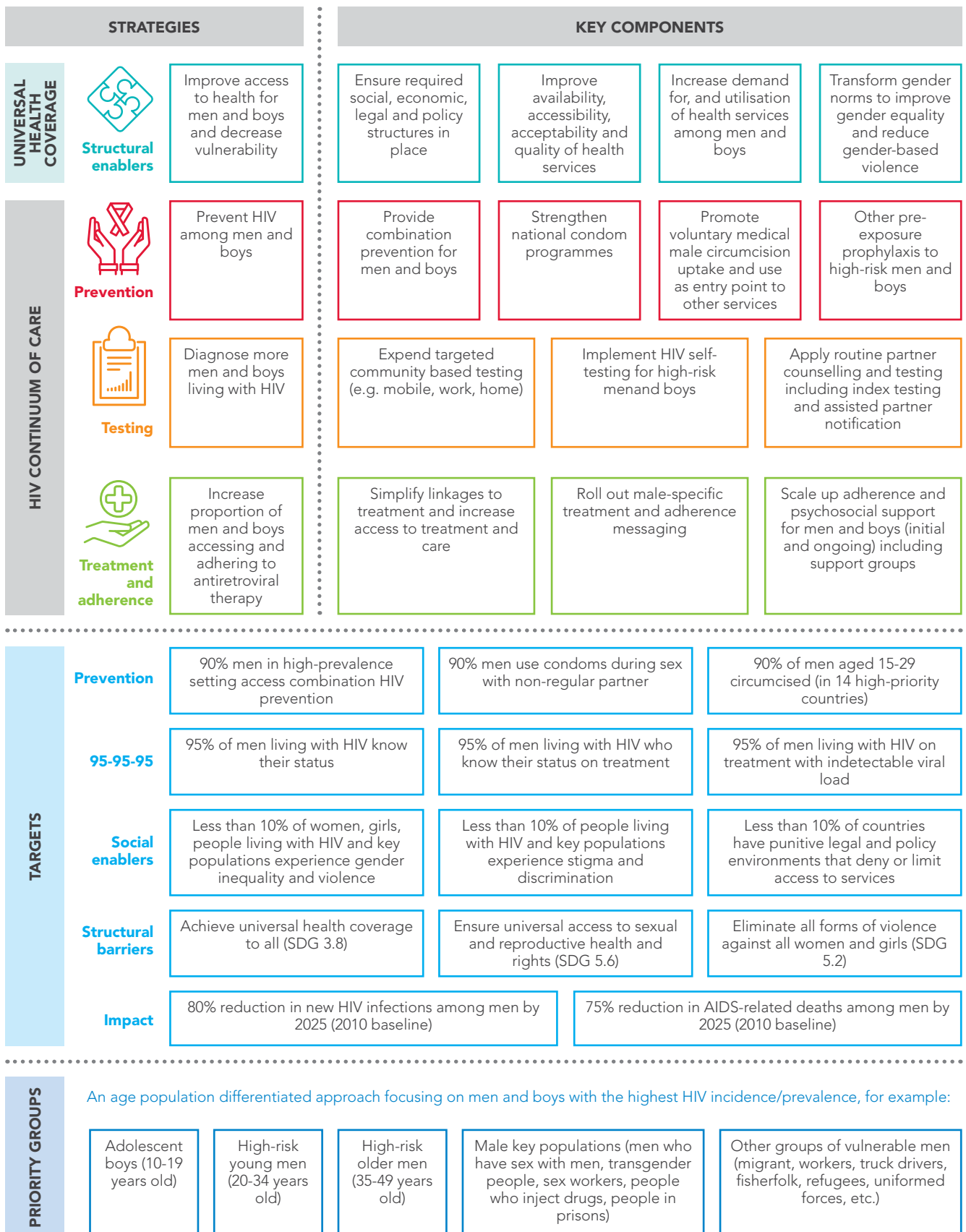
Framework for action

The framework for action for male engagement in HIV testing, treatment and prevention in eastern and southern Africa (Figure 1) provides a foundation for country-led movement to achieve the globally agreed HIV goals in the Global AIDS Strategy 2021–2026 and work towards achieving gender equality (17). Integral to achieving these targets is successfully reducing new HIV infections and AIDS-related deaths among men and boys and decreasing HIV-related vulnerability. The framework categorizes existing research and best practice, outlining the necessary building blocks for planning, implementing and monitoring improvement in the HIV response among men and boys within a broader gender equality framework.

The framework outlines effective strategies in two overarching areas:

- **Structural enablers:** these support universal health coverage and HIV-specific goals. Specific prevention, testing, treatment and adherence strategies rely on these broader strategies. They are also essential for engaging men and boys in the health sector more generally. Strategies include transforming social, economic, legal and policy structures; addressing supply- and demand-side factors; and transforming gender norms. For any of these interventions to be effective, a comprehensive and multifaceted response at scale is required.
- **HIV-specific programmatic strategies:** these include interventions across the HIV continuum, such as prevention, testing, treatment, care and support. They happen through a differentiated care approach within health facilities and the community.

Figure 1. Framework for action for male engagement in HIV testing, treatment and prevention in eastern and southern Africa



This framework is not a toolkit to be implemented as is. Instead, it summarizes what is currently working across eastern and southern Africa and provides an overview of what is required at the country level to meet the globally agreed HIV Fast-Track goals.

Priority groups and a differentiated approach

Men and boys are not a homogeneous group. They have diverse experiences and identities, and each man has his own specific health needs. Some groups of men and boys, however, have a distinct set of HIV-related health needs due to particular risks and vulnerabilities. This is primarily due to age, sexual orientation and intersections with a range of other factors, including poverty and inequality. An age- and population-differentiated approach should be used, focusing on the groups of men and boys with the highest HIV incidence and prevalence according to each country's latest epidemiological data.

Where to start?

To turn the framework for action into a workable plan, the following country-level steps are suggested:

- 1** Convene a national working group on men's and boys' health to discuss and coordinate actions around country-level data, including gaps and high-priority actions to address toxic sociocultural norms, gender inequalities and poor HIV outcomes among men and boys. This group could be a technical working group or similar mechanism closely linked to existing HIV-related technical working groups.
- 2** Develop a national road map for action, including a clear timeline and country-specific targets. The road map will outline key programmes and activities to reduce new HIV infections and AIDS-related deaths among men and boys, and decrease their HIV vulnerability. The road map should include adolescent-centric approaches that address high-priority issues for boys aged 10–19 years.
- 3** Integrate men's and adolescent boys' health needs into health plans and policies, such as including men as a target population with particular vulnerabilities, and addressing harmful gender norms and harmful masculinities in national HIV plans and other health policies and strategies. Developing separate national men's and adolescent boys' health policies has been shown to improve men's health, advance gender-transformative health care for men and women, and advance gender equality more broadly (18).
- 4** Commit to strengthening data collection and publishing HIV and antiretroviral therapy data disaggregated by age, sex and other available stratifiers. National monitoring and evaluation systems such as DHIS2, and separate HIV monitoring and evaluation systems, may need to be adapted to enable this.

- 5** Strengthen strategic alliances, partnerships and outreach. Build collaboration at all levels, including with non-health ministries, the private sector, networks of key populations, youth and women's organizations, trade unions, and networks working with men and boys.

These steps require the support of diverse stakeholders and partners. The following global and regional actions are proposed for researchers, programmers, policy-makers, donors and civil society:

- Provide coordination and technical support. The Joint United Nations Programme on HIV/AIDS (UNAIDS) in collaboration with WHO and UNWOMEN are to coordinate this body of work for the first two or three years. After this, an assessment should be conducted to map a more feasible and efficient coordination mechanism. In the long term, UNAIDS should consider setting up an interagency working group on men, adolescent boys and HIV in eastern and southern Africa. This working group could consist of governments, donors, United Nations entities, civil society and research partners that provide high-quality technical support to each of the focus countries.
- Share what works. UNAIDS will make available, through a clearing house, the latest research, guidance and best practice on what works to engage men and boys and address harmful masculinities in the HIV response (19). This clearing house will run under the auspices of the coordinating entity and, as this is a rapidly evolving field, be updated regularly.
- Mobilize resources. Specific funding is required to strengthen male engagement in the HIV response and to support countries developing and implementing their road maps. Funding will need to be sourced innovatively as these initiatives will not be able to rely entirely on traditional donors. Likewise, new programmes can not be supported from existing budgets without the risk of negatively affecting the situation for women and girls.

Conclusion

To end the HIV epidemic by "getting to zero", there needs to be accelerated action, at multiple levels and across the HIV cascade, to reach men and boys with HIV services. The framework for action outlines the required building blocks for planning, implementing and monitoring improvements in the HIV response among men and boys within a broader gender equality framework.

INTRODUCTION

Background

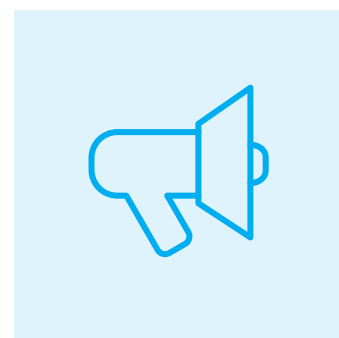
Over the past decade, it has become increasingly clear that men and boys are less likely than their female counterparts to test for HIV, initiate antiretroviral therapy and remain engaged in care. They are also dying from AIDS-related causes at disproportionately higher rates. Globally, knowledge of HIV status is lower among men and boys, and antiretroviral therapy coverage of men lags behind that of women (1).

In many countries in eastern and southern Africa, the region with the highest HIV burden globally, more than half of men aged 24–35 years living with HIV are unaware of their HIV-positive status and are not on treatment. This imperils their own health and increases the risk of transmission (2). The identification and diagnosis of men who do not know their HIV-positive status is essential in improving men's health and in breaking the cycle of HIV transmission (3).

Gender inequalities and associated harmful gender norms about femininities and masculinities disproportionately affect women's and girls' sexual and reproductive health and rights, with only 55% of women having autonomy in reproductive health decision-making and being empowered to exercise their reproductive rights (11, 12). This contributes in clear and direct ways to women's and girls' vulnerabilities to HIV (13–16). Similarly, prevailing norms that are co-created and co-enacted by men and women have a direct impact on the health of men and boys (20).

For the global HIV response to be effective and to improve the overall health of men and women, greater attention must be paid to addressing the crisis of men's and boys' access to, and outcomes in, HIV care (21). Since 2009, a growing number of studies have raised the alarm about men's and boys' low involvement in HIV services and urged action on two fronts: to challenge the social, cultural and gender norms about manhood that encourage men to take excessive risks, be overcontrolling, and view health-seeking behaviours as a sign of weakness (4, 5); and to improve health system policies, programmes and service delivery strategies to ensure better provision of HIV services for men and boys (6).

The health and lives of men and boys intertwine with those of women and girls. Transforming harmful gender norms among men and boys will decrease vulnerability for men, their partners and their children. Working to improve access to health services for men—such as extending clinic operating hours or improving community- or work-based service provision—alongside other health system interventions will go a long way to improving access to health services for communities. Enabling men to stay free from HIV, get tested regularly, and start and stay on treatment will not only improve male health outcomes but also contribute to declines in new HIV infections among women and girls.





Artists visiting South Africa to raise awareness about HIV. July 2015. © UNAIDS.

Transforming harmful masculinities is also critical to reducing risks and vulnerabilities to HIV among women and adolescent girls, including by respecting their sexual and reproductive health and rights and upholding zero tolerance for violence against women and girls. Intimate partner violence perpetrated by men and adolescent boys is associated with a 50% higher chance of women survivors of such violence acquiring HIV in high-prevalence settings (22). In eastern and southern Africa, the proportion of women who have ever experienced physical or sexual violence by their husband or male partner ranges from 6.4% to 46.7% (median 35.4%) (23). We must implement far more ambitious interventions aimed at advancing gender equality and women's and girls' rights and agency, and improving men's and boys' access to sexual and reproductive health and rights and HIV education and services.

Health-system challenges contribute significantly to men's and boys' low uptake of HIV-related services in many countries in the region (10). Although some barriers are the product of prevailing gender norms—such as men viewing clinical settings as “female spaces” dominated by women and children and female nurses—many other factors also contribute (10, 24, 25). Men and boys lack the universal entry points to health systems that women have due to menstrual health needs,

contraceptive methods, and increased health-care visits during pregnancy (9, 26). Limited opening hours and facility-based health care are access barriers for men and women who work outside their communities during the day (27–29). Some researchers have argued that many men are ready and willing to engage in HIV services but are deterred by poor access and other barriers (28, 29). When HIV testing is provided where men are—for example, in the community or in the workplace—men use these services at the same rates as women (7, 30). Similarly, antiretroviral therapy initiation and adherence rates greatly improve when community-based service delivery models are used (31–33).

To address other health-system obstacles, a broader enabling environment needs to be intentionally created, including laws, policies and health strategies. In most countries globally, men and boys are largely missing from public health policies and strategies, which omit activities to improve men's and boys' access to HIV and other health services (28, 34). Similarly, national health indicators often focus on women's and children's health, largely disregarding men's use of services and their subsequent health outcomes (35).

As a result, researchers increasingly highlight the global gender gap in men's health-care access and outcomes as a worrying blind spot in global health research, policy and practice (36–38). By engaging men as clients of health services themselves—and intensifying their engagement more broadly as partners and agents of change for gender equality and HIV prevention—their own health is improved and the risk of HIV transmission to their sexual partners is reduced (14).

In eastern and southern Africa, the HIV epidemic is largely heterosexually transmitted. To effectively address a predominantly sexually transmitted infection, both partners must be tested and people who test positive must be started on treatment. It is imperative to address the relational dynamics of mitigating HIV risk between partners (39). Additionally, it is critical to reach people from key populations and other high-risk groups, such as people who inject drugs, people in prisons and other closed settings, gay men and other men who have sex with men, transgender people, and adolescents and young people. These people face multiple layers of marginalization, stigma and discriminatory laws and policies, and they may have limited access to health services. Gay men and other men who have sex with men are key in flattening the curve of new infections. As almost all countries in the region still criminalize same-sex relationships, a substantial number of gay men and other men who have sex with men may not identify as such, or may only have sex with other men occasionally and under specific circumstances (e.g. when confined in a correctional facility). They may not be aware of their risks and may have less access to information and services designed specifically for people from the lesbian, gay, bisexual, transgender and intersex (LGBTI) community (40).

In the era of the Sustainable Development Goals, it is recognized that HIV does not operate in a silo. As part of universal health coverage, HIV policies, programmes and services need to be integrated into existing primary health services, systems and budgets. There needs to be accelerated action at multiple levels to reach men and boys with HIV services.

Purpose and scope

This framework provides the building blocks required to plan, implement and monitor improvements in the HIV response among men and boys. It was developed following a comprehensive literature review (41). The review covered 300 peer-reviewed articles and grey literature published since 2014 with a focus on eastern and southern Africa and drew on an unpublished 2015 literature review (42). The framework was refined during a regional consultation in May 2019, convened by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Sonke Gender Justice, which included governments, academia, traditional and religious groups, civil society organizations, United Nations partners and donors. It provides a summary of what is currently working and, following country dialogues, can be rapidly and strategically taken to scale.

Peer educators in an artisanal mining community, Kadoma District, Zimbabwe. November 2019. © UNAIDS/C. Matonhodze.





Soud Khamis Soud,
a volunteer at ZAPHA+
and a young person
living with HIV. Zanzibar,
Tanzania. October 2019.
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HIV EPIDEMIC AMONG MEN AND BOYS

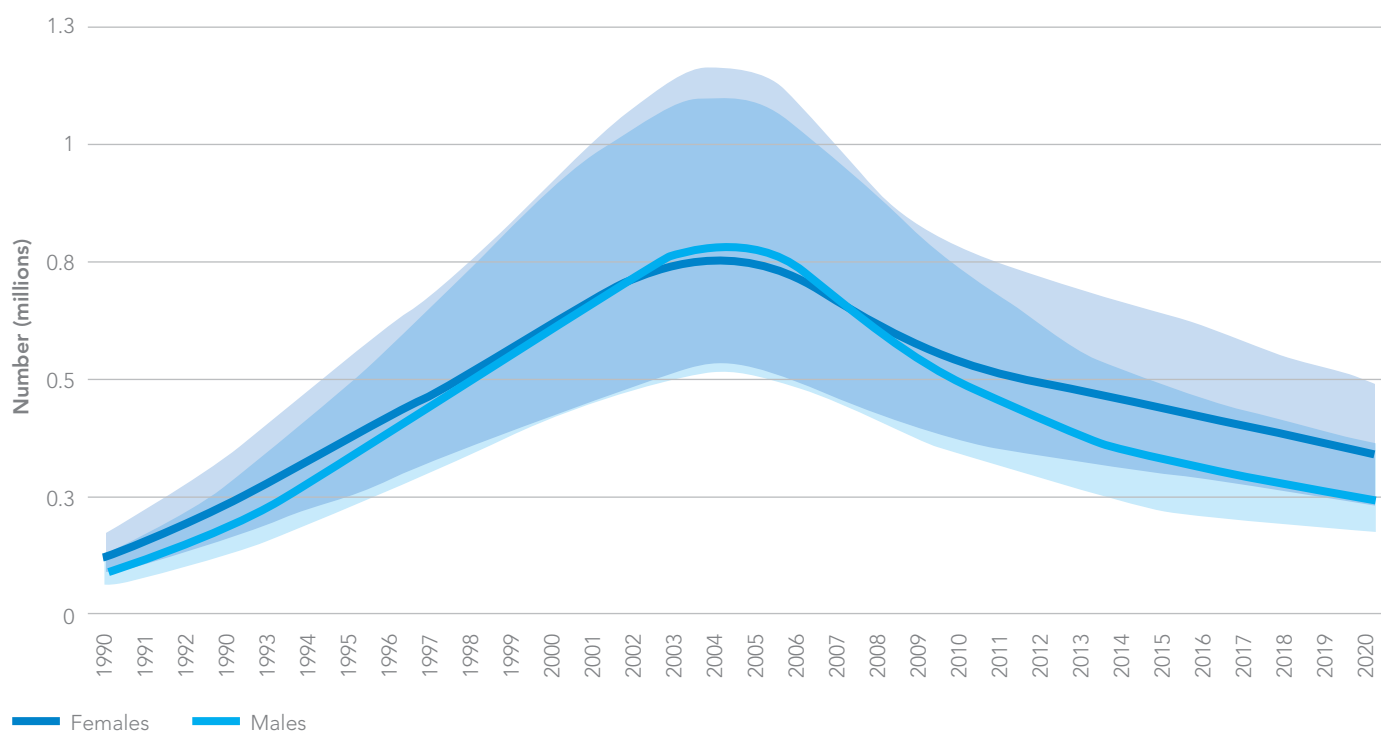


Overview

According to UNAIDS 2021 estimates, there are 20.6 million people living with HIV in eastern and southern Africa (12.9 million females, 7.7 million males), with 63% of new infections among women and 37% among men of all ages (43). Women are therefore disproportionately represented.

When comparing prevalence figures with AIDS mortality, however, one report stated: "AIDS prevalence may have the face of a woman, but AIDS mortality has the face of a man" (28). In 2020, there were 680 000 AIDS-related deaths globally, of which 57% were among men and 43% among women of all ages (43). Over time, globally, the success of expanding treatment coverage among women has led to more rapid declines in deaths among women living with HIV (Figure 2). Among people who initiated antiretroviral therapy in 14 sub-Saharan countries, men had a 37% increased risk of death compared with women (44). This pattern is replicated at the global level: there is a life expectancy gap of up to 10 years between men and women living with HIV (7), and men in antiretroviral therapy programmes are 70% more likely to die than women (45).

Figure 2. AIDS-related deaths among people aged ≥ 15 years, by sex



Source: UNAIDS epidemiological estimates, 2021.

AIDS-related deaths among men aged 15–24 years are broadly static year on year, but they are decreasing considerably among young women of the same age. Between 2010 and 2020, AIDS-related deaths declined by 31% among women aged 15–24 years but increased by 5% among males of the same age (43).

HIV prevention

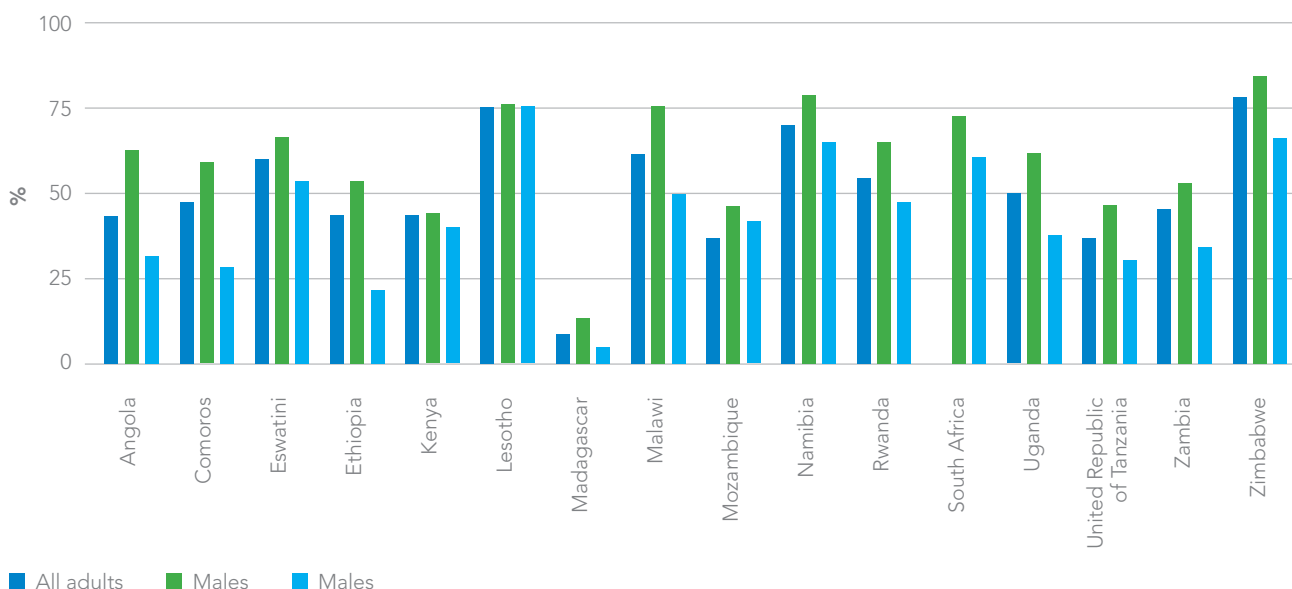
The number of new HIV infections in eastern and southern Africa fell from 1.3 million in 2010 to 670 000 in 2020 (43), but this was a long way short of the Fast-Track target of a 75% reduction by the end of 2020 (46). Of the 600 000 new HIV infections in adults aged 15 years and over in the region, 65% are among women and 35% among men (43).

Condom use is an important marker for understanding the state of the HIV epidemic. Condoms significantly reduce the risk of HIV transmission (and unintended pregnancy) and are a male-controlled and primarily male-initiated barrier method. Understanding condom trends and ensuring consistent accessibility and use of condoms by men is important in halting the HIV epidemic. In eastern and southern Africa, condom use among men is far from consistent. In only 4 countries did more than 75% of men report using a condom at last high-risk sex (Figure 3) (43).



WHILE AIDS-RELATED DEATHS ARE DECREASING CONSIDERABLY AMONG YOUNG WOMEN, THE NUMBERS OF DEATHS REMAIN STATIC FOR MEN OF THE SAME AGE GROUP.

Figure 3. Condom use by people aged 15–49 years at last high-risk sex, by country



Source: Global AIDS Monitoring, 2020.

The percentage of men who use a male condom during sex with a nonmarital, non-cohabiting partner declines dramatically among older men. Data from population-based surveys conducted in 23 countries in sub-Saharan Africa between 2008 and 2016 show that 36% of men aged 20–24 years did not use a condom during their last sexual intercourse with a nonmarital, non-cohabiting partner—but this number was 47% for men aged 30–34 years and 90% for men aged 55–59 years (1). These older men were more likely to be living with HIV, as prevalence peaks among men aged 40–44 years across the 23 countries. Of men aged 40–44 years, 20% had sex with a nonmarital, non-cohabiting partner during the past 12 months, and only half used a condom when they did (1). The data appear consistent with studies showing a cycle of HIV transmission in high-prevalence settings, such as in KwaZulu-Natal in South Africa, from older men to younger women, and from adult women to adult men of a similar age (3).

Other elements of a combination prevention approach include access to pre-exposure prophylaxis (PrEP) and voluntary medical male circumcision. No sex-disaggregated data are available for PrEP for eastern and southern Africa, and only 4 countries in the region (Botswana, Kenya, Lesotho, Zimbabwe) reported more than 1000 people receiving oral PrEP in 2019 (47). There is a global target to provide voluntary medical circumcision to an extra 25 million young men aged 10–25 years between 2016 and 2020 in 14 high-priority countries, all within eastern and southern Africa (48). Between 2016 and 2019, 15.1 million voluntary medical male circumcisions were carried out in eastern and southern Africa, with the largest contributors being South Africa, Uganda and the United Republic of Tanzania (47).

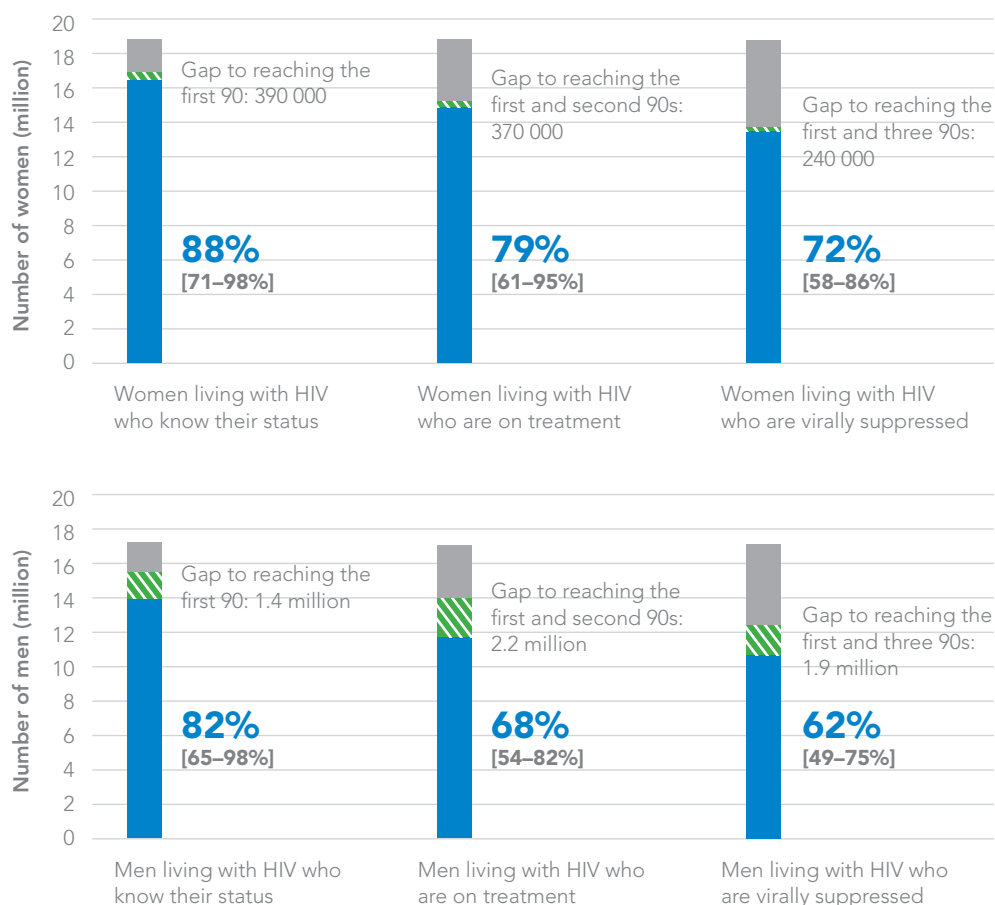


Peer educators in an artisanal mining community, Kadoma District, Zimbabwe. November 2019. © UNAIDS/C. Matonhodze.

Access and uptake across the HIV diagnosis, treatment and care cascade

In the era of antiretroviral therapy, a person who knows their HIV-positive status should have uninterrupted access to good-quality treatment and adherence support and should not die from AIDS-related causes. In general, men have a lower life expectancy than women (about 5 years) (49); this gap is even higher between men and women living with HIV (up to 10 years) (7). Globally, men living with HIV are less likely than their female counterparts to know their HIV-positive status and to initiate antiretroviral therapy; they initiate antiretroviral therapy at an older age and with more advanced disease; and they are less likely to remain engaged in care (1, 8, 50). There is, therefore, a greater gap in meeting all three 90–90–90 targets among men and boys (Figure 4).

Figure 4. HIV testing and treatment cascade, people aged 15 years and over, global, 2020

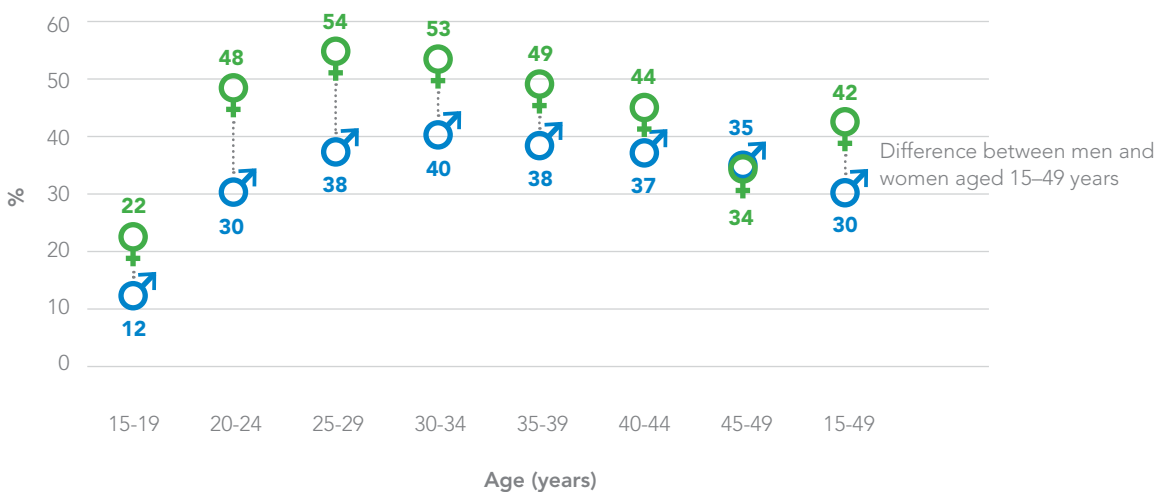


Source: UNAIDS special analysis, 2021.

HIV testing

The entry point to the HIV treatment and care cascade is HIV testing. Knowledge of HIV status is lower among men than women at most ages in sub-Saharan Africa, but this gap is particularly stark among adolescent boys. According to population-based surveys, only 11% of boys and young men aged 15–19 years have ever taken an HIV test and received the results, compared with 22% of girls and young women of the same age (Figure 5) (1). The significant differences in testing rates between women and men are evident across the 15–45 years age range but disappear in the 45–49 years age range. The testing gap appears to reflect women’s entry points into health systems through sexual and reproductive health and rights programmes. In some settings, men and non-pregnant women initiate voluntary counselling and testing and initiate antiretroviral therapy at similar rates (28).

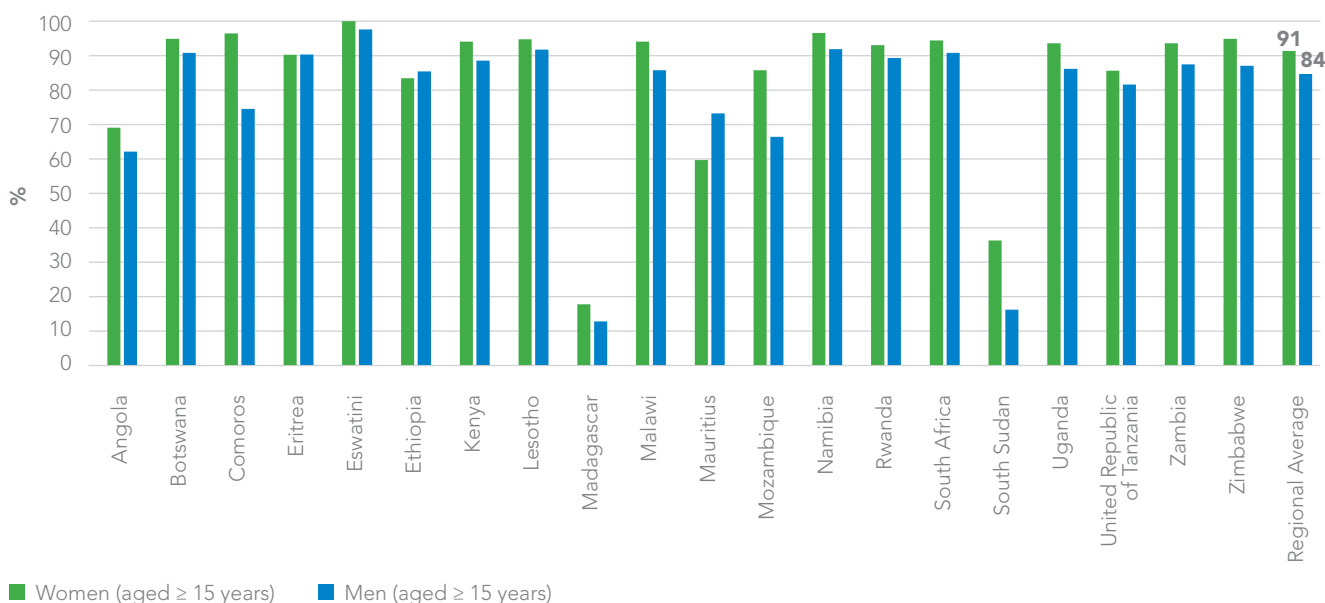
Figure 5. Percentage of adults who have ever tested for HIV and received their results, by age and sex, sub-Saharan Africa, 30 countries, most recent data, 2011–2016



Across eastern and southern Africa, the percentage of women living with HIV who know their status is higher than men in every country except Ethiopia and Mauritius (Figure 6) (47).

Testing for HIV remains the critical first step for linkage into the HIV cascade of care (51). Some evidence suggests that when people know their HIV status, they may be more likely to take steps to remain free from HIV (52, 53). It is clear that low HIV testing rates among men endanger their own health and increase their risk of unknowingly transmitting HIV to their sexual partners. In particular, there is a cycle of transmission, with men aged 24–35 years transmitting HIV to women aged 15–24 years, who then transmit HIV to their male peers aged 24–29 years (3). Tied into this are intergenerational transactional sex, power imbalances and gender inequality.

Figure 6. Percentage of people living with HIV who know their status, by sex, eastern and southern Africa



Source: prepared by Regional Support Team Strategic Information Hub based on Joint United Nations Programme on HIV/AIDS estimates, 2020.

Treatment adherence and antiretroviral therapy coverage

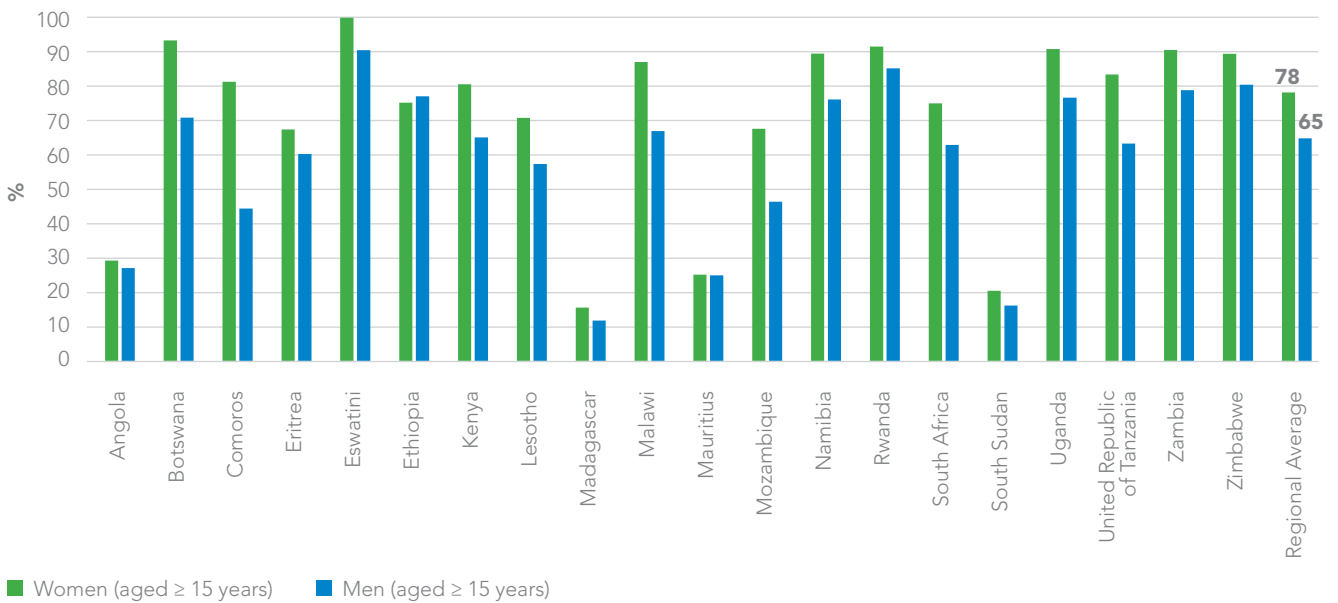
HIV testing is the gateway to lifesaving treatment for people living with HIV and a means to reinforce prevention among people who are free from HIV. This can decrease morbidity, mortality and risk of transmission, and contribute to people living longer and healthier lives (54). This has major implications for all—undiagnosed and untreated HIV infection means higher viral loads, increased chance of transmitting HIV, significant and expensive challenges restoring people to good health, and increased mortality (55).

Across sub-Saharan Africa, antiretroviral therapy coverage among men lags behind that of women (38, 43, 44, 56, 57). In eastern and southern Africa, antiretroviral therapy coverage is 78% among women living with HIV and 65% among their male counterparts (Figure 7) (47). When men do seek treatment, they tend to have more advanced disease and are more likely to interrupt treatment and be lost to follow-up than women (58, 59). Due to late initiation of treatment, mortality rates are higher among men than women living with HIV (60).

Gender norms

Gender inequalities and associated harmful gender norms about femininities and masculinities disproportionately affect women’s and girls’ sexual and reproductive health and rights. Worldwide, only 55% of women have autonomy in reproductive health decision-making and are empowered to exercise their reproductive rights (11, 12). Transforming harmful masculinities is critical to reducing the risks and vulnerabilities to HIV among women and adolescent girls. In eastern and southern Africa, the proportion of women who have ever experienced physical or sexual

Figure 7. Percentage of people living with HIV on antiretroviral therapy, eastern and southern Africa

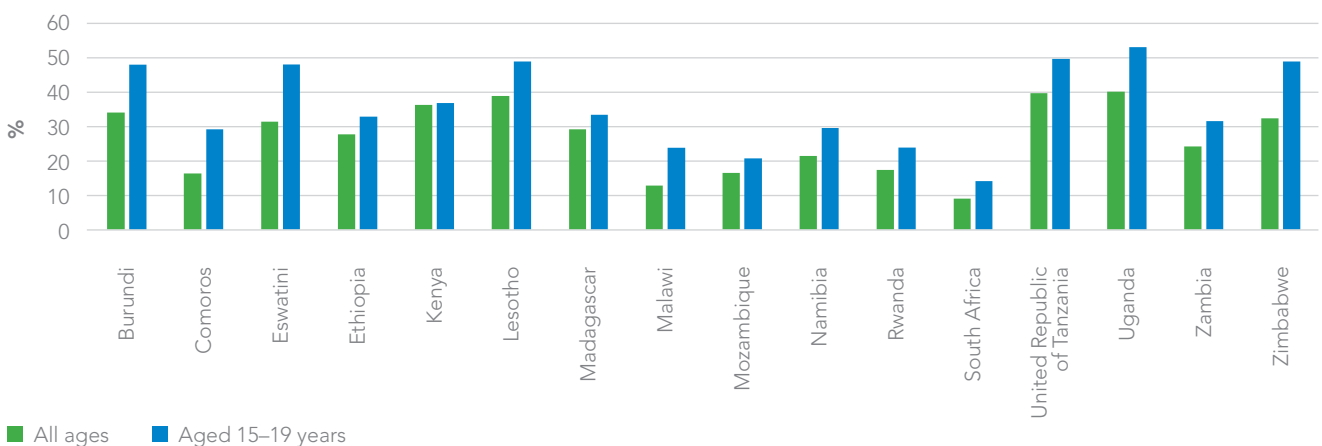


Source: prepared by Regional Support Team Strategic Information Hub based on Joint United Nations Programme on HIV/AIDS estimates, 2020.

violence by their husband or partner ranges between 6.4% and 46.7% (median 35.4%) (23).

These levels of gender-based violence do not look like they are going to decrease, as demonstrated by the proportion of men who believe wife-beating is “justifiable” for at least one reason (Figure 8).¹ The median proportion of men of all ages who believe wife-beating is “justifiable” is 28%, but this increases to 33% for men aged 15–19 years in every country (23).

Figure 8. Men who believe wife-beating is “justified” for at least one reason



Source: Demographic and Health Surveys (latest year available, 2007–2020).

¹ The options given are burning food, arguing with him, going out without telling him, neglecting children, and refusing to have sex with him.

Men in all their diversity

Men are not a homogeneous group, and some are at far greater risk of acquiring HIV than others. For example, the risk of acquiring HIV is 27 times higher among gay men and other men who have sex with men than men in the general population; the highest median prevalence among this population is found in sub-Saharan Africa (43). Gay men and other men who have sex with men are more likely to acquire HIV at a younger age. They may face structural barriers to accessing HIV and other services as a result of their sexual or gender identity and widespread homo- and transphobia and criminalization of same-sex relations (61).

In South Africa, where the constitution protects human rights regardless of gender or sexual identity, the prevalence of HIV among gay men and other men who have sex with men is still troublingly high (13.5% in Soweto, 49.5% in greater Johannesburg), and knowledge of HIV status among those living with HIV is low (62). Baseline results from the Mpumalanga Men's Study, which assessed the Project Boithato HIV prevention intervention in two districts of South Africa, found that fewer than 1 in 5 participants living with HIV were linked into care, and only 1 in 10 were on antiretroviral therapy (62). Additional research into effective methods to link and retain gay men and other men who have sex with men into care is urgently needed.

Thobani Ncapai gets his haircut by Nceba Noubewu, in Khayelitsha, Cape Town, South Africa. 2017.
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Dwayne Senior.





Pride event in Maseru, Lesotho, organized by People's Matrix Association, campaigning for the rights of LGBTI people. November 2019. © UNAIDS/M. Hyoky.

People in prisons and people who inject drugs are at increased risk of HIV. These populations are also disproportionately men. For example, people in prisons in South Africa are 2.4 times more likely to be living with HIV than people in the general population (61). Globally, the ratio of people detained short and long term is 3 to 1 (on any given day, 30 million people are in short-term correctional facilities and 11 million are detained for a longer term) (63). The health of people in prisons is paramount as both a human rights and a public health issue. As the vast majority of people in prisons are in short-term detention, HIV incidence in correctional facilities has a spillover effect on the broader community once people are released (64).

Other groups that are neglected despite their particularly high risk for HIV include migrant and mobile workers, male sex workers (46), and heterosexual men aged 24–35 years in high-prevalence countries (2). Research is needed on the intersectional risk of acquiring HIV for men belonging to two or more key population groups (e.g. gay men and other men who have sex with men who use drugs).

FRAMEWORK FOR ENGAGING MEN AND BOYS IN THE HIV RESPONSE



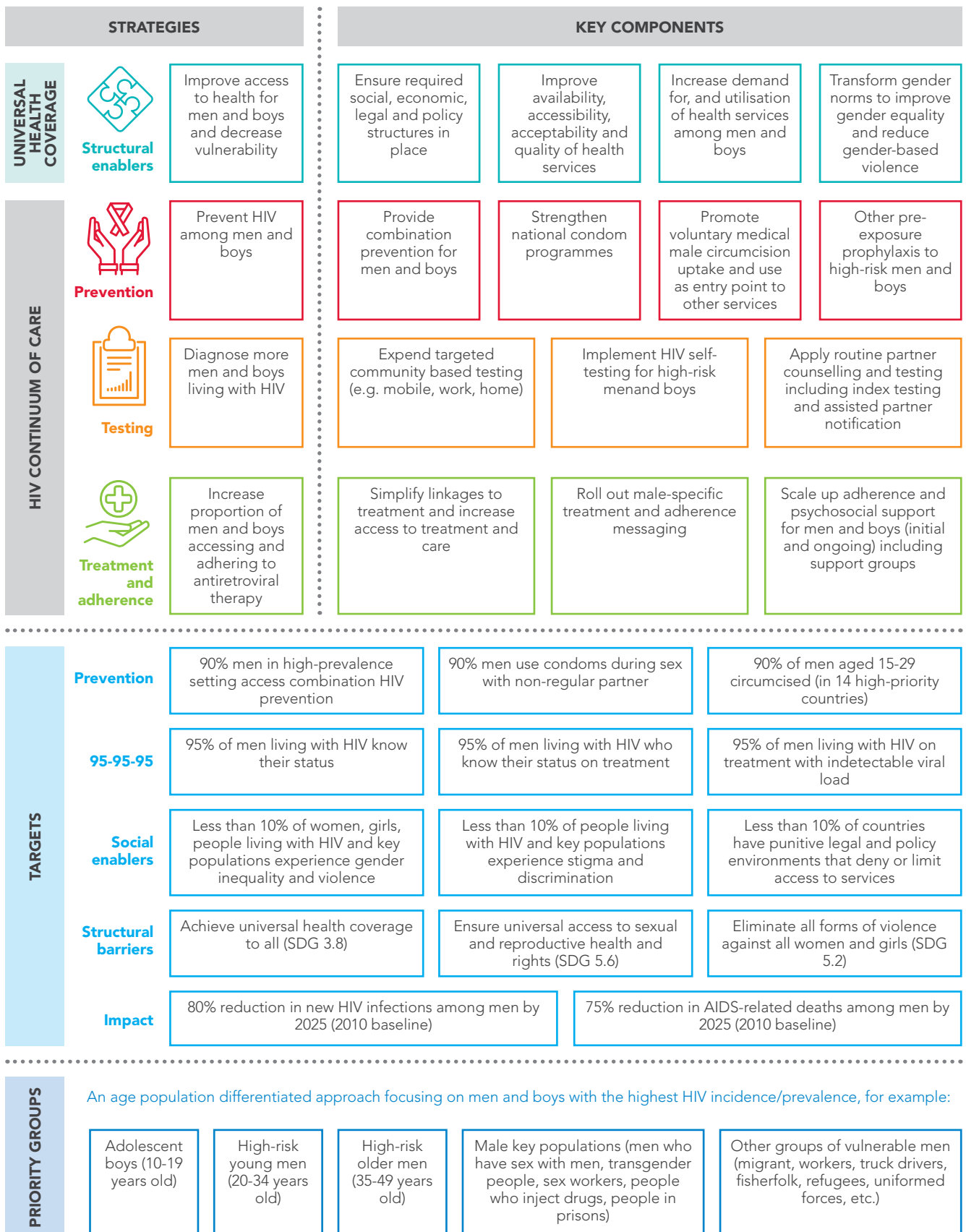
This framework provides a foundation for country-led movement to achieve the globally agreed HIV goals stipulated in the Global AIDS Strategy 2021–2026 (17) and work towards gender equality (Figure 9). This will be possible only through successfully reducing new HIV infections and AIDS-related deaths among men and boys and decreasing HIV-related vulnerability. The framework categorizes existing research and best practice, outlining the necessary building blocks for planning, implementing and monitoring improvement in the HIV response among men and boys within a broader gender equality framework.

The framework outlines effective strategies in two overarching areas:

- **Structural enablers:** these support universal health coverage and HIV-specific goals. Specific prevention, testing, treatment and adherence strategies rely on these broader strategies. They are also essential for engaging men and boys in the health sector more generally. Strategies include transforming social, economic, legal and policy structures; addressing supply- and demand-side factors; and transforming gender norms. For any of these interventions to be effective, a comprehensive and multifaceted response at scale is required.
- **HIV-specific programmatic strategies:** these include interventions across the HIV continuum, such as prevention, testing, treatment, care and support. They happen through a differentiated care approach within health facilities and the community.

The strategies and their accompanying key components are covered in detail in the rest of this document.

Figure 9. Framework for action for male engagement in HIV testing, treatment and prevention in eastern and southern Africa





Tšelisó Mosoeu participated in dialogues on GBV organized by the local community council. Braakfontein, Lesotho. 2019. © UNAIDS/M. Hyoky.

STRUCTURAL ENABLERS



A combination of cross-cutting structural enablers is needed to improve male engagement in the broader health sector and in HIV programmes and services. These strategies include transforming social, economic, legal and policy structures; addressing supply- and demand-side factors; and transforming gender norms. They support the achievement of the specific prevention, testing, treatment and adherence strategies and are also essential for engaging men in the health sector beyond HIV.

Ensuring social, economic, legal and policy structures are in place

The social, economic, legal and policy environment, especially health policies and health strategies, is central to scaling up men's engagement, both for gender equality and for creating more male-friendly HIV services (65, 66).

Policies and strategies that include men's health needs

Health-service delivery is guided by policies and strategies. There is little recognition of men's distinctive health needs in HIV and broader health policies (36, 37). Despite occasional calls for an increased emphasis on men's health, national strategies and local programmes tend to focus on women's health (28). For example, in World Health Organization (WHO) guidelines, progress reports, toolkits, manuals and policy briefs published between 1999 and 2015, women are mentioned three times for every time men are mentioned (67). Similarly, men were generally absent from a 2017 review of national policies on health, HIV, sexual and reproductive health and mental health in 13 countries in eastern and southern Africa (34).

Part of the problem is the framing of gender programmes within these strategies and policies. Most national policies and national strategic plans acknowledge the importance of gender within HIV interventions but often equate gender with "women" (68). Although this is well intentioned—especially due to the disproportionate impact of new HIV infections and gender inequality on women—the result is often the exclusion of men from gender-sensitive and gender-transformative programming.

This framing is damaging to women's and men's health. It further moves the burden of HIV prevention on to women, expecting women to access services and be responsible for safe sex practices within their homes (69). Equating gender with only heterosexual women does not take into consideration nonconforming gender and sexual identities, creating structural barriers to care for people from high-risk groups who are often already marginalized within society. It also neglects the way in which gender impacts on men's health and does not acknowledge the relational aspects of gender, thus missing key opportunities to address communication

and gender power dynamics within sexual partnerships that influence men's and women's risk of HIV.

A more inclusive approach to gender-responsive programming is required that encompasses men and women in all their diversity.

Political will and associated fundings

Male engagement strategies can be guided by global and regional policies and commitments within which national strategies are situated. Historical focus on women and children, and lack of engagement and investment in men's health, are important root causes of policy gaps and health service inadequacies at national and local levels (8, 70, 71). In recent years, the invisibility of men's health has begun to be recognized by global policy-makers, international funding bodies and country programmes.

The Presidential Fast-Track Initiative to End AIDS as a Public Health Threat in Uganda by 2030 launched in June 2017 includes a five-point plan to engage men in HIV prevention, accelerate the implementation of test and treat, and reach the 90–90–90 targets, particularly among men and young people (72). At the global level, there was a one-day forum on men and HIV before the International AIDS Society Conference in July 2019 (73), and a special issue of the Journal of the International AIDS Society on men and HIV published in June 2020 (74).



CASE STUDY: building political will for male engagement

A policy paper on improving male engagement in HIV and sexual and reproductive health and rights services in urban settings in Namibia was developed in 2018 by UNAIDS, the City of Windhoek, and the Ministry of Health and Social Services. The development of the paper was sparked by the Mayor of Windhoek,

who has committed to bringing male engagement to all areas of Namibia. By early 2019, the paper had been used to inform four municipal-level HIV strategic plans, and the cities of Gobabis, Swakopmund, Walvis Bay and Windhoek had incorporated male engagement into their operational plans (75, 76).

Supportive legal environment

In many instances, legal barriers make it difficult or impossible for people from key populations to access services or for entities to fund interventions for such populations. This criminalization has a clear adverse effect on the HIV and broader health outcomes of key populations (77–82). The removal of legal barriers is an essential step to ensuring every person has access to services and to removing gender inequalities perpetuated through structural stigma.

Disaggregated and reliable data

There is a scarcity of local, national and global data on men's health needs and outcomes (36, 83). Among 140 global health institutions, only a third disaggregated their data by sex (84). Only 3 of 13 countries in eastern and southern Africa specifically included men in a situational analysis and included specific targets related to the health of men and boys (34). The dearth of such data makes it impossible to identify and address gender-driven health inequalities (8). Although efforts are being made to improve the production and use of sex-disaggregated data at the local, regional and global levels (8, 43), more still needs to be done.

Accurate data are essential for designing and evaluating programmes, developing priorities, and ascertaining funding needs. Generating accurate data is not easy. Many sub-Saharan African countries rely on prevalence estimates extrapolated from antenatal care sentinel surveys, which totally exclude men (85). A total of 10 of 12 Demographic and Health Surveys underestimated male HIV prevalence, with bias-corrected estimates up to 9% higher than the original estimates (86). In another study, the sex gap in HIV prevalence disappeared after correcting for nonparticipation, with prevalence in men increasing from 12% to 21% (87).

Mathematical models that evaluate HIV interventions also need to be improved. A validation study assessing the ability of 10 mathematical models to predict HIV burden in South Africa found that 8 models projected declining male HIV prevalence, conflicting with empirical data showing increasing prevalence. This may be partly because the models assumed equal antiretroviral therapy uptake among men and women (88). Future models should account for sex differences in HIV testing, antiretroviral therapy initiation and retention, and viral suppression to estimate the impact of interventions more accurately (7).

Increasing availability, accessibility, acceptability and quality of health services for men

Institutional barriers contribute significantly to men's health-seeking behaviours (28, 89). There is a lack of standard entry points to health services for men. For example, in Malawi, the Ministry of Health expects women to attend health facilities 176–433 times, depending on their contraceptive methods used, during their reproductive age span (15–44 years), but men to attend only 30 times (9, 26). This highlights the contraceptive burden placed on women, but it also shows that men have far fewer standard or routine entry points to health services.

Creating services that are acceptable to men and reflect their needs is another crucial entry point. Clinic hours and locations may prevent men and women who work outside their communities during the day from accessing services (1, 7). Patterns of seasonal or annual labour migration can create difficulties in accessing regular care (90). Service use among both men and women is compromised further by stigma and fear of breaches of confidentiality (91).



THERE IS A SCARCITY OF DATA ON MEN'S HEALTH NEEDS ON LOCAL, NATIONAL AND GLOBAL LEVEL WHICH CREATES CHALLENGES TO IDENTIFY GAPS AND ELIMINATE GENDER-RELATED INEQUALITY.

Service delivery adaptations within health facilities

Strategies implemented within health facilities that have successfully increased men's uptake of services include the following:

- Extending service hours allows people who work during the day to access services without risking their employment. Expanded hours reach men effectively, but they also benefit women who work or need more flexible health service hours (92, 93). Offering services after hours, however, may be challenging due to resource constraints or safety concerns.
- Providing separate male health clinics (94) and separate service hours for men and women (70) have been tried. This has successfully increased uptake of health services among men, especially when accompanied by community-based promotion programmes and supported by peer referrals (94). Sustainability and equity concerns have been raised, however, due to the relatively high cost of providing such services and limited resources for health (8).
- Hiring more male staff at primary health-care facilities, training existing health-care workers to offer client-centred clinical services, and providing incentives for young men to work in health settings, such as scholarships for male nurses, may increase men's use of health services (2). Health-care providers are not always aware of, or sufficiently knowledgeable about, services or programmes offered for men, and providers tend to have less experience with male clients (28, 95).
- Reducing waiting times and improving client confidentiality can increase men's use of health services. In Eswatini, men's uptake of sexual health services improved when health-care providers were more sensitive to their privacy concerns and time restrictions (96). This can be done through easier booking systems, including the use of m-health tools. In South Africa, booking a male circumcision appointment was made easier through a toll-free number, and text messages were sent for booking confirmations and appointment reminders. These changes boosted the number of circumcisions by 30% (97). The Health4Men project in South Africa uses a mobile phone app to direct men to public health clinics where health workers have been trained and mentored to provide stigma-free services (98).

Many of these changes, such as longer opening hours and improved clinic operations, will also improve access to health facilities by women, people from key populations and people from other high-risk populations.

Strengthening integration between primary health care, sexual and reproductive health and rights, and HIV services

Integration of health services has become widely recognized as essential to avoiding missed opportunities, increasing coverage of services for more people, and ensuring access for all (99, 100). Since men access health care far less than women, any entry points could become critical opportunities to address general health and link men to the HIV cascade of care.



WHILE HARMFUL GENDER NORMS ARE A KEY BARRIER, SETTING STRATEGIES WITHIN HEALTH FACILITIES TO MAKE SERVICES MORE ACCESSIBLE TO MEN MAKES A PROVEN DIFFERENCE.

One successful strategy is using sexual and reproductive health and rights and voluntary medical male circumcision services as entry points for a broad range of HIV and other health services. This includes improved referral pathways between sexually transmitted infection service delivery points and voluntary medical male circumcision service delivery points for people who test negative for HIV, and improved referral to antiretroviral therapy services for men living with HIV.

In Eswatini, Kwakha Indvodza has linked voluntary medical male circumcision services with a comprehensive package of male health services, including counselling and testing for HIV and other sexually transmitted infections, and information on HIV, male health issues, and gender awareness sensitization (101). For example, male clients may come in for erectile dysfunction or other libido issues, but this can often be a result of undiagnosed diabetes, high blood pressure or high cholesterol, or the result of using certain medicines, including some antiretroviral medicines (102). The International Planned Parenthood Federation and United Nations Population Fund Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys includes HIV as a core component of a sexual and reproductive health and rights package to be offered (103).

For these entry points to work, primary health-care facilities need to be integrated so that different services can be received in one consultation from the same provider. Primary health-care facilities that provide integrated service delivery within each consultation room increase access to and uptake of health services and improve client satisfaction and provider satisfaction (104, 105). Integration is therefore an important system-level strategy for improving men's engagement (8).

Getting services out of clinics and into communities and workplaces

When a community-based service delivery model is used, men's uptake of HIV services can increase to the same level as women's, especially for HIV counselling and testing, but also for linkages to care and ongoing support (7, 8, 30). Specific strategies include increasing proximity of clinical services to where men work or congregate (70), offering community-based service delivery such as home or mobile testing and community-based support and adherence groups (7), and expanding self-care interventions such as HIV-self testing.

Communities should be at the centre of developing and implementing community-based service delivery (7). These approaches often vastly outperform clinic-based services for men (8), but they must maintain high standards of confidentiality and provide good-quality services, with strong linkages to care, especially for self-care interventions such as HIV-self testing (1).

Increasing demand for health services among men

Any activity aimed at increasing health-seeking behaviour among men should foster appropriate risk perception and improve awareness and acceptability of health-care services. This includes behavioural interventions such as information and education campaigns delivered in schools; comprehensive sexuality education

offered in and out of formal learning institutions, health settings and communities, and through the media; and attempts to shift harmful and negative mindsets and perceived norms through peer and social network-driven interventions. Once demand has been generated, it needs to be maintained.

Mass media

Mass media approaches that challenge gender norms and link men to services have been shown to increase demand for men's services and increase support for women's HIV services, particularly in high-prevalence areas (46). Entertainment education ("edutainment") is an innovative and engaging mass media communication strategy that uses an entertainment medium such as radio or television to share messages that seek to bring about social and behavioural change (106). An example is soap operas that offer modern-day representations of lived realities and have the capacity to increase audience knowledge and awareness about health and other social issues. Successful examples include MTV's HIV awareness drama *Shuga*, which has impacted on young people, with 80% saying the show changed their thinking about having multiple concurrent partners, HIV testing and stigma associated with HIV (107). Other examples include *Soul City*, Africa's most popular soap opera, and *Intersexions* (108, 109).

The multilevel Brothers for Life campaign used an integrated approach combining new and traditional mass media with community mobilization (110). It focused on creating a movement of men to address harmful gender norms and values by encouraging men to make positive changes for their own and their partners' health. The campaign promoted the uptake of sexual and reproductive health and rights, HIV and gender-based violence services for men by using a social modelling approach. It successfully increased men's use of health services, particularly voluntary medical male circumcision, HIV testing and HIV treatment, and increased men's support for women's HIV prevention and treatment services, including prevention of mother-to-child transmission of HIV (110–112).

Peer influence

Peer influence and peer support can encourage uptake of voluntary medical male circumcision, HIV testing, and engagement and retention in care (1, 7). One promising platform, especially for younger men and adolescent boys, is the use of well-designed sports-based programmes (113). The Grassroot Soccer model uses games and soccer language to enhance learning; uses team structures to strengthen the social support networks that enable people to actualize and sustain change; and engages slightly older men as mentors and educators to deliver programmes to adolescent boys, providing participants with relatable role models. This model has increased participants' use of HIV testing (114) and voluntary medical male circumcision (115).

A successful peer-to-peer approach is READY+, implemented in Eswatini, Mozambique, the United Republic of Tanzania and Zimbabwe. Through this intervention, young people living with HIV are trained to be community adolescent

treatment supporters, who provide information, counselling and support to other young people living with HIV and encourage adherence to HIV treatment during home and clinic visits (116).

m-Health and e-health technology

Tools such as apps and text messages have the potential to support HIV prevention, diagnosis and self-care behaviours, providing reminders of appointments and the need to repeat tests and take treatments, and general health information (97, 117–119). These tools can be used to direct men to male-friendly services. Gender-specific phone-sharing patterns and concerns regarding privacy must be fully considered in the development and scale-up of m-health programmes (120). Internet-based interventions can also be used to develop innovative ways to use social networking sites to scale up HIV prevention interventions, especially among high-risk groups (121, 122).

Structural interventions

Structural interventions to promote demand for HIV services include cash transfers and livelihood support (123–125). Among men and boys, some interventions have shown promising results such as the use of small cash incentives to encourage them to test (125, 126), but other interventions have not worked, such as using a lottery system to encourage men to be circumcised (127, 128).

A study from southern Africa among adolescents found that a combination of social protection interventions, especially a “cash plus care” mix, increased the likelihood of antiretroviral therapy adherence. These provisions included cash or cash-in-kind, such as government welfare grants, food security, school fees and materials, and clothing; and care, such as HIV support groups, sports groups, positive parenting, and parental supervision or monitoring (129).

When designed correctly, cash transfers and other social protection interventions have an important role to play in increasing demand (130), but there are equity, sustainability and rights concerns surrounding the conditions attached to the transfers, such as what happens to adolescents who default and therefore lose access to both the cash transfer and the accompanying support (131, 132).

Transforming gender norms to improve gender equality and reduce gender-based violence

Inequitable gender norms influence how men interact with their partners, families and children on a wide range of issues, including health-seeking behaviours, condom use, sexual and physical violence (against women and between men), domestic chores and parenting (133, 134). This increases men’s risk of morbidity and mortality and the risk of HIV transmission to their sexual partners (25, 65, 135). The International Men and Gender Equality Survey found that men with less equitable attitudes towards gender are less likely to go for HIV testing (136).



A COMBINATION OF SOCIAL PROTECTION INTERVENTIONS HAS PROVEN TO INCREASE THE LIKELIHOOD OF ANTIRETROVIRAL THERAPY ADHERENCE.

Evidence is lacking on whether men endorse the notion that men should not access health services, but this is frequently offered as an explanation for their low use of HIV services. There is some evidence that men hold exaggerated ideas about the extent to which their peers avoid seeking health services or endorse the idea that health-seeking is a sign of weakness. In rural Mpumalanga province in South Africa, 26% of young male respondents thought seeking health services was a sign of weakness, but they believed a much higher proportion of their peers thought so (137). Qualitative research on men's barriers to accessing HIV services needs to be triangulated to ensure policy and programmatic prescriptions are based on rigorous research rather than stereotyping.

Both men and women are placed at risk by certain norms related to masculinity. In some settings, being a man means being tough, brave, risk-taking and aggressive, engaging in high-risk sexual activities with concurrent partners, and not caring for one's body. Men's and boys' engagement in some risk-taking behaviours, including substance and alcohol abuse, unsafe sex and unsafe driving, may be seen as ways to affirm their manhood (133). Masculine ideals, such as restriction of emotional expression and pressure to conform to expectations of dominance and aggression, may heighten the potential for men and boys to engage in acts of violence, including bullying, assault, and physical and verbal aggression (138). Gender-based violence, including intimate partner violence and sexual violence, are prime examples of this (139).



Truck drivers at Forbes border clinic, Mutare, Zimbabwe. November 2019. © UNAIDS/C. Matonhodze.

Community mobilization, education and outreach

Community mobilization involves programmes that encourage community dialogue and action around shared concerns (140). Key components of such interventions that have been gender-transformative include fostering critical examination of gender norms and gender-inequitable attitudes, transforming gender norms, and creating gender-equitable norms and relationships (133). Many

of these interventions have been embedded within broader efforts to improve gender equality and reduce gender-based violence (8). The positive effects of these strategies are numerous, including preventing HIV; reducing gender-based violence, alcohol and substance use, and total number of concurrent sexual partners (141–144); and increasing condom use and HIV testing (145).

Community mobilization interventions can have positive benefits, but a systematic review of interventions engaging men and boys in sexual and reproductive health and rights found that only 8.4% of community mobilization included gender-transformative interventions (146, 147). Engaging men and boys without explicit attention to gender inequalities can be harmful by undermining women's rights and autonomy or continuing to perpetuate the status quo of gender inequalities. The assumption that engaging men and boys in sexual and reproductive health and rights services, including HIV, in and of itself can promote gender equality is not true and must be challenged (146). It is important to ensure programmes are evidenced-based and include explicit attention to issues of male privilege, power and position in relation to women (146, 148).

The following are examples of successful gender-transformative programmes:

- The Stepping Stones initiative offers training that includes 13 single-sex group sessions, 3 mixed sessions, and a community meeting at the end of the programme. Sessions include discussions about communication, assertiveness, reducing gender-based violence, sex and love. After 9–12 months, male participants reported having fewer partners, higher condom use, less transactional sex, less substance abuse, and less perpetration of intimate partner violence (149).
- The Sonke Gender Justice One Man Can campaign uses multiple approaches to engage men in understanding, reflecting on and reconfiguring masculinities and gender inequalities in their families and communities (150). The programme has demonstrated significant positive impact: 50% of participants reported taking action to address acts of gender-based violence in their community; 25% accessed HIV voluntary counselling and testing services; and 61% reported increasing their use of condoms. More than four out of five participants also reported having subsequently talked with friends or family members about HIV, gender and human rights (151).
- The SASA! community mobilization intervention takes communities through a process of change using activities and experiences to encourage community action and change social norms that perpetuate women's vulnerability to violence and HIV. The level of physical intimate partner violence against women was 52% lower in SASA! communities, and 76% of women and men in SASA! communities (compared with 26% in control communities) believed physical violence against a partner is not acceptable (152–154).
- The HeForShe community-based initiative on engaging men and transforming harmful norms to prevent violence and HIV is a programme adapted by UN Women from the HeForShe global movement. It has been introduced at the community level and seeks to address men in their natural settings to deal with



BOTH MEN AND WOMEN ARE PLACED AT RISK BY CERTAIN NORMS RELATED TO MASCULINITY.

toxic mindsets and behaviours that result in vulnerability to HIV and gender-based violence. It has yielded initial positive results in increasing uptake of HIV testing among men to 54% (155).

Gender-transformative and community mobilization strategies also work for adolescent boys and people from marginalized, vulnerable and high-risk populations. Examples include the following:

- Very Young Adolescence 2.0: A Curriculum to Promote Gender Equality and Sexual and Reproductive Health in Malawi focuses on challenging and redefining what it means to be a girl or boy. It enables boys and girls to recognize and question unequal relations of power and privilege that undermine very young adolescents' well-being; recognize and challenge harmful gender norms; appreciate sexual and reproductive changes happening in their bodies in age-appropriate ways; and recognize violence and develop the skills to challenge and prevent it (156).
- The Project Boithato HIV prevention intervention in South Africa mobilized peer support for HIV testing of gay men and other men who have sex with men through a multipronged approach that included intervention counsellors, dedicated community volunteers, small-group workshops, and informal and formal outreach. The project was associated with increased regular testing among gay men and other men who have sex with men and linkages to care (157).
- The Gender, Migration and HIV programme included a male engagement component by integrating the One Man Can campaign into International Organization for Migration Zambia health programmes. Gender-transformative workshops and murals were used to challenge prevailing gender roles and norms in migrant fisherfolk communities. Murals worked well as community education tools by sparking curiosity and offering a constant message in busy spaces, particularly those frequented by people from migratory populations that would otherwise be hard to reach (158).

Men and boys can and will change gender-related attitudes and practices, including decreasing their use of violence and other forms of risky behaviour, when reached by interventions mostly focused on men and community-wide interventions that target both women and men. Many of these interventions, however, have been conducted at a relatively small scale, and there are questions of sustainability and scalability in resource-limited settings (159).

Causal factors that increase the likelihood of intimate partner violence include mental health factors, such as mood and anxiety disorders due to the pressure of societal gender norms (e.g. unemployment) and health and HIV-related worries and fears (160). Men who were abused as children, men who have experienced other traumatic life experiences, and men with depressive symptoms are more likely to perpetrate intimate partner violence in their lifetime (161). These causal factors do not excuse men's perpetration of intimate partner violence; rather, they show that strategies to prevent violence against women need to take into account men's mental health, because transforming gender norms alone is not sufficient.



CASE STUDY: transforming gender norms through community mobilization

Tsima was a three-year community mobilization intervention implemented in rural Mpumalanga in South Africa between 2015 and 2018 by Sonke Gender Justice and research partners. Tsima means “working together”. One of the main focuses was engaging men and women as agents of change to improve the uptake of HIV services. Interventions included:

- Regular mixed-sex workshops that included critical reflection and taking action around health, gender equity, human rights and stigma.
- Explicit messages to shift gender norms that inhibit HIV service use and justify sexual and gender-based violence.
- Male and female community action teams assigned to each village.

Embedded within the implementation was a cluster randomized controlled trial to study the effects of the intervention. The study showed that population-level shifts in gender norms are possible—there were large increases in equitable gender norms in both intervention and control communities. Qualitative research suggests these shifts were influenced by recent rapid increases in access to media through satellite television and smartphones, where more gender-equitable relationships were modelled.

The intervention led to decreases in partner violence, with the odds of intimate partner violence among women aged 18–29 years halving. The decrease was attributed to couples learning better communication skills through Tsima. More equitable and constructive couple communication also facilitated HIV service uptake (162, 163).

Engaging religious leaders, traditional leaders and traditional healers

Religious and traditional spaces are critical for reaching men and strengthening gender-equitable practices. Leaders from traditional and faith sectors offer cultural insight, locally relevant knowledge and social capital that may reach a wide constituency with messages of non-discrimination, compassion, gender equality, and the importance of health care (101). Religious and traditional leaders are primarily men, and religious institutions are dominated by men and masculinist perspectives. The result can be the perpetuation of gender inequality and problematic unhealthy notions of manhood that encourage men to be only stoic, powerful, non-vulnerable and risk-taking.

Civil society organizations and governments have long realized that if they want to tackle important social issues in rural communities, they must get traditional leadership on board (164). If this is to work, and to avoid reinforcing unequal power relations, it is important to ensure gender-transformative programmes are in place to influence harmful attitudes, gender equality and women’s empowerment, and to harness this influence to challenge and change social norms and behaviours within their own networks and communities (165).

In many settings, men make active use of traditional health practitioners, but with little interaction with biomedical health services, except for some isolated examples around male circumcision (166, 167).



CASE STUDY: engaging religious and traditional leaders for gender equality

In Nigeria, the Voices for Change Consortium engaged with over 400 traditional and religious leaders, with the aim of influencing their attitudes towards men's power over women, gender equality and women's empowerment, and harnessing this influence to challenge and change social norms and behaviours within their own networks and communities. This engagement was informed by three key principles (165):

- Transform the self: start on transformation within the leaders themselves via workshops to allow people to critically reflect on and analyse ingrained patriarchal attitudes and behaviours, and make changes in their own lives that mirror their commitment to gender justice.
- Build alliances to trigger change: collaborative and learning relationships built with citizen-based organizations with experience of engaging religious and traditional leaders on social issues.
- Take a long-term view: changing gender norms, attitudes and behaviours is a complex long-term process. One of the most strategic entry points was the integration of gender justice issues by religious and traditional leaders into their outreach practices. A platform for leaders to share their own journey and experiences was provided to give ongoing support.

The programme had good results. Since attending the training workshop, religious and traditional leaders have reported a wide range of positive changes to their own awareness and behaviour, and in their ability to influence others on the issue. Over two-thirds of the religious and traditional leaders who took part in the workshops have taken actions against discriminatory beliefs that prevent young women from realizing their potential, sharing their gender justice messages directly with more than 400 000 people through a combination of sermons, conferences and workshops.

Key recommendations following the project include:

- Engage religious and traditional leaders using a gender-transformative approach.
- Use language that is familiar and comfortable.
- Adopt an interfaith ecumenical approach.
- Ensure workshop facilitators are experienced and skilled in the application of participatory learning and gender-transformational methodologies.



Thobani Ncapai lives with HIV in Khayelitsha, Cape Town. 2017.
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Dwayne Senior.

Comprehensive sexuality education

There is a clear and urgent need to provide comprehensive sexuality education for adolescent boys and girls. The programme should be curriculum-based and have an explicit focus on gender rights and power dynamics. Such programmes have been found to be five times more effective at reducing rates of sexually transmitted infections and unintended pregnancies than HIV-prevention curricula that do not address gender norms (168). These programmes can be implemented in school or in the community, including through sports-based interventions.

It is also paramount to reach out-of-school boys, such as through social and behavioural communication activities and community-led activities, to ensure they receive information regarding health, sexuality and healthy relationships and have a mentoring figure to turn to in case of need. This can help to dispel common myths and harmful traditional practices such as the “dry sex” practice in heterosexual relationships (169, 170).



Azizi Lai,
a motorbike taxi
driver living with
HIV. Tanzania, 2020.
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INCREASING HIV PREVENTION AMONG MEN AND BOYS



A strong primary prevention response should include biomedical, behavioural and structural dimensions, closely integrated with HIV testing and treatment scale-up. This section covers key strategies to improve HIV prevention among men following the HIV Prevention 2020 Road Map (171).

Combination HIV prevention

Combination prevention combines behavioural, social, structural and biomedical methods. As well as the behavioural, biomedical and gender-transformative interventions outlined earlier, interventions include provision of information and demand generation for HIV prevention; provision of comprehensive sexuality education; addressing harmful masculinities, gender norms and gender-based violence; improving access to sexual and reproductive health and rights services; and respecting women's and adolescent girls' sexual and reproductive health and rights. Such interventions should pay particular attention to engaging the male partners of adolescent girls and young women in high-prevalence locations and male key populations.

Successful HIV prevention programming requires engaging communities in the planning process and responding to the social environmental factors that shape health and behaviour in the specific local context, including gender norms and stigma about accessing HIV testing services (172, 173). This is particularly true for programmes aimed at people from key populations, who often face multiple levels of stigma (174). Programmes should be implemented at scale, be community-based and community-led, and be tailored to the HIV and wider sexual and reproductive health and rights needs of people from these populations (171, 175).

Availability of condoms and lubricants

Use of condoms together with water-based lubricants remains an essential intervention to prevent HIV, other sexually transmitted infections and unintended pregnancy (176). Within a combination prevention framework, promotion and distribution of condoms and water-based lubricants is most effective when integrated with other services as part of an informed choice approach to prevention. Strategies for ensuring equitable access to condoms and lubricants among men, including those from key populations, include the following:

- Effective and impactful government stewardship and ownership of condom programmes: governments should gradually assume full ownership of condom programming, including forecasting, quantification, procurement and logistics, and financing of free male and female condoms (2). Governments should work

with the private sector to strengthen condom brands and create healthy markets based on willingness to pay for condoms (176, 177).

- Integration of condom programming into other interventions: condom distribution and promotion must be effectively integrated into voluntary medical male circumcision, HIV testing, PrEP, broader health services, key population programmes and community health programmes (178). Integration should take place in clinical and community settings, with community health-care workers, peer educators and other community outreach workers distributing condoms, and condoms available free of charge at all health facilities (2).
- Targeted condom promotion and free distribution: adequate and sustainable supplies of free condoms should be available, specifically targeting people from key and vulnerable populations. These programmes should be population-specific, as determinants of condom use vary between different groups of men and between men and women (179). Programmes should include a targeted approach for adolescent boys on condom awareness, including through comprehensive sexuality education programmes, to ensure condom use is the norm once adolescents become sexually active (180, 181).
- Increased promotion and availability of water-based lubricants: safe condom-compatible lubricant is essential to reduce tearing and risk of HIV transmission in anal and vaginal sexual intercourse. Among gay men and other men who have sex with men, rates of consistent condom use are low (182), but lubricant use can be high (183), providing an opportunity to co-market condoms and water-based lubricants. Governments should aim to ensure lubricants are available at all places where condoms are found (184).

Voluntary medical male circumcision uptake and use as an entry point to other services

Voluntary medical male circumcision can reduce the risk of HIV transmission from women to men by about 60% (185). It is not associated with higher-risk sexual behaviours among heterosexual men (186, 187). It can also confer additional health benefits (48). When voluntary medical male circumcision was first rolled out, information campaigns were effective; since 2010, however, campaigns have failed to increase the prevalence of male circumcision among adults to above the 80% target, suggesting the need for different demand-creating strategies (188). A variety of strategies have been shown to have success:

- Peer-led approaches: peer support, especially from men who have been circumcised recently, is important in a man's decision to circumcise as it normalizes circumcision and reduces fear (189–191). In the United Republic of Tanzania, the recruitment of early circumcision adopters as voluntary community advocates contributed to a fivefold increase in the number of circumcisions conducted at intervention sites (192). Peer-led approaches have increased acceptability of male circumcision but have not consistently increased demand (193).



- Incentives: a commonly reported barrier to male circumcision is the loss of earnings while undergoing the procedure (194). Financial compensation has been effective in increasing circumcision uptake among men in Malawi (195) and Kenya (128), as it addressed economic barriers and behavioural biases in decision-making. In South Africa, 70% of the men enrolled in a study that coupled financial compensation (2.5 days minimum wage) with motivational interviewing agreed to be circumcised, largely due to motivational interviews with a male circumcision adviser (83.1%) and time compensation (39.4%) (196). Lotteries did not increase demand (127, 128). Any use of financial incentives needs to be done with fully informed consent about the surgical procedure.
- Changing social norms surrounding voluntary medical male circumcision: including traditional leaders, religious leaders, healers, circumcisers and female partners increased acceptance of voluntary medical male circumcision (197–205). In the United Republic of Tanzania, mothers and female partners had an important influence on men's decisions to seek voluntary medical male circumcision, both directly by partners denying sex and indirectly through discussion, advice and providing information to uncircumcised partners and sons (206).

Truck drivers at Forbes border clinic, Mutare, Zimbabwe. November 2019. ©UNAIDS/C. Matonhodze.

- Leveraging existing cultural practices: local beliefs and practices about voluntary medical male circumcision can influence uptake and effectiveness (207). In Eswatini, a three-day mentoring residential camp is used to dispel young men's fears and suspicions about male circumcision. The camp builds on the existing cultural practice of circumcision as a sign of coming of age. At the end of the camp, participants are offered a comprehensive package of male health services, including voluntary medical male circumcision and counselling and testing for HIV and other sexually transmitted infections. Uptake of voluntary medical male circumcision and HIV testing after the camp were 86% and 87%, respectively, compared with a national average of 19% (101).
- Addressing knowledge deficits: lack of knowledge about male medical circumcision led to low uptake (208, 209). Men with lower levels of knowledge include adolescents, men living in rural areas, and men with lower levels of education (210). Messaging must be tailored and provided in a way that speaks to the target population (203). In Zimbabwe, a single 60-minute sport-based intervention increased voluntary medical male circumcision uptake among secondary school boys aged 14–20 years by 7.6% (115).
- Addressing health facility barriers: adaptations to health facilities can increase demand, notably adjustments to increase patient privacy (191), introducing time-saving measures (e.g. advance scheduling of procedures) (203), making services more available (e.g. extending clinic operating hours to include Saturdays), and training nurses and clinical officers to provide voluntary medical male circumcision services (211).

Voluntary medical male circumcision can be used as an entry point for men, especially young men and adolescent boys, to a broader range of health services (61). For many adolescent males in southern and eastern Africa, voluntary medical male circumcision services may represent their first self-initiated encounters with the health-care system and provide a useful opportunity for engaging them in services for HIV prevention, sexual and reproductive health and rights, and other health needs (212). This has often been a missed opportunity, however (196, 213, 214).

PrEP for men at high risk of HIV infection

PrEP empowers people to take control of their own HIV risk discreetly. When taken regularly, PrEP is highly effective at reducing HIV infections among people at high risk. WHO recommends that PrEP is used in all people from groups at substantial risk of HIV infection, defined as an incidence of 3 or more cases per 100 person-years (215). These groups include sex workers, gay men and other men who have sex with men, adolescents, and serodiscordant couples in high-prevalence settings (46).

Among gay men and other men who have sex with men, PrEP provides a much-needed additional prevention option. In Kenya, 83% of gay men and other men who have sex with men surveyed were willing to take daily oral PrEP, largely to stay free from HIV and protect their partners. Potential barriers to adherence were a history of poor treatment adherence, fear of side-effects and HIV-related stigma (216). There is evidence that sexual risk behaviours may increase among men using



ALTHOUGH HIV-PREVENTIVE TECHNOLOGIES ARE CRITICAL TO SLOWING THE AIDS EPIDEMIC, THEY DO NOT ADDRESS STRUCTURAL ISSUES AND CANNOT STEM THE TIDE OF TRANSMISSION ALONE.

PrEP. Programmes must stress that PrEP is not a substitute for safer sex: rather, it is an additional prevention choice in combination with other forms of HIV prevention, including condoms and lubricants (217, 218).

More inclusive access to and uptake of PrEP can be achieved by investing in community awareness and education campaigns, removing financial barriers (including expanding health insurance coverage for PrEP), and educating health-care providers about PrEP (1, 216, 219). Gender norms and cultural contexts also need to be taken into consideration within PrEP messaging and promotion, given concerns raised by some men that use of PrEP by their female adolescent sexual partners raised questions of infidelity and side-effects on men (220).

Although HIV-preventive technologies are critical to slowing the AIDS epidemic, they do not address structural issues and cannot stem the tide of transmission alone. PrEP should be an additional prevention choice in a comprehensive package of services.



Patrick Chidyamatiyo, a truck driver at Forbes border clinic, Mutare, Zimbabwe. November 2019. © UNAIDS/C. Matonhodze.



Thobani Ncapai with his daughter, Khayelitsha, Cape Town. 2017.
© UNAIDS/Dwayne Senior.

TESTING: DIAGNOSING MORE MEN WHO ARE LIVING WITH HIV



Testing for HIV remains critical for monitoring the effectiveness of prevention interventions and linkages into the HIV cascade of care (51). Knowledge of HIV status is lower among men than women at most ages in sub-Saharan Africa. Factors that encourage HIV testing among men include men's concerns about their own health, an accurate perception of their HIV risk, a sense of responsibility to their partners and families, knowledge of someone who has taken an HIV test, support from a partner or friend, and making services more convenient (7). Men are more likely to test when concerns about stigma and confidentiality are addressed, when perceptions of health facilities as "women's spaces" are addressed, and when offered a test when visiting a health facility for another health reason (7, 221, 222). Understanding the local context, current response and existing coverage gaps is critical in determining the best strategies and adding an appropriate mix of HIV testing approaches to existing facility-based testing.

Community-based HIV testing

Community-based counselling and testing includes home-based testing, mobile and workplace testing at temporary facilities set up in communities or workplaces, and integrating with other health campaigns. This approach is highly acceptable to men (223), reaches large numbers of first-time testers, and diagnoses HIV at earlier stages of infection (221, 224–226). This approach is an extension to, rather than a replacement, of facility-based testing. It should be prioritized and focused on high-burden areas, workplaces and populations.

Community-based testing strategies include the following:

- Home-based testing: this involves door-to-door HIV testing in a catchment area with high HIV prevalence and a high proportion of people who do not know their HIV status. This approach is likely to reach more women than men. In Botswana, a home-based testing project reached 85% of women but only 50% of men because visits were done during working hours, when many employed people (mostly men) were away from home (227).
- Mobile and workplace testing: this involves testing at temporary facilities set up in communities and workplaces. A trial in Zimbabwe had 53% uptake when workplace testing was offered on site, compared with 19% for off-site testing, underscoring the importance of convenient access (228). Buy-in from trade unions and employers is important, especially in large workplaces, along with outreach work in communities to accompany the workplace programme (229).



- Multi-disease campaigns integrating HIV counselling and testing: integrating screening of multiple diseases, including HIV, is a promising approach, especially for reaching people who have never tested for HIV (224, 230, 231). When the Sustainable East Africa Research on Community Health (SEARCH) study combined HIV testing with screening and treatment for diabetes, hypertension and malaria in communities in Kenya and Uganda, 86% of male community residents participated in community health campaigns or home-based testing (230).

There is no single approach to community-based HIV testing. Some men prefer to test at home (232), but others have concerns about the confidentiality of home testing (233) and consider mobile testing to be more private (234). Community testing should be tailored to the needs of men and adapted to the realities of their lives to optimize coverage and effectiveness (7). It should also be coupled with improved facility-based testing. In a large community study in three countries, the introduction of community-based testing services alongside standard facility-based services was associated with four- and nine-fold increases in the number of people receiving their first HIV test in the United Republic of Tanzania and Zimbabwe, respectively (145).

The men of Braakfontein, Lesotho, participated in GBV dialogues. October 2019. © UNAIDS/M. Hyoky.

Although not all of these testing outreach programmes are specifically targeted at men, they have reached more men than are currently testing at facilities (8). This includes groups of harder-to-reach men. A systematic review of studies has confirmed a clear preference for community-based testing for other hard-to-reach groups of men, including gay men and other men who have sex with men, and adolescent boys (235, 236).

Some important limitations to, and concerns about, community-based HIV counselling and testing exist. Without effective linkages to prevention, care and treatment, the benefits of community-based HIV testing are severely constrained, but this is not assessed in many studies (236). Studies show that interventions that actively link tested clients to care dramatically outperform community-based testing programmes that do not do this (236, 237). Home-based tests and mobile testing can overcome many of the hindrances associated with facility-based testing, but they do not provide an HIV diagnosis, which still requires a confirmatory test according to the national testing algorithm. Proximity to clinics, follow-up, and the structure of clinical operations therefore remain important considerations (1, 8).

HIV self-testing

HIV self-testing is a convenient, low-cost and discreet approach (238). Self-testing allows people to choose where and when to test and does not require the presence of a health-care worker. It is an effective strategy for increasing men's access to and uptake of HIV testing, with high acceptability and uptake reported in a number of studies (128, 239, 240).

Distribution strategies for self-tests include the following:

- Partner-delivered: pregnant or postpartum women attending maternal health services are given HIV-self test kits to take home and give to their male partners (119). This approach has also been used with HIV-negative sex workers to give to their clients (241).
- Distribution by peers and social networks: this approach was piloted in fishing communities in Uganda and found to be safe, with a high uptake rate of 82% (242).
- Provision to gay men and other men who have sex with men: a study in South Africa provided up to nine HIV self-test kits to gay men and other men who have sex with men over a two-year period to use or distribute to their networks. Of the participants, 91% used the self-test kits and over 80% preferred self-testing to clinic-based testing (243).
- Pharmacy provision: this approach requires regulatory approval from the government. Evidence on uptake and use is not currently available.

HIV-self test kits are seen as acceptable and convenient, with consistently high uptake, but there are barriers to wider adoption. The relatively high retail cost of oral HIV test kits has raised questions about cost-effectiveness (119). Instructions for use need to be improved, as they are often too complicated or poorly



RETHINKING HIV SELF-TESTING STRATEGIES AND ADAPTING THEM TO MEN'S NEEDS CAN BE A GAME-CHANGER IN DETECTING TRANSMISSIONS.

understood by people with low levels of literacy (243, 244). One of the biggest challenges is providing counselling and linkages to services following self-testing. Studies have explored facilitating linkages to confirmatory HIV testing (based on national testing algorithms), prevention and treatment services, including counselling on how to manage a positive HIV test result (119, 240, 245). Further research, policies and guidelines should regulate, market and distribute HIV self-tests, ensure quality assurance of tests and human rights, and link testing to ongoing HIV care (246).



CASE STUDY: increasing access to HIV self-testing

UNAIDS estimates that only 58% of people living with HIV in Kenya know their HIV-positive status. In line with Kenya's national HIV prevention policy framework, the Ministry of Health seeks to increase the number of people aware of their HIV status to 90% of the population, particularly in areas such as the city of Kisumu, where adult HIV prevalence is nearly 20%.

A pilot study across several sites in Kisumu explored secondary distribution of HIV self-test kits by women to their sexual partners. Secondary distribution is a strategy in which easier-to-reach individuals—in this case, women accessing health services—are given multiple self-tests to distribute to harder-to-reach individuals—such as male sexual partners or sex clients.

The study recruited women free from HIV aged 18–39 years accessing antenatal or postpartum care, and female sex workers accessing HIV prevention and care services at a drop-in clinic. The results were promising:

- **62% of women in antenatal clinics** and 91% of their male partners reported using a self-test.
- **77% of postpartum women** and **86% of their male partners** reported using a test.
- **71% of sex workers** and **75% of their male clients** reported using a test.
- **Up to 85% of men reported** that the self-tests were easy to use, and 98% of participants would recommend HIV self-tests to their friends.

Overall, the study showed that secondary distribution of self-test kits by women to their male sexual partners is a cost-effective, safe and creative strategy to reach men, especially among male partners of pregnant women (241, 247).

Couples counselling and testing, including assisted partner notification

People in stable relationships account for almost two-thirds of new HIV infections in sub-Saharan Africa. Half of these infections are the result of transmission within the couple (248). Couples counselling and testing has been shown to encourage

healthy communication between couples, increase condom use and reduce HIV transmission, particularly between serodiscordant partners (249–252).

Useful strategies for increasing couples counselling and testing include the following:

- Focusing on male partners of pregnant women: male partners of pregnant women respond well to offers of counselling and testing, especially when supported with messaging that testing could help protect their unborn child, or when testing is combined with broader health screening (253, 254). Distributing self-test kits to pregnant and postpartum women in Kenya achieved 91% testing coverage in male partners within 3 months, compared with 51% among men who were invited to take a test at a clinic (241). A study in Uganda found that home-based HIV testing for pregnant couples resulted in higher uptake of male partner and couple testing, and higher rates of HIV status disclosure and identification of serodiscordant couples (255).
- Active or assisted partner notification: assisted partner notification involves health-care workers tracing, notifying and offering counselling and testing to the partners of people living with HIV. This is an effective and safe strategy for identifying undiagnosed people living with HIV, shifting the burden of engaging male partners from pregnant women to the health system (235, 256). Active tracing does not appear to be associated with an increase in intimate partner violence or abuse (257). The approach reaches more men than passive notification, in which people newly diagnosed with HIV notify their sexual partners and refer them to a clinic (145). In Europe, partner notification has proven to be highly acceptable among gay men and other men who have sex with men (258, 259). In Malawi, nearly half of men whose partners attended antenatal clinics learned their HIV-positive status through partner tracing. Among those who learned their status, there was a substantial decline in unprotected sex among serodiscordant couples (from 94% to 23%) (237). Assisted notification imposes additional workload on overburdened health-care workers, however, and presents a challenge in settings with staff and resource constraints (259).

These strategies must take into account gender power dynamics, which, if not acknowledged and addressed on a case-by-case basis, can increase women's vulnerability to intimate partner violence and limit their decision-making power over their own bodies and in their relationships. Male engagement should be actively encouraged, especially in antenatal care, but health facilities must never require men's participation for women to access services. Health providers must be trained and supervised to ensure protection of the rights of women and adolescent girls to make informed and autonomous decisions about partner notification, and to privacy and confidentiality in disclosure of test results. Women should be offered support and assistance in engaging their male partners and disclosing a positive HIV diagnosis, but this disclosure should never be undertaken by the clinic without a woman's full and voluntary consent (260, 261).



STRATEGIES TO INCREASE COUPLES COUNSELING MUST TAKE INTO ACCOUNT GENDER POWER DYNAMICS TO AVOID INCREASING WOMEN'S VULNERABILITY.



Health4Men clinic in
Yeoville, Johannesburg,
South Africa. 2013.
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ENABLING MORE MEN TO START AND STAY ON TREATMENT



Linking men who test positive for HIV to care and enabling them to remain on treatment and achieve stable viral suppression is a major challenge (1). Community-based testing and self-testing may avert some barriers associated with facility-based testing, but people must still travel to clinics, sometimes repeatedly, and wait to be linked to care and initiate antiretroviral therapy (262).

Simpler access to treatment and care

Once a man has a confirmed HIV diagnosis, he needs accessible enrolment into care and lifelong retention. Up to half of men who test positive for HIV in eastern and southern Africa do not get linked into or retained in care, resulting in a cascade of losses at each stage of the continuum of care and new infections due to poor uptake and adherence (263). A study in South Africa found that among gay men and other men who have sex with men, the biggest gap across the HIV testing, treatment and adherence cascade is in access to antiretroviral therapy (264).

One of the biggest obstacles to linking men into HIV treatment and care services is their lack of universal entry points to health systems (9, 26), which is compounded by barriers such as limited opening hours, inconveniently located facilities and unpredictable waiting times (27–29). The following strategies have effectively increased men's uptake of and adherence to antiretroviral therapy using differentiated models of care:

- **Test-and-treat:** in 2015, WHO recommended that all people living with HIV should initiate antiretroviral therapy as soon as they are diagnosed, irrespective of CD4 count or illness (265). Where test-and-treat has been implemented, linkages to treatment have been strengthened, and retention and viral suppression have improved (7), especially among men. In Kenya and Uganda, test-and-treat used alongside community-based testing achieved viral suppression among 76% of all men living with HIV within 2 years (31). In Mozambique, immediate initiation of antiretroviral therapy and use of telephone reminders improved linkages to care and retention: 70% of people remained in care after 12 months, compared with 46% in the control group (266). A similar approach in Eswatini achieved high rates of treatment initiation and retention, with no difference between men and women (267).
- **Improving efficiency of health facilities:** where a facility-based model to provide treatment is used, adherence among men and women tends to be strongest when services address people's concerns about confidentiality and stigma, are decentralized to primary health facilities, and are organized to minimize travel and wait times; when trusting relationships exist between clients and caregivers;

and when clients recognize the effect of treatment on their health and their ability to provide for their partners and families (268–270). Flexible clinic hours and less complicated referral processes also support retention in care.

- Community-based treatment: outreach treatment strategies and linkages to care improve men's and women's engagement in the HIV cascade of care. Approaches that include the option of community-based treatment should be considered, as the cost and inconvenience of travelling to clinics is a common reason for failing to link to, or dropping out of, care. Evidence shows that community-based antiretroviral therapy is not inferior to facility-based programmes, and it may even be cost-saving (33, 271, 272). In Malawi, treatment uptake was higher when people living with HIV had the option of initiating treatment with the assistance of a community health-care worker at home; there was no difference in retention after six months (273).
- Multi-month dispensing: multi-month dispensing of antiretroviral medicines is a differentiated model of care that can help reduce the burden of HIV care on clients. Stable clients receive either three or six months of medicines in one visit, thus eliminating the need for monthly clinic or community facility visits. This reduces travel and time costs, creates a greater sense of normalcy, and improves adherence and viral suppression (274, 275). It also reduces provider workloads and the annual unit cost of providing care to stable clients (274, 276).
- Incentives to link to care: using a conditional fixed financial incentive substantially increased the odds of men's linkages to care or prevention after a partner delivered a self-test. This was regarded as cost-effective given the high uptake of tests and high levels of linkages to care (119).
- Point-of-care CD4 testing: better care and ongoing support can be provided if the client's CD4 count is known on treatment initiation, particularly for people who risk interrupting treatment (277). The availability of point-of-care CD4 tests outside clinic settings is crucial to creating strong linkages. In a study examining home-based counselling and testing combined with same-day point-of-care CD4 testing, linkages to care improved among people receiving point-of-care CD4 testing rather than laboratory-based methods (278, 279).



CASE STUDY: using male-friendly clinics to link men to HIV care in treatment services

Through the support of the United States President's Emergency Plan for AIDS Relief, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) introduced comprehensive men's clinics at selected high-volume health facilities in Lesotho to scale up the test-and-start approach among men living with HIV.

The 2017 Lesotho Population-based HIV Impact Assessment showed that only 71% of men living with HIV knew their HIV-positive status, compared with 81.5% of women living with HIV. Treatment coverage among men living with HIV aged 15–59 years is 63% compared with 74% among their female counterparts.

To address this gap and provide a differentiated model of HIV testing, care and treatment services targeted at men, EGPAF worked in collaboration with the Lesotho Ministry of Health to design a programme to scale up access to comprehensive HIV services for men. Baseline focus group discussions were held to obtain an understanding of what "male-friendly" services would entail. Using lessons learned from this assessment, EGPAF identified space in existing Government health facilities to establish male-friendly clinics, and male nurses and counsellors were recruited and trained to run them.

These clinics leverage existing infrastructure to provide separate spaces or dedicated times for men to access primary health-care services. This aims to address sociocultural barriers impeding men from visiting health-care facilities, since Basotho men often view services at health units as "being for women and children". The client-focused services in the men's clinics offer programmatic benefits, including flexible appointment schedules, longer working hours, service delivery by staff trained in providing male-friendly services, multi-disease consultations, one-stop shops for consultations and medicine dispensing (e.g. antiretroviral medicine refills), short waiting times, and a focus on male health care needs.

The male-friendly clinics were initiated as a pilot beginning in June 2017. After 6 months, the country team observed a high HIV testing yield (over 10%) in men aged 20–49 years, and over 100% linkages to treatment for males aged 25–50 years. This high linkage rate was possible as some men previously known to be living with HIV attended the men's clinics to initiate treatment. Sustainability of the initiative will be strengthened through the use of Ministry of Health staff to provide services in the male clinics (94).

Male-specific treatment and adherence messaging

Messaging about HIV has often been fear-based, with men depicted as the reason for HIV spreading within a community (20). Interviews with men, especially those from communities with a high burden of HIV, show they associate HIV with sickness and death and regard a positive diagnosis as the end of life as they know it (10). Due to societal stigma, men fear public disclosure of their HIV-positive status (280).

Messaging that antiretroviral therapy can allow men to regain their health, restore self-esteem compromised by HIV, and provide for their families can be a powerful motivator for engagement in care (10, 281). Effective messages should be nuanced and local-specific, vary by men's age, make use of trusted partners, be ongoing and long-term, and be delivered in settings where men feel comfortable discussing their concerns, even if perhaps not traditionally associated with the health sphere (7).

Overcoming existing negative perceptions of antiretroviral therapy takes time and requires an incremental approach on an individual level, with repetitive education and affirmation. It also requires a “rebranding” of what treatment means at a societal level (e.g. through the use of mass media) and making HIV prevention and support for people living with HIV a collective challenge for the whole community (10).

Focusing on overcoming men’s negative beliefs towards treatment is important for men and their female sexual partners. In Malawi and Zimbabwe, men’s lack of accurate information about HIV and antiretroviral therapy meant that women commonly experienced their male partners discouraging them from initiating and adhering to antiretroviral therapy. Strengthening men’s understanding about HIV and antiretroviral therapy could improve men’s health and also enhance women’s ability to initiate and adhere to antiretroviral therapy (24).

Male adherence and psychosocial support

Treatment adherence support for all people living with HIV is important. The effects of any adherence intervention wane after the intervention ends, and there is little information on how to promote adherence within populations who have been receiving antiretroviral therapy for long periods of time (268). Adherence can be challenging both in the early stages of treatment (integrating taking medicines into daily life) and in the long term (maintaining clinical connections and remaining in clinical care and virally suppressed). Interventions to support men to prevent interruptions in treatment and care may have a greater impact on clinically important outcomes over time than interventions targeted only at medicine-taking behaviours (282).

Specific strategies to support adherence among men include the following:

- Facilitating antiretroviral medicine refills outside health facilities: more convenient arrangements to pick up medicines, such as dispensing outside of health facilities, have been effective at increasing men’s treatment adherence (7). Home, workplace and mobile pickup sites for medicines can be particularly convenient for men and women. Home visits by community health-care workers and telephone reminder messages support retention in care (236).
- Male support groups and adherence clubs: support groups, men’s dialogue groups and adherence clubs provide an opportunity for men to meet with peers and share challenges and experiences of taking treatment or living with HIV. Some groups also provide monthly distribution of antiretroviral medicines and health screening by community health workers for men who are stable on treatment (283, 284). Targeted outreach for participation in adherence clubs and training men living with HIV to act as peer supporters has improved men’s retention in care, and provides another effective strategy to improve health and reduce HIV transmission (285). Support groups and peer counselling can be more difficult for men as they may experience more stigma than women after an HIV diagnosis, and may have an increased fear of losing respect or being perceived as a failure for acquiring HIV (7, 25, 281). Support groups



for men that emphasize responsible fatherhood and skills training, challenge harmful gender norms, and address mental health problems such as depression increase engagement in care (28, 286). Support groups specifically for gay men and other men who have sex with men can help overcome the multiple layers of stigma they face (287).

- Online information and support: providing a variety of trusted resources online can help men living with HIV, especially those newly diagnosed, understand that they are not alone and where to find support. For example, the Breaking the Cycle project set up a video library with stories, advice and “life hacks” from men living with HIV, including interviews, testimonials, discussion groups and other self-generated content (10).
- Point-of-care viral load testing: increasing the availability of point-of-care HIV viral load testing increases access, improves turnaround times, and may reduce the time to detection of treatment failure (288), improving clinical management of people with suspected treatment failure, supporting adherence, preserving the efficacy of treatment regimens, and preventing the spread of drug-resistant HIV (289).

Members of the Khoelenya community council, Braakfontein, Lesotho. October 2019.
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These strategies should be coupled with promoting professional client-centred services, decentralizing services to the community, and integrating HIV care into broader primary health care (8, 104). Financial barriers can prevent men from accessing health facilities due to the cost of transport involved and the potential loss of earnings. Nutritional barriers, although not male-specific, must be taken into consideration for vulnerable clients where a consistent food source is not available to take with medicines (290, 291).

Despite their diversity, men living with HIV share some concerns, including increased risk for developing mood, anxiety and cognitive disorders. People living with HIV are twice as likely to have depression than those not living with HIV (292). Programming strategies to support adherence of men living with HIV must incorporate the diagnosis and treatment of mental health problems.



CASE STUDY: improving retention in antiretroviral therapy through community adherence groups

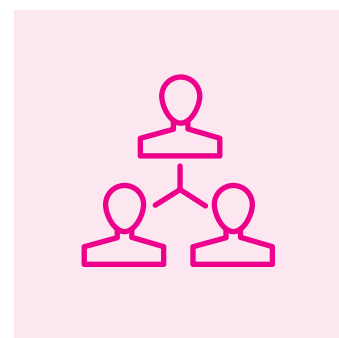
The Centre for Infectious Disease Research in Zambia (CIDRZ) developed and is implementing community-based adherence groups (CAGs) to provide routine antiretroviral therapy management, decongest high-volume health facilities, and minimize difficulties in accessing antiretroviral therapy sites. Groups are self-forming, and clients may join groups where they are comfortable. The groups develop and maintain a feedback system with the health facility through community health workers. Clients follow an agreed code of conduct. Members take turns visiting the health facility to collect a three-month supply of medicines for all group members. They also complete a routine clinical examination during the visit.

Clients who participate in CAGs are more likely to stay on treatment. Antiretroviral therapy retention is 97% for CAGS clients, compared with 76% for clients in standard care at health facilities. Local medicine collection at a convenient time has resulted in high client satisfaction.

Service providers and clients at health facilities report benefits of reduced waiting times and lowered congestion at antiretroviral therapy clinics. Providers perceive a decrease in burden of care and are advocating for wider use of differentiated care programmes.

At the end of 2017, CIDRZ ran 856 CAGs at 21 facilities across 5 districts in the Lusaka, Eastern and Southern Provinces of Zambia (293).

PRIORITY GROUPS AND A DIFFERENTIATED APPROACH



Men and boys are not a homogeneous group. They have diverse experiences and identities, and each man has his own specific health needs. Some groups of men and boys, however, have a distinct set of HIV-related health needs due to particular risks and vulnerabilities. This is primarily due to age, sexual orientation and intersections with a range of other factors, including poverty and inequality.

An age- and population-differentiated approach should focus on groups of men and boys with the highest HIV incidence and prevalence, based on the latest epidemiological data for each country.

Age

Three age groups are at particular risk in different countries and in different settings:

- Adolescent boys aged 10–19 years: unique developmental processes take place during this time, and adolescents have specific characteristics that must be considered. Focusing on adolescent boys and young men is key for fostering healthy attitudes and behaviours and modelling positive masculinities. Many boys become sexually active at this time, and their health practices take shape and become cemented. Comprehensive sexuality education and social and behavioural communication programmes are particularly important, along with programmes that increase access to voluntary medical male circumcision and wider health service packages. These should be targeted at boys aged 10–14 years and those aged 15–19 years, with age-appropriate content for each group. In some countries, building on traditional initiation practices and providing voluntary medical male circumcision and wider health education as part of rites of passage may provide an additional strategy (48).
- Higher-risk young men aged 20–34 years: young men face the highest risk of HIV acquisition at this age. Those at highest risk are men with a high number of sexual partners (e.g. more than five in the past year), high levels of alcohol abuse, and highly inequitable gender norms (163). Key programmes for these men include those transforming gender norms, targeting HIV prevention programming, and encouraging frequent HIV testing with clear linkages to care for men who test positive for HIV.
- Higher-risk older men aged 35–49 years: older high-risk men are more likely to be living with HIV but less likely to know their positive status. They are often married but with concurrent transactional relationships and with partners more than five years their junior (163). Key programmes for these men include HIV prevention (especially condom use), programmes that transform gender norms, and targeted HIV testing and linkages to treatment where needed.

Sexual orientation

Sexual orientation refers to a person's capacity for emotional, physical and sexual attraction to, and intimate and sexual relations with, people of the opposite sex (heterosexual), of the same sex or gender (homosexual), or of more than one sex or gender (bisexual). The term "men who have sex with men" refers to all men who engage in sexual or romantic relations with other men. The term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of the motivations. Some men who have sex with men also form relationships with, or are married to, women. Some men sell sex to other men, regardless of their sexual identity.

Sexual orientation and homophobia have a significant impact on health-care needs. These needs can differ depending on the stage of life. Young people who think they might be gay, are gay, or are perceived to be gay can experience stigma and discrimination in school and in their communities. Some may be excluded by their families or face bullying due to their sexual orientation, leading to a sense of isolation, exclusion and clinical depression (294).

Gay and bisexual men and other men who have sex with men are at higher risk of sexually transmitted infections, including HIV. Some men may not feel secure about obtaining or using condoms and lubricant for sex because this might be interpreted as a disclosure of gay identity. Young men rarely receive appropriate sex education in school, including discussions about same-sex relationships. This can make it more challenging for young gay men to feel comfortable about negotiating safer sex.

Gender norms that value a heterosexual ideal place men at increased risk of poor HIV and broader health outcomes, especially gay and bisexual men and other men who have sex with men, transgender people, and people who do not conform to prevailing gender norms. These people face many barriers to accessing sexual and reproductive health and rights services and commodities due to repressive legal environments, stigma, discrimination or violence as a result of their sexual orientation or gender identity. Specific programming should be developed following the WHO consolidated guidelines for key populations (295).

Other intersecting vulnerabilities

Intersecting vulnerabilities related to poverty, employment, circumstances, behaviours and inequality make some groups of men particularly vulnerable to poor HIV outcomes. These include men who inject drugs, men in prisons, men with disabilities, migrant workers, long-distance truck drivers, local transport workers, fishermen, homeless men and refugees. Depending on the local epidemic, specific programmes should be designed to address these risks and ensure people from these groups access HIV prevention and testing with clear linkages to care. Specific programming should be developed following the WHO consolidated guidelines for key populations (295).

WHERE TO START?

This framework is not a toolkit to be implemented as is. Instead, it summarizes what is currently working across eastern and southern Africa and provides an overview of what is required at the country level to meet the globally agreed Fast-Track goals. To put the relevant key components into practice for different countries and different settings, the country, regional and global actions described below are required.



Country-level actions

To turn the framework into a workable plan, the following country-level steps are suggested:

- 1** Convene a national working group on men's and boy's health to discuss and coordinate actions around country-level data, including gaps and high-priority actions to address toxic sociocultural norms, gender inequalities and poor HIV outcomes among men and boys. This group could be a technical working group or similar mechanism, closely linked to existing HIV technical working groups. It should include feminist, HIV, gender equality and masculinity experts to ensure the guiding principle of engaging men and boys in relation to women's health and rights is upheld.
- 2** Develop a national road map for action, including a clear timeline and country-specific targets. The road map will outline key programmes and activities to reduce new HIV infections and AIDS-related deaths among men and boys, and decrease their HIV vulnerability. The road map should include adolescent-centric approaches that address high-priority issues for boys aged 10–19 years.
- 3** Integrate men's and adolescent boys' health needs into health plans and policies, such as including men as a target population with particular vulnerabilities, and addressing harmful gender norms and harmful masculinities in national HIV plans and other health policies and strategies. Developing separate national men's and adolescent boys' health policies has been shown to improve men's health, advance gender-transformative health care for men and women, and advance gender equality more broadly (18).
- 4** Commit to strengthening data collection and publishing HIV and antiretroviral therapy data disaggregated by age, sex and other available stratifiers. National monitoring and evaluation systems such as DHIS2, and separate HIV monitoring and evaluation systems, may need to be adapted to enable this.
- 5** Strengthen strategic alliances, partnerships and outreach. Build collaboration at all levels, including with non-health ministries, the private sector, networks of key populations, youth and women's organizations, trade unions, and networks working with men and boys.



George Mbogo and Japhes Baitani provide community-based health care and peer education. Tanzania, 2020. © UNAIDS

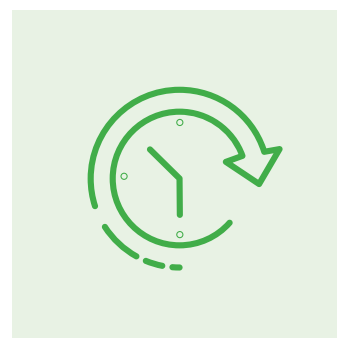
Regional and global support

The country-level actions outlined above require the support of diverse stakeholders and partners. The following global and regional actions are proposed for researchers, programmers, policy-makers, donors and civil society:

- Provide coordination and technical support. UNAIDS in collaboration with WHO and UNWOMEN is responsible for coordinating this body of work for the first two to three years. After this, an assessment should be conducted to map a more feasible and efficient coordination mechanism. In the long term, UNAIDS should consider setting up an interagency working group on men, adolescent boys and HIV in eastern and southern Africa. This working group could consist of governments, donors, United Nations entities, civil society and research partners that provide high-quality technical support to each of the focus countries.
- Share what works. UNAIDS will make available, through a clearing house, the latest research, guidance and best practice on what works to engage men and boys and address harmful masculinities in the HIV response. This clearing house will run under the auspices of the coordinating entity and, as this is a rapidly evolving field, be updated regularly (18).
- Mobilize resources. Specific funding is required to strengthen male engagement in the HIV response and to support countries developing and implementing their road maps. Funding will need to be sourced innovatively as these initiatives will not be able to rely entirely on traditional donors. Likewise, new programmes can not be supported from existing budgets without the risk of negatively affecting the situation for women and girls.

CONCLUSION: THE TIME FOR ACTION IS NOW

A range of complex factors contribute to men's and boys' low uptake of HIV-related services, often underpinned by prevailing harmful gender norms. Men and boys lack the universal entry points to health systems that women have. This is compounded by opening hours and facility-based service delivery models that limit access for men who work outside their communities. Health-system barriers go beyond the service delivery level, and a broader supportive enabling environment needs to be intentionally created, including laws, policies and health strategies. In most countries, men and boys are largely missing from public health strategies, and there is little mention of strategies or activities to improve their access to health and HIV services. As part of universal health coverage, HIV policies, programmes and services need to be integrated into existing primary health services, systems and budgets. To end the AIDS epidemic as a public health threat, there needs to be accelerated action, at multiple levels and across the HIV cascade. Existing barriers to men's and boys' use of HIV services must be addressed, and what has been proven to work must be scaled up.



Japhes Baitaini and George Mbogo giving counsel to a motorbike taxi driver. Dar es Salaam, Tanzania, 2020. © UNAIDS.

The next steps are clear. This framework for action outlines building blocks for planning, implementing and monitoring improvement in the HIV response among men and boys within a broader gender equality framework. Urgent and sustained action is needed in each country in eastern and southern Africa to put this framework into action so the globally agreed Fast-Track targets to end the AIDS epidemic as a public health threat by 2030 can be achieved.

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