
HIV and AIDS

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Evidence around engaging men in HIV prevention and treatment

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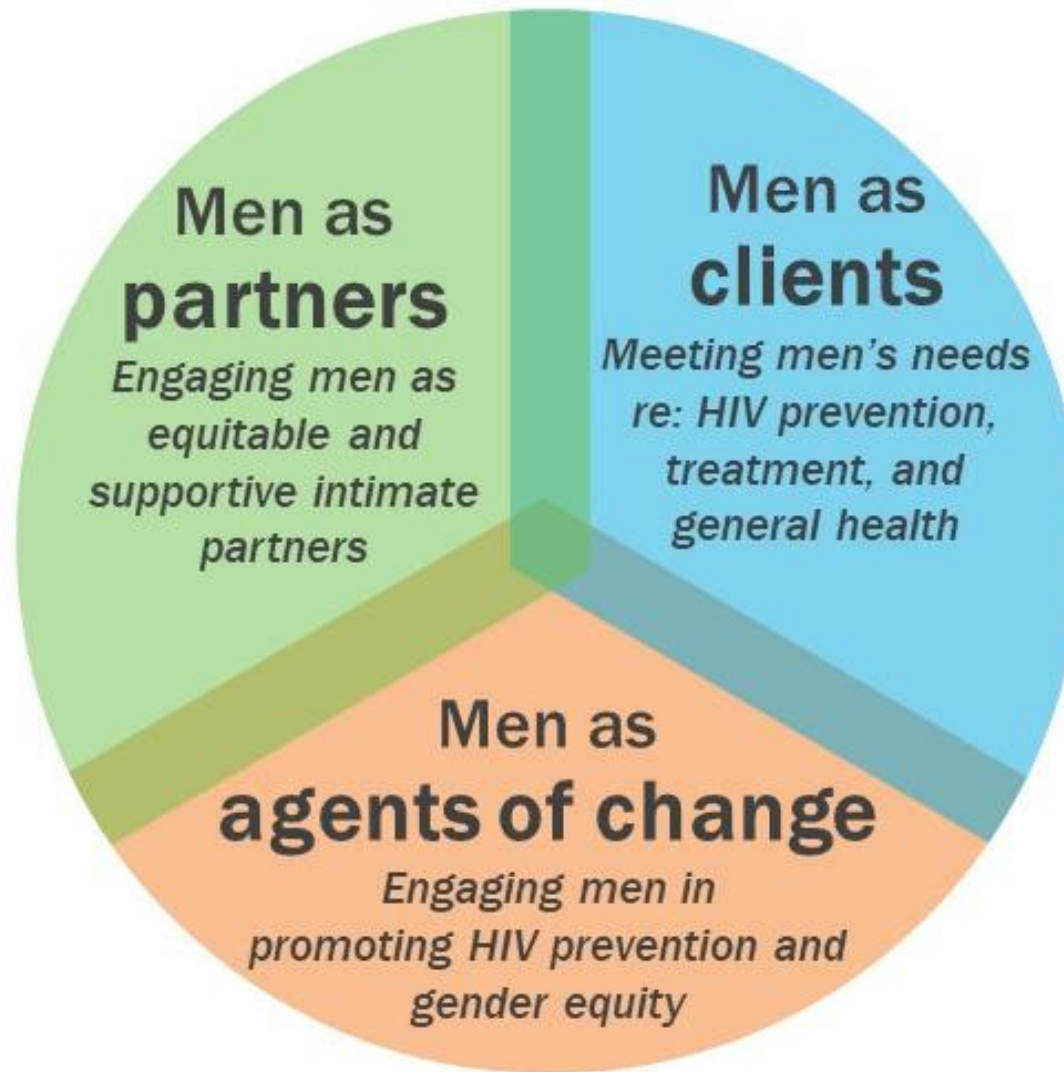
Evidence around engaging men in HIV prevention and treatment

**Drs. Julie Pulerwitz,
Ann Gottert, Jerry Okal, &
Sanyukta Mathur**

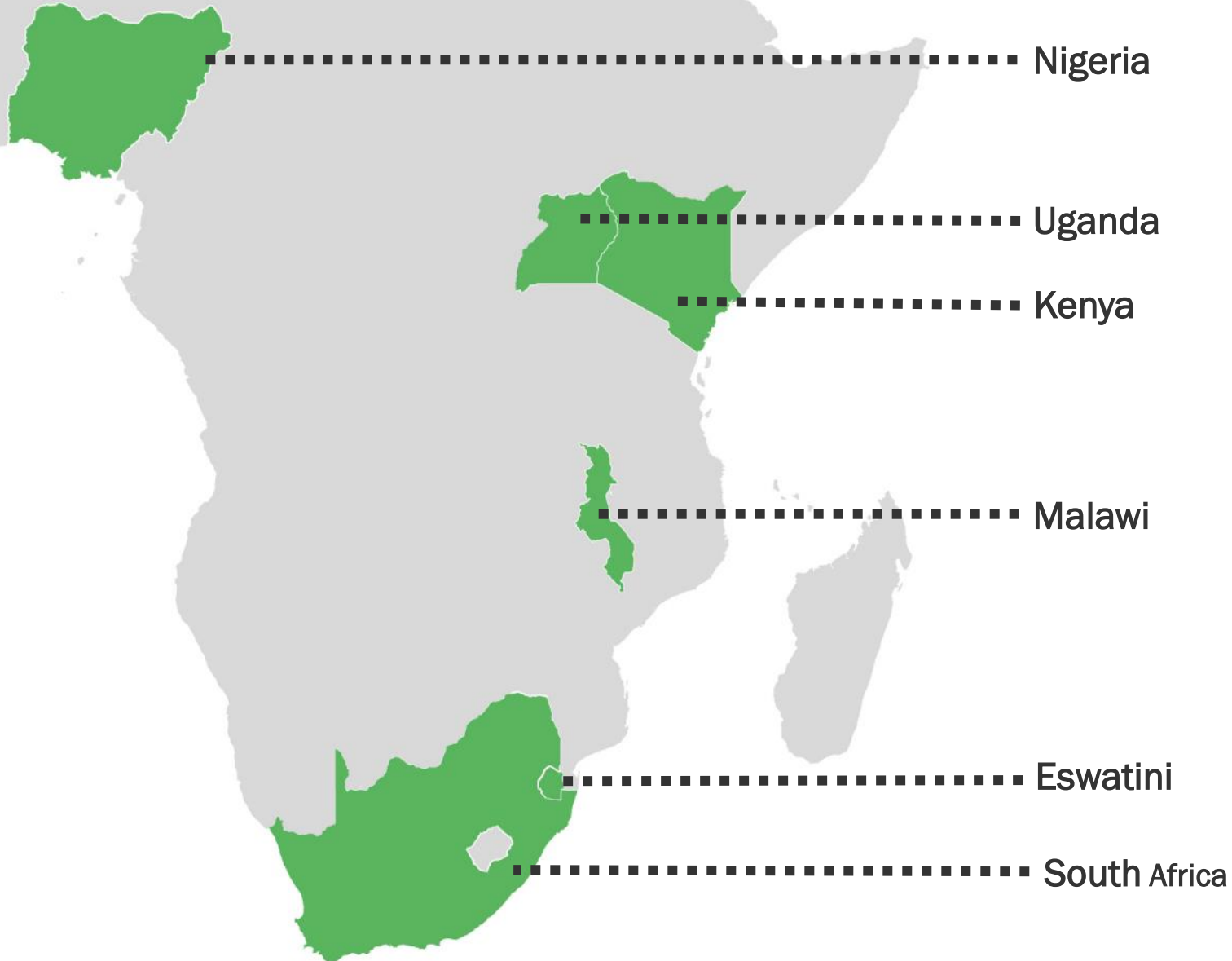
**Webinar
15 April 2020**



Framing for today's presentation



Settings of implementation research



Study designs/methods

	Study portfolio/ funder	Quantitative data with men (<i>cross-sectional surveys unless otherwise noted</i>)	Qualitative data with men	Program implementing partners
Eswatini (2017–18)	DREAMS	n=843 (Round 1/MEASURE Evaluation survey) n=1180 (Round 2)	66 IDIs	3 FGDs
Kenya	SOAR	n=124 facilities; n=277 clients	32 IDIs	8 IDIs
Malawi (2018–19)	SOAR	n=612	4 FGDs	ADD
Nigeria	NIH	Cohort, n=257 MSM	—	—
Nigeria	Elton John AIDS Fnd.	Monitoring data from >11,000 MSM	—	—
South Africa (KZN) (2017–18)	DREAMS	n=962 (Round 1) n=886 (Round 2)	72 IDIs	3 FGDs
South Africa (Mpumalanga) (2016–19)	SOAR	n=1,149 men & women (Round 1) n=1,189 men & women (Round 2)	59 IDIs	39 IDIs
Uganda (2017–18)	DREAMS	—	126 IDIs	9 FGDs



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Engaging men as **partners**

Who are the men/male partners of adolescent girls and young women?

- There are distinct subgroups/profiles of men/male partners, who should be targeted differently with programming
- Not just older high-risk men, younger men have high HIV risk profiles too.
- Risk profiles of older and younger men don't look the same.



**OLDER
HIGH
RISK**
23%
of sample



**OLDER
LOW
RISK**
25%
of sample



**YOUNGER
HIGH
RISK**
18%
of sample



**YOUNGER
MODERATE
RISK**
34%
of sample

Study site: South Africa, n=1,846 (Similar groupings, with nuances, found in Eswatini)

Gottert, A., Pulerwitz, J., Heck, C.J., Cawood, C. & Mathur, S. Creating HIV risk profiles for men in South Africa: A latent class approach using cross-sectional survey data. *Journal of the International AIDS Society (JIAS)* (under review).

Promising approach to creating HIV risk profiles

- Latent class analysis (LCA) uncovers ‘hidden’ groupings in data
 - Simultaneously combines multiple characteristics (e.g., demographics, attitudinal and behavioral)
- Builds on benefits of other quantitative and qualitative approaches
 - Opportunity to develop complex picture using large sample



What are the factors that distinguish HIV risk?



**OLDER
HIGH
RISK**

23%
of sample



**YOUNGER
HIGH
RISK**

18%
of sample



**YOUNGER
MODERATE
RISK**

34%
of sample



**OLDER
LOW
RISK**

25%
of sample

36 years old

27 years old

23 years old

29 years old

Married/cohabiting

Unmarried

Unmarried

Married/cohabiting

Informally/formally
employed

Informally employed

Unemployed,
despite being university/
tech college grads

Informally employed

Moderate # of partners

High # of partners

High # of partners

Low # of partners

High age difference

Moderate age difference

Low age difference

Moderate age difference

Many high-end transact.
relationships

Many low-end transact.
relationships

Some transactional
relationships

Minimal transactional
relationships

High alcohol abuse

High alcohol abuse

Moderate alcohol abuse

Moderate alcohol abuse

Moderate gender inequity

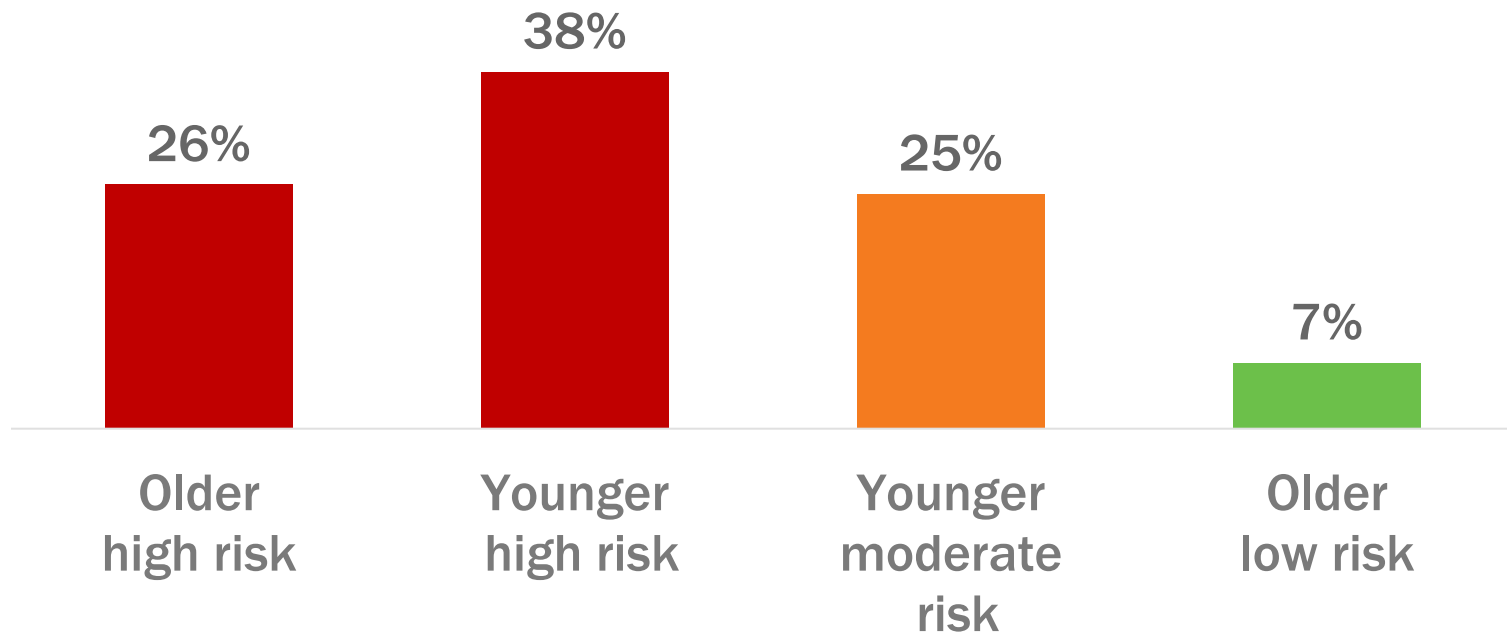
High gender inequity

Moderate gender inequity

Low gender inequity

Gender attitudes a key distinguishing factor

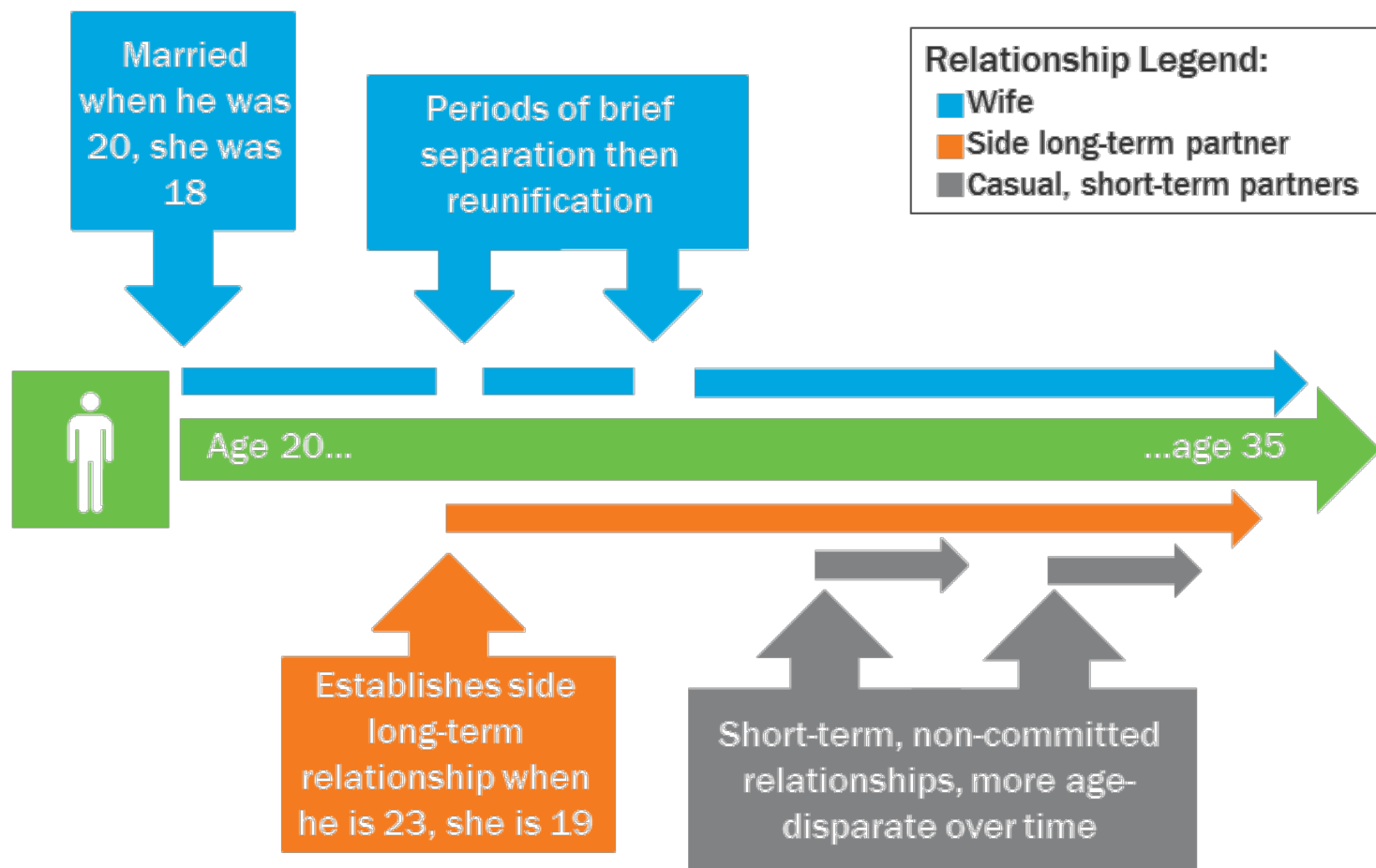
Highest-risk group = most gender-inequitable



Endorsement of highly inequitable gender norms

What are men's relationships like?

Increasingly complex relationship patterns as men grow older



Study site: Uganda (n=94 IDIs)

Relationships are dominated by conflict and miscommunication

- Marital relationships filled with conflict—seen as inevitable and unresolvable
- Most relationships characterized by ineffective communication and distrust, resulting in delays in formalized partnerships and/or many side partners

...it is caused by lack of trust in relationships such that sticking to having one partner might cause issues such as if she cheats. So, it is very difficult to commit yourself to one individual; we end up having several partners.

—Man from Eswatini

Men think about their relationships in transactional terms

- Men see money and gifts as the only way of establishing and maintaining relationships with women
- Men see most young women as active agents in pursuing transactional sex and mainly seeking material goods
- Many men intentionally seek young women because they are more compliant (i.e., power dynamics)

A man without money get a wife or sexual partner? It doesn't exist in our community.

—Man from Uganda

The young women listen and cooperate all the time, yet older women argue.

—Man from Eswatini



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Engaging men as **clients**

What are we learning about reaching men with HIV services?

Men in higher-risk profiles were less or no more likely to use HIV services than lower-risk profiles

	Younger mod. risk	Younger high risk	Older low risk	Older high risk
Tested for HIV in last 12 months	72%	73%	70%	71%
Received VMMC in last 5 years	52%***	36%	21%	14%

*p<0.05 | **p<0.01 | ***p<0.001

Study site: South Africa, n=1,846 (Similar results in Eswatini)

Large gaps in men's HIV treatment knowledge

	South Africa (2017–2018)	Eswatini (2018)
Believes that/knows about:	n=1,847	n=1,099
Take treatment, stay healthy and live long	94%	75%
Good to take breaks from ART (false)	22%	14%
Treatment as prevention	55%	50%
Pre-exposure prophylaxis (PrEP)	23%	42%

Treatment literacy was not much better among men living with HIV in our studies in each country

Men's reactions to HIV testing vary

- **Willing yet non-proactive testers:** most common

I didn't decide [to test], I met people like you doing door to door testing so I just used that chance and tested. (Age 31)

- **Vigilant testers:** perceived importance of early treatment

...it is wiser to know your status and hence take your ARVs before the sickness weakens your immune system to near death, causing...people to gossip about you. (Age 34)

- **Resistant testers:** smallest group, yet also highest risk

...testing has to come from my heart before taking that decision....I don't want to take the decision yet in the end that thing will haunt me. ...I have never tested.... (Age 23)

What differentiates facilities with high vs. low volume of men coming for HIV testing?

- Offer services 6 or 7 days/week (vs. 5)
- More likely to offer male key population services
 - IDU (54% vs. 27%, $p < 0.01$)
 - MSM (60% vs. 35%, $p = 0.01$)
 - MSW (48% vs. 28%, $p = 0.03$)
- Less likely to provide PMTCT services (57% vs. 85%, $p = 0.001$)
- No difference by public vs. private

Study sites: Nairobi, Kenya (n=124 facility surveys)

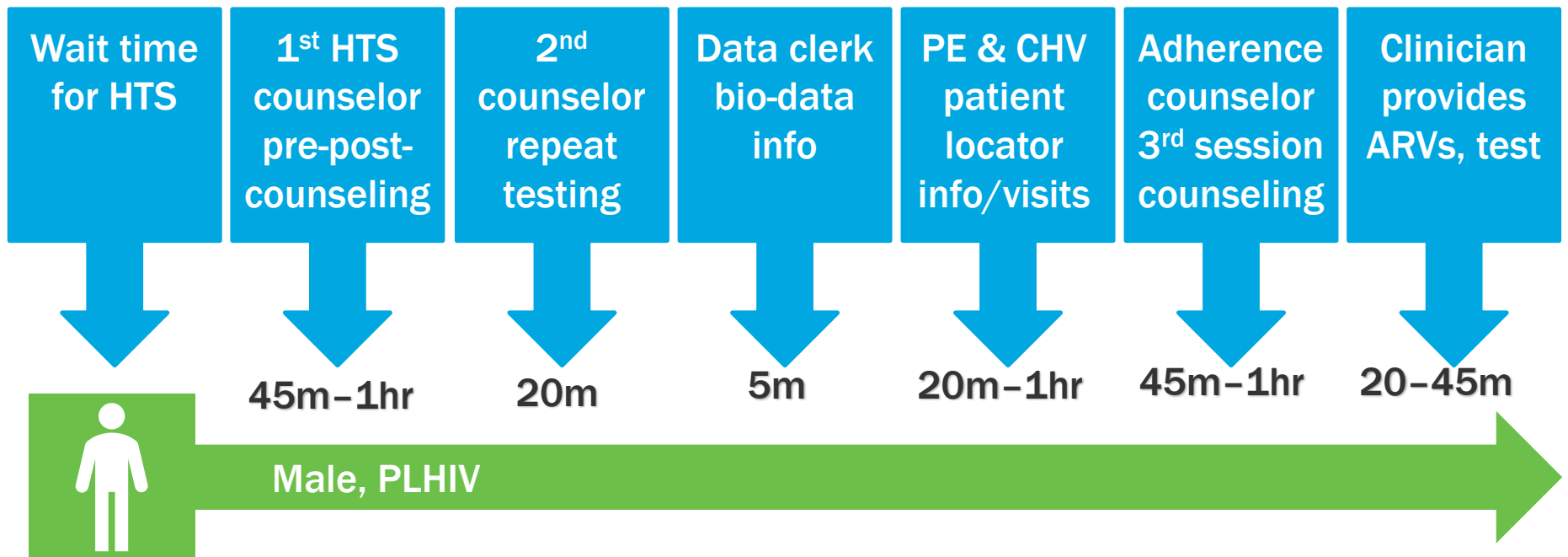
Note: facilities considered high volume if the proportion of male clients accessing HTS was >45% for each quarter during 2017

What are men's testing experiences at facilities?

- Most seeking HIV testing at facilities were repeat-testers:
 - 87% had previously tested for HIV
- Typically test at facilities close to their home or workplace:
 - Almost 40% tested at a facility because it was close to their home; 33% because near their workplace.
- Some men are not receiving post-test counselling:
 - 30% of repeat-testers were not counselled after last test

Study sites: Nairobi, Kenya (n=277 men seeking HTS at public facilities)

Steps and time required to access HIV care



Study sites: Nairobi, Kenya (n=30 IDIs with HIV positive men)

Okal, J., Lango, D., Matheka, J., Onyango, F., Ngunu, C. et al. "It is always better for a man to know his HIV status": A qualitative study exploring the context, barriers and facilitators of HIV testing among men in Nairobi, Kenya. *PLOS One*. Forthcoming

What about key populations that may be harder to reach with services, such as MSM?

- Peer educators (PEs) distributed oral HIV self-testing (HIVST) kits to their MSM networks
 - 320 recruited in 32 days by 12 PEs
- Oral HIVST is highly acceptable
- Most liked features:
 - Easy to use
 - Convenient
 - Private and confidential
- ~20% had never tested for HIV
- 5% tested positive
 - All linked to treatment



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Study site: Nigeria (n= 320)

Tun. W., Vu, L., Dirisu, O., Sekoni, A., Shoyemi, E. et al. Uptake of HIV self-testing and linkage to treatment among men who have sex with men (MSM) in Nigeria: A pilot programme using key opinion leaders to reach MSM. *Journal of the International AIDS Society* 2018, 21(S5):e25124

What are we learning about ART initiation and adherence?

Agency and ownership over own health

" When I finally came to and confirmed my status...they asked me whether they could start me on treatment. I said there is no negotiation over that; it is automatic that I start right away. I told them that is what brought me here. " (Uganda)

Supportive-yet-directive counseling from providers

"It was clinic counselors during the 7-day classes [that helped me decide to start ART]. They give you genuine information during these classes, so that by the time you leave, you are able to separate facts from the stories, as far as HIV and ARV treatment goes. " (South Africa)

Informational & instrumental social support

"[In] the support groups, we are able to encourage one another. So when you hear encouragement like this, you wonder, 'Can I stop taking the medication?' Then you tell yourself that, 'I must continue taking them. ' " (Malawi)

Still, few men knew if they had received viral load testing or if they were virally suppressed and few were aware of the effects of viral suppression on preventing transmission to their partners.

Hub and spoke model for improved access to HIV and support services

- **Peer navigation model** for providing HIV treatment and psychosocial support services for MSM in Nigeria
 - **Hub:** Population Council safe-space community health center
 - 37 counselors/testers selected from MSM networks
 - **Spokes:** 22 surrounding public health facilities
 - 335 health care workers capacitated/sensitized to provide MSM-friendly services
- **Community advisory committee:** provided structural oversight and advocacy for project; critical in highly homophobic context
- **Virtual social networking sites:** increasingly a viable recruitment platform for hard-to-reach men
- **Results:** Between June 2016 and Dec 2018—11,276 MSM were reached with HTS, 971 (8.6%) tested HIV positive, and 773 (80%) were enrolled in treatment



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Engaging men as **agents of change**

Community-based gender transformational programming: promising strategy

- *Tsima* “Working together”—3 year community mobilization intervention (2015-18) in rural Mpumalanga, South Africa
 - Main focus: Improving uptake of HIV services
- Strong focus on engaging men (and women) as agents of change
 - Regular mixed sex workshops 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
 - Village leadership publicly supported activities
 - Community Action Teams/program staff assigned to each village—both men and women



Baseline demonstrated importance of shifting gender norms for both men and women

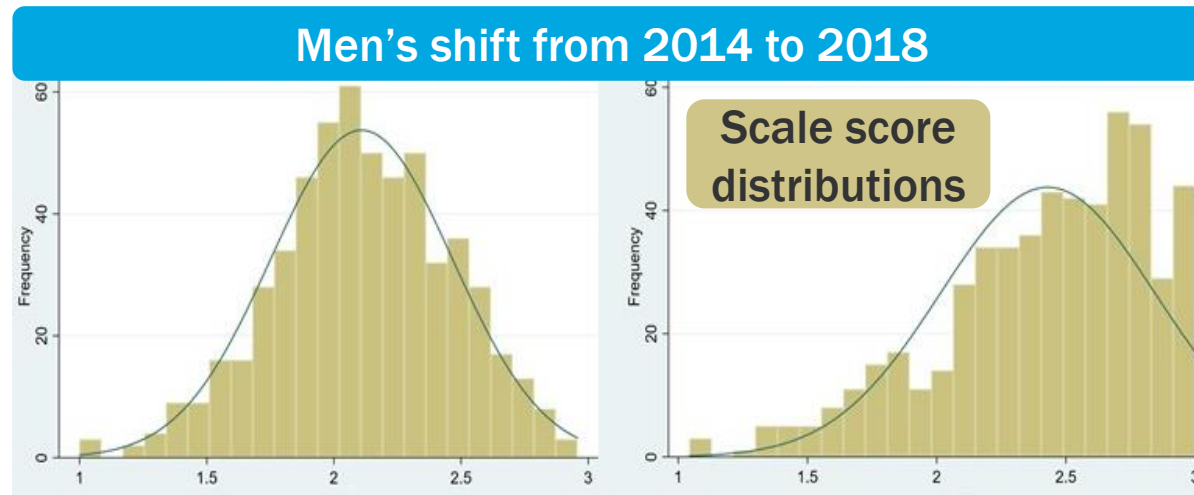
- Endorsement of inequitable gender norms associated with lower odds of treatment (ART) use

	HIV-positive WOMEN (n=122) aOR	HIV-positive MEN (n=48) aOR
GEM Scale (mean score, 23 items) Higher=more inequitable	0.2** (0.1, 0.5)	0.6 (0.1, 3.8)
Men's violence and control over women	0.3* (0.1, 1.0)	1.1 (0.2, 5.4)
Men as decision-maker in a couple	0.2** (0.1, 0.5)	0.3* (0.1, 0.9)
Men's toughness and avoidance of help-seeking	0.4* (0.1, 1.0)	0.8 (0.2, 4.1)

*p<0.05 **p<0.01 ***p<0.001; Controlling for age, marital status, education

Population-level shifts in gender norms are possible

- Cluster randomized controlled trial of Tsimba showed large increases in equitable gender norms in both intervention and control communities



➔ Qualitative research suggested shifts were influenced by recent, rapid increase in access to media (satellite TV, smartphones)

Intervention led to decreases in partner violence

- Among women ages 18–29, the intervention was associated with half the odds of IPV
 - Adj. Odds Ratio 0.48 ($p < 0.05$)
- Qualitative findings:
 - Reduced IPV in intervention villages was attributed to couples learning to communicate more constructively through Tsimba
 - Broader shifts in norms may have been critical enabler of reduced IPV

I was not communicating with her...She was always complaining about it, arguing and sometimes I was abusing her physically when she complained, but Tsimba has changed that, we always communicate nowadays.

—Male community member

More equitable and constructive couple communication also facilitated HIV service uptake

I will give you an example about a man who attended support groups...He told us that his wife did not trust him and there was no communication with her...Tsimba helped him. He disclosed his status to his wife and children, and they remind him to take his treatment.

—Female community member

Note: Analyses are still underway regarding effect of Tsimba on primary trial outcomes of HIV testing and treatment uptake

New resource that sums up today's findings

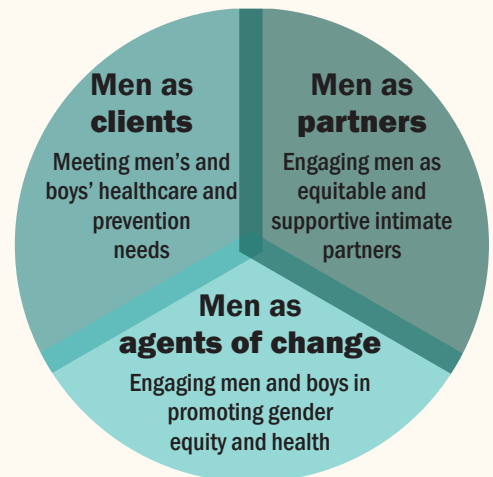
- Developed by the Male Engagement Task Force of USAID Interagency Gender Working Group (IGWG)
- Intended for programmatic and policy audiences
- Brief 2-pager
- Applicable across health areas – RH, HIV, MCH (and others, e.g., GBV)
- Represents lessons learned over time



DO's & DON'Ts for engaging men & boys

What should you do, and not do, when engaging men & boys in promoting health and gender equity? This resource brings together recent best practices and lessons learned for male engagement across health areas. It is intended to inform decision-making about programs, policy, media coverage, and funding priorities.

Why should you engage men & boys? Because they have their own distinct health needs and vulnerabilities, and because engaging men can benefit everyone—including women and girls. The reality is that inequalities in social value, power, and opportunities of men and women have provided men with many advantages, while at the same time men are disproportionately affected by many health challenges (e.g., homicide, alcohol abuse). Confronting both issues requires a careful balance, and the guidance below seeks to provide practical suggestions around how to do this.



Adapted from Greene, Mehta, Pulerwitz, et al. 2006



DO recognize and meet men's distinct needs.

- Engage men and boys in ways that acknowledge and meet their unique needs—as clients, as partners, and as agents of change.
- Don't overlook men and boys as clients, including within reproductive health programs. Men often access health services later than advised (including for HIV/STIs), which can lead to adverse outcomes and high mortality rates.
- Take into account the high rates of violence, depression, and substance abuse men experience, linked to harmful norms around masculinity. Ideally, seek to prevent these experiences, through intervention and legal/policy reform.



DON'T engage men at the expense of women.

- Ensure that male engagement efforts do not compromise women's safety and ability to make decisions and access services. Track this carefully.
- Pay particular attention to any potential increases in gender-based violence; know referral pathways to provide adequate support to survivors.
- Provide sufficient staff training—including refresher training—around how best to balance engaging men and women, and monitor programs to make sure that women aren't left out.



DO seek to transform harmful gender relations and norms.

- Recognize that some common gender norms and dynamics are harmful.
- Implement programs that explicitly seek to shift gender norms—called “gender transformative” programming—which are more effective in improving health outcomes than those that do not (see link to resources on the back). Investing in transforming gender norms can also be cost-effective and improve program sustainability.
- Engage men in caregiving as a powerful entry point for transforming gender relations and norms.



DON'T discount the structural barriers men face when accessing health services.

- Ensure privacy, convenience (e.g., after-work hours), and a welcoming environment (e.g., staff prepared to receive men). Like other clients, men need options and information that meet their needs.
- Don't assume that health facilities are necessarily the best place to provide health services. Often, community-based services can best reach men.
- Advocate for policy change that breaks down structural barriers preventing men from accessing services.



DO gather evidence with men and boys (and not just women and girls).

- Speak directly to men and boys, in addition to women and girls, when designing a male engagement program/policy or evaluating its effects.
- Seek to understand the kinds of issues raised in these DO's and DON'Ts: for example, diversity and needs across the life course, structural barriers to accessing services, and the impact of transforming gender norms.
- Ensure that all research follows ethical standards, especially around sensitive subjects like relationship violence.
- Use the research tools and measures already available whenever possible.



DON'T start with the assumption that all men are bad actors.

- It is counter-productive to hold negative assumptions about men as a group, even though men who engage in harmful behaviors like partner violence must be held accountable.
- Find and amplify the voices of men who support gender equity and those who are positively changing.
- Engage men and boys in recognizing how restrictive masculine norms negatively affect their own health and well-being, as well as that of partners, children, and families—and how moving away from these norms can benefit everyone.



DO start early in the life course.

- Start building equitable gender norms in childhood to promote healthier decision-making later in life. Messages about men's and women's expected roles and behavior are internalized starting early in life.
- Ensure boys' and young men's access to mentors who endorse equitable gender norms and model healthy behavior.
- Implement evidence-based interventions to prevent and address children's exposure to adverse experiences like violence and trauma, which are common among both boys and girls. These experiences affect men's and their partners' health outcomes later in life.



DON'T overlook the diversity of men and boys in the population.

- Design programming and activities to reflect critical dimensions of men's diversity, such as gender identity, sexual orientation, race/ethnicity, fatherhood, class, religion/faith, and age.
- Intervene during transformative moments in the life of men and boys (e.g., puberty, school graduation, marriage, parenthood), when their needs and outlooks are changing.



DO engage men on their own and in groups of men, as well as together with women.

- Consider implementing male-only groups as spaces for men to consider harmful gender norms and the benefits of change, as well as to freely discuss sensitive topics, express worries, practice healthy communication, and seek advice.
- Avoid **ONLY** engaging men in male-only spaces, which can reinforce inequitable gender norms. Ensure opportunities for men and boys to engage in dialogue that includes women and girls.
- Seek to build skills around positive communication and shared decision-making among genders within couples and families, in all program activities.



DON'T overlook scale and sustainability for achieving impact.

- Consider how to reach entire populations or communities and how to sustain those efforts over time.
- Seek to build effective male engagement strategies into policies, institutions, and systems—for example in healthcare, education, the workplace, and government.
- Use one of the existing, evidence-based male engagement strategies and activities whenever possible.

For more resources, visit www.igwg.org/priority-areas/male-engagement

Suggested citation: J. Pulerwitz, A. Gottert, M. Betron, and D. Shattuck on behalf of the Male Engagement Task Force, USAID Inter-agency Gender Working Group (IGWG). 2019. "Do's and don'ts for engaging men & boys." Washington, D.C.: IGWG.

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COVID-19 commentary under development

“Men and COVID-19: Where should our focus be?”

- Key suggestions for COVID-19 response:
 - Address barriers to men's timely engagement in care (particularly critical for COVID-19), that are deeply rooted in gender norms and beliefs
 - Use available tools to promote healthy communication and mitigate conflict among couples/families during stay-at-home orders
 - Build in research on the gendered effects of COVID-19, including disproportionate mortality among men, taking race/ethnicity, age, and other factors into account
- Authors (from Male Engagement Task Force): Myra Betron, Ann Gottert, Julie Pulerwitz, Dominick Shattuck, Natacha Stevanovic-Fenn

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DREAMS Male Partner Studies

Population Council: Ann Gottert, Julie Pulerwitz, Sanyukta Mathur, Louis Apicella, Jerry Okal, Craig Heck, Nrupa Jani, John Mark Wiginton, Cristian Valenzuela, Pamela Keilig, Ellen Weiss, Sherry Hutchinson

South Africa

Local research partner—Epicentre: Cherie Cawood, Elsa Marshall, David Khanyile, Dominique O'Donnell, Research assistants. *In collaboration with:* South African DOH, SANAC, eThekweni Municipality, PEPFAR-South Africa, DREAMS implementing partners

Eswatini

Local research partner—Institute for Health Measurement (IHM): Patrick Shabangu, Kelvin Sikwibele, Bhekumusa Lukhele, Feziwe Makhubu, Vimbai Tsododo, Bheki Mamba, Research assistants; Muhle Dlamini (SNAP); Muziwethu Nkhambule (NERCHA).

In collaboration with: Ministry of Health, NERCHA, SNAP, PEPFAR-Eswatini, DREAMS implementing partners

Uganda

Local research partner—Makerere University, Child Health and Development Centre (CHDC): Godfrey Siu, Anne Katahoire, Florence Ayebare, Research assistants. *In collaboration with:* Ministry of Health, District local government, PEPFAR-Uganda, DREAMS implementing partners

With funding support from the [Bill & Melinda Gates Foundation](#)

Project SOAR

Malawi DREAMS

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University of Malawi, College of Medicine: Effie Chipeta, Wanangwa Chimwaza, Vincent Samuel, Victor Mwapasa

South Africa Gender Norms

Population Council: Ann Gottert, Nicole Haberland, Julie Pulerwitz

Wits/MRC-Agincourt Unit: Lumbwe Chola, F. Xavier Gómez-Olive, Chodziwadiwa Kabudula, Kathleen Kahn, Nkosinathi Masilela, Stephen Tollman, Rhian Twine, Ryan Wagner

Wits/MRC-Agincourt Unit and University of North Carolina: Aimée Julien, Audrey Pettifor

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Sonke Gender Justice: Rhandzekile Mathebula, Dean Peacock, Dumisani Rebombo

Right to Care: Ian Sanne

Kenya HTS

Population Council: Jerry Okal, Avina Sarna, James Matheka, Daniel Mwanga, Roopal Jyoti Singh

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Nairobi County Health Centers Staff

All SOAR studies: Study participants

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Nigeria

HIVST among MSM

Population Council: Waimar Tun, Lung Vu, Osasuyi Dirisu, Adekemi Sekoni, Liz Shoyemi, Jean Njab, Sade Ogunsola, Sylvia Adebajo

With funding support from [U.S. National Institutes of Health](#)

Strengthening integrated delivery and access

Population Council: Osasuyi Dirisu, Sylvia Adebajo, George Eluwa, Waimar Tun, Jean Njab, Michael Kunnuji

With funding support from [Elton John AIDS Foundation](#)

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