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Evidence around engaging men in HIV prevention and treatment

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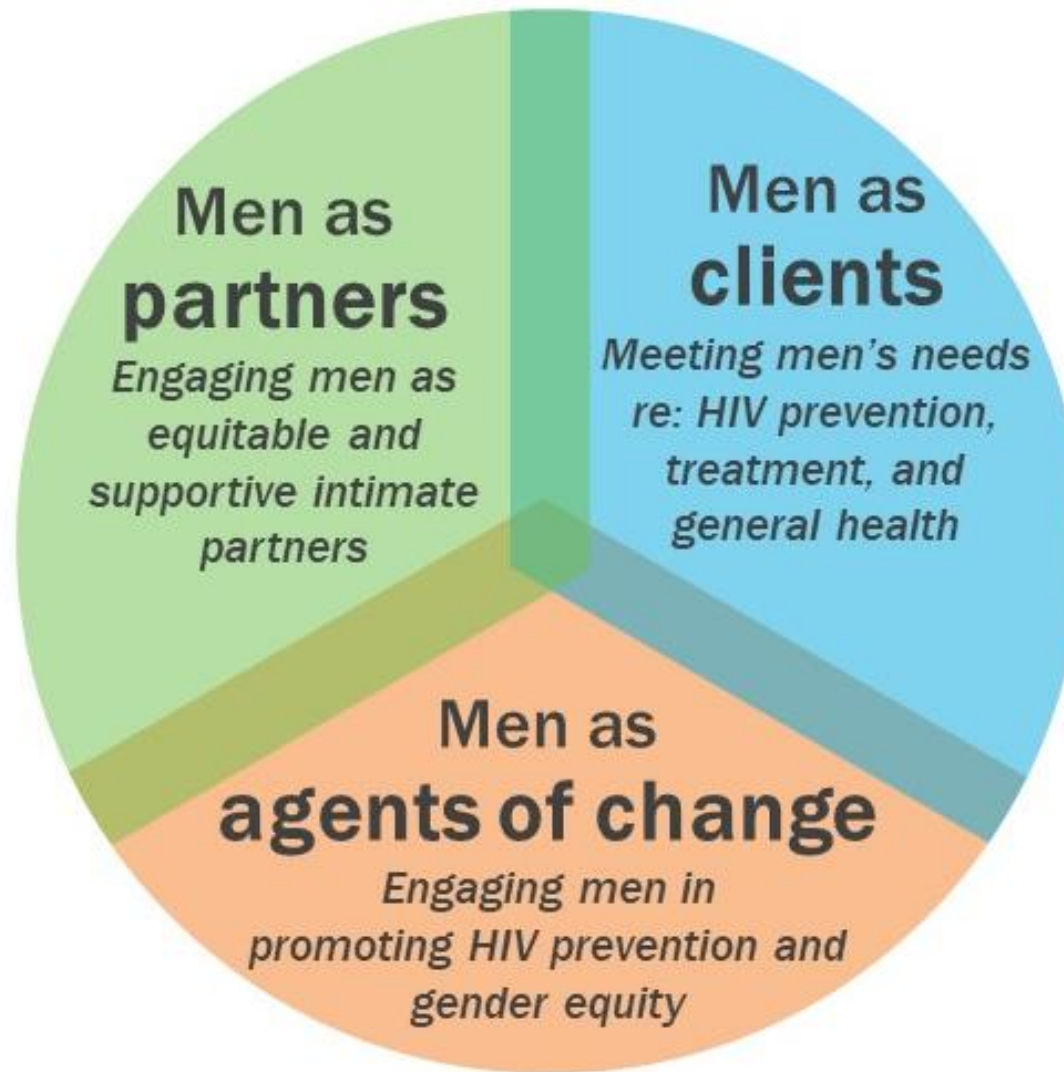
Evidence around engaging men in HIV prevention and treatment

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

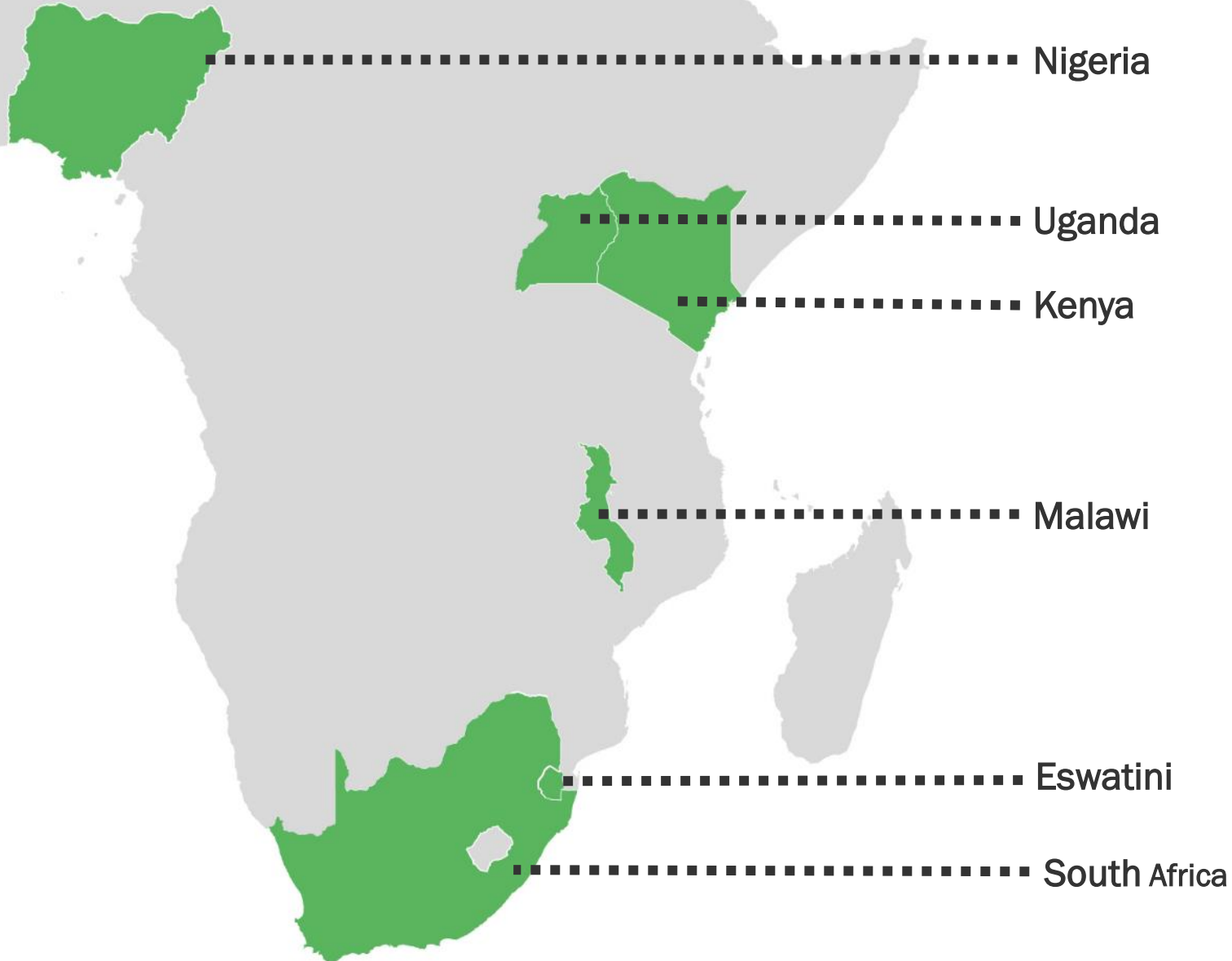
**Webinar
15 April 2020**



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)

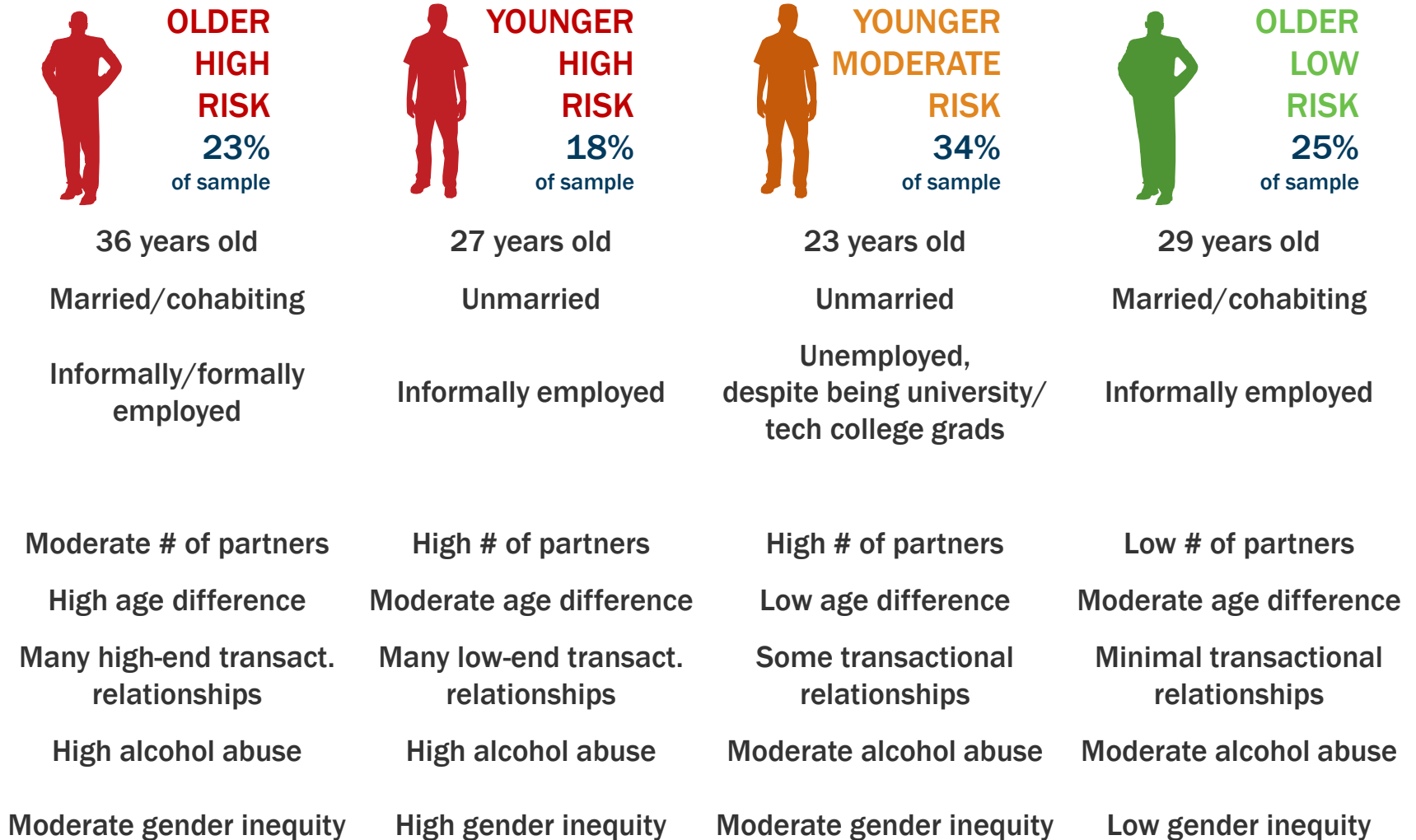
Gottert, A., Pulerwitz, J., Heck, C.J., Cawood, C. & Mathur, S. Creating HIV risk profiles for men in South Africa: A latent class approach using cross-sectional survey data. *Journal of the International AIDS Society (JIAS)* (under review).

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

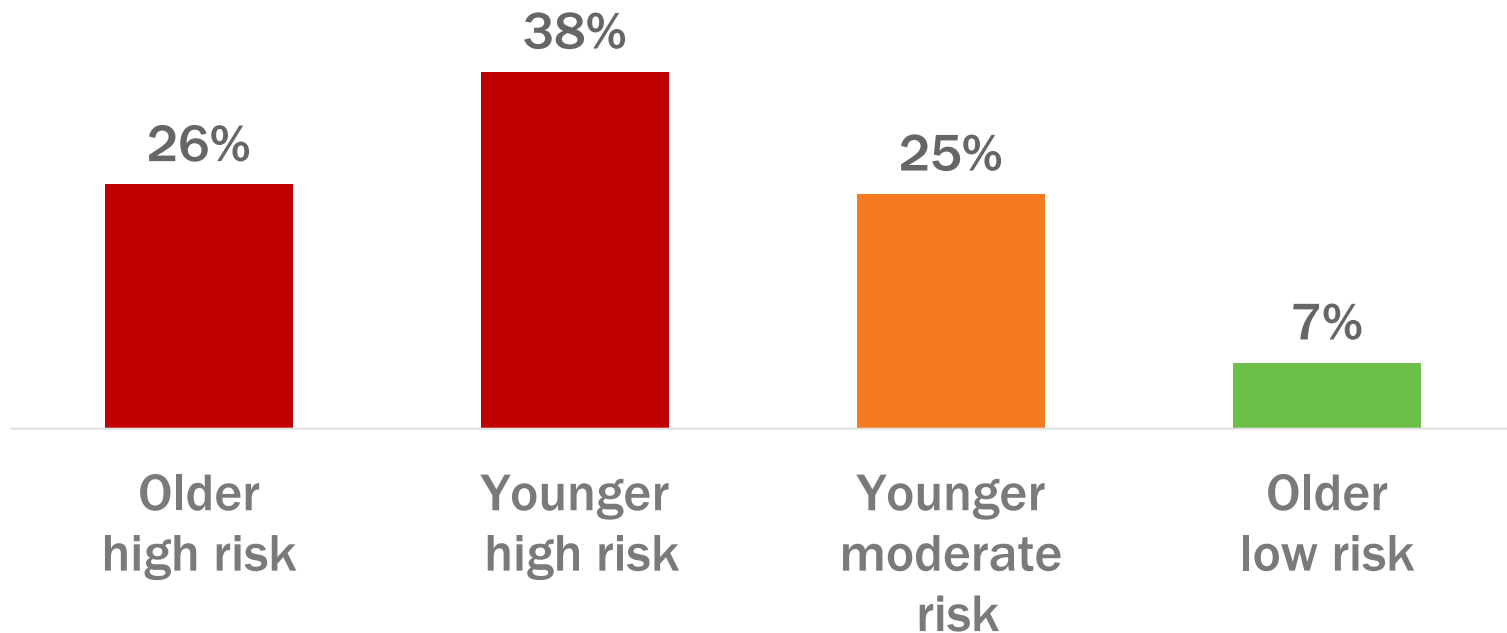


What are the factors that distinguish HIV risk?



Gender attitudes a key distinguishing factor

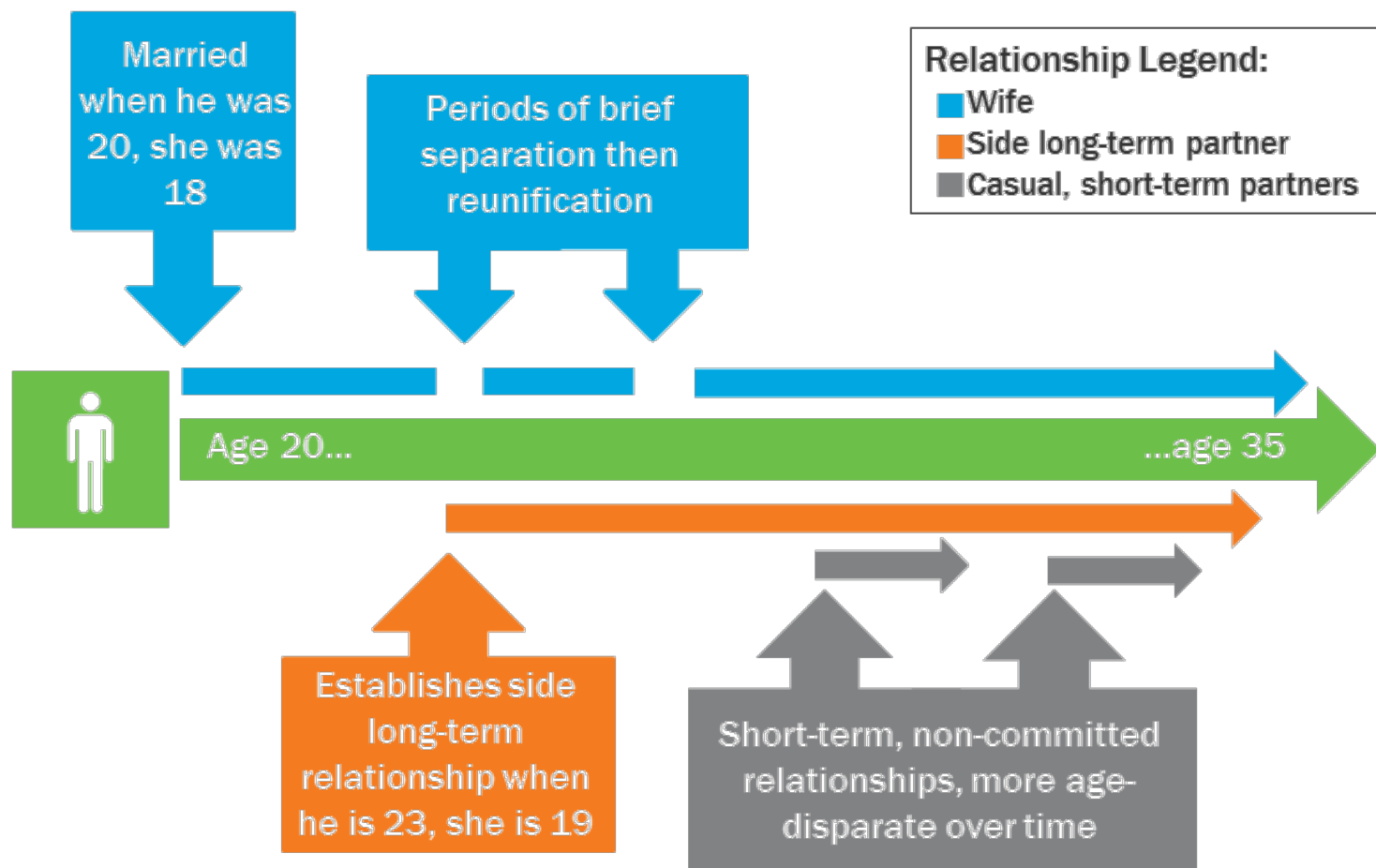
Highest-risk group = most gender-inequitable



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)

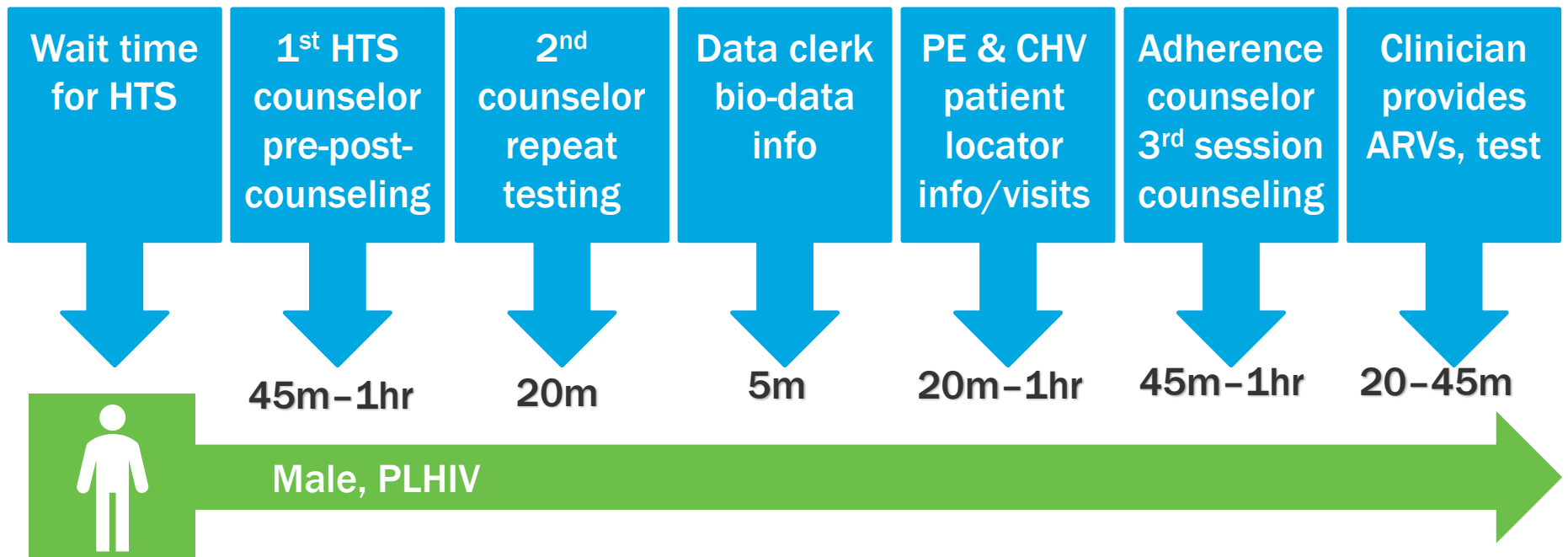
Note: facilities considered high volume if the proportion of male clients accessing HTS was >45% for each quarter during 2017

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* 2020, 15(4): e0231645.

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

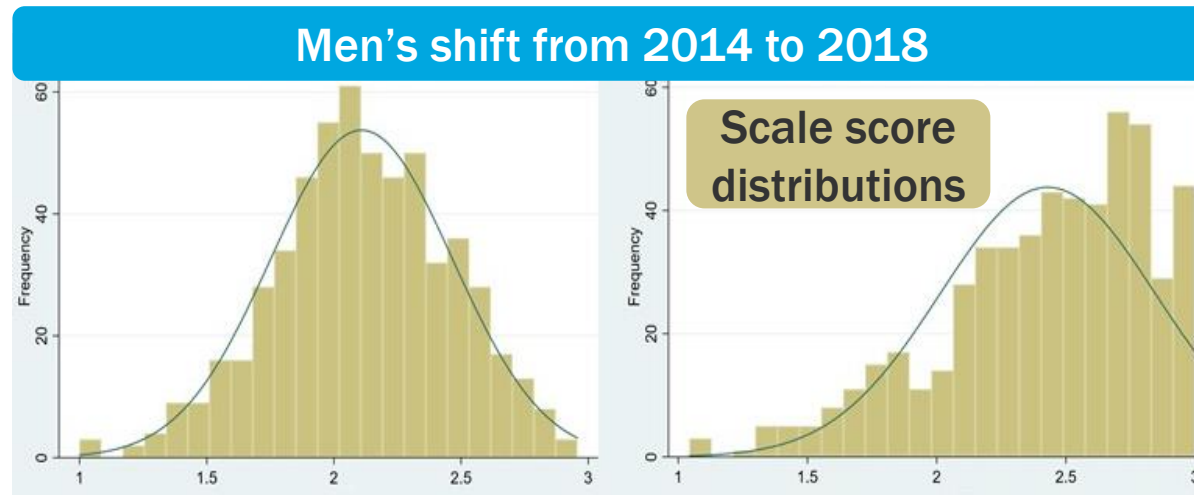
- Endorsement of inequitable gender norms associated with lower odds of treatment (ART) use

	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 recognize and meet men's distinct needs.



DON'T engage men at the expense of women.



DO seek to transform harmful gender relations and norms.



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



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



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



DO start early in the life course.



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



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



DON'T overlook scale and sustainability for achieving impact.

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

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Project SOAR

Malawi DREAMS

Population Council: Sanyukta Mathur, Nanlesta Pilgrim, Lyson Tenthani, Tracy McClair, Nrupa Jani, Kasoda Kondwani

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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University of California, San Francisco: Mi-Suk Kang-Dufour, Anna Leddy, Rebecca West

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

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