

HEARING FROM MEN IN ESWATINI: SHIFTS IN HIV RISK AND SERVICE UPTAKE

FINDINGS FROM DREAMS IMPLEMENTATION SCIENCE RESEARCH

HIV prevention efforts across sub-Saharan Africa are increasingly focused on engaging men, for their own health and that of their partners and families. We examined whether and how HIV risk and protective factors are changing among men in Eswatini (formerly Swaziland)—a country with a substantial HIV burden. The study is part of the [Population Council's implementation science research portfolio](#) on the DREAMS* Partnership¹, a large-scale initiative to reduce new HIV infections among adolescent girls and young women (AGYW) and their partners. Our studies related to male partners of AGYW were carried out in [Eswatini](#), [South Africa](#), and [Uganda](#).

Engaging men/male partners is key to addressing AGYW's risk, and DREAMS aims to do so by getting men/male partners of AGYW into HIV testing, voluntary medical male circumcision (VMMC), linkage to HIV care and antiretroviral treatment (ART), and implementing programming to change harmful gender norms in communities, including among men/male partners. In each of the DREAMS settings, program teams worked with AGYW to characterize their typical male partners to target outreach accordingly. In this study we sought to shed light on emerging trends around male engagement in the HIV response in Eswatini. The aims of the study were to:

- Identify successes and challenges of linking men to HIV services.
- Assess shifts in men's HIV risk factors over time.
- Assess exposure to and impact of USAID/PEPFAR-related activities, for men.

*DREAMS stands for Determined, Resilient, Empowered AIDS-free, Mentored, and Safe.

KEY FINDINGS

Between 2016–17 and 2018 (~1.5 year time-span), there were promising increases in HIV service use, and particularly in HIV testing.

There were no significant changes in HIV risk behaviors (e.g., numbers of sexual partners, inconsistent condom use, hazardous drinking, intimate partner violence), which remained prevalent.

Despite respondents' elevated HIV-related risk, there was also minimal exposure to community-based HIV prevention programming at each round.

In qualitative research, men described eagerly participating in HIV-related programming, which they believed supported them to reduce their number of sexual partners and improve relationship dynamics and HIV service engagement.

Location: 19 districts (Tinkhundlas)

Study Duration: 2016–2019

Funder: Bill & Melinda Gates Foundation

This research was conducted in close collaboration with: Institute for Health Measurement (IHM) Southern Africa, MEASURE Evaluation, the Eswatini National AIDS Programme, and the National Emergency Response Council on HIV and AIDS

METHODS

We conducted two cross-sectional surveys in 19 Tinkhundla (districts) of Eswatini with men ages 20–34 (the DREAMS target age range for men/male partners of AGYW in that country). This included 650 men at Round 1 (R1; December 2016–February 2017) and 741 men at Round 2 (R2; June–September 2018) who reported at least one sexual partner in the last year. Respondents were recruited from hot-spot venues across districts where intensive combination-prevention programs, including DREAMS, were taking place. These hot spot venues were identified by key informants as places where men at potentially higher risk of HIV infection congregate and where they meet AGYW and form relationships.²

We assessed changes over time in key HIV service use, risk behaviors, and program exposure among the men, controlling for age, marital status, employment status, and Inkhundla, and adjusting for the clustered survey design.

Surveys were complemented by 26 qualitative in-depth interviews in 2018 with male partners of AGYW who had recently participated in HIV services and/or HIV prevention programming, including a subsample of men living with HIV. These men were recruited via DREAMS implementing partners or based on their Round 2 survey responses (i.e., reported HIV service/program participation and/or living with HIV). Thematic data analyses followed a team-based, iterative process to arrive at final themes.

Who are the survey respondents?

(similar across the 2 rounds)

Mean age: 26;
range 20–40 years

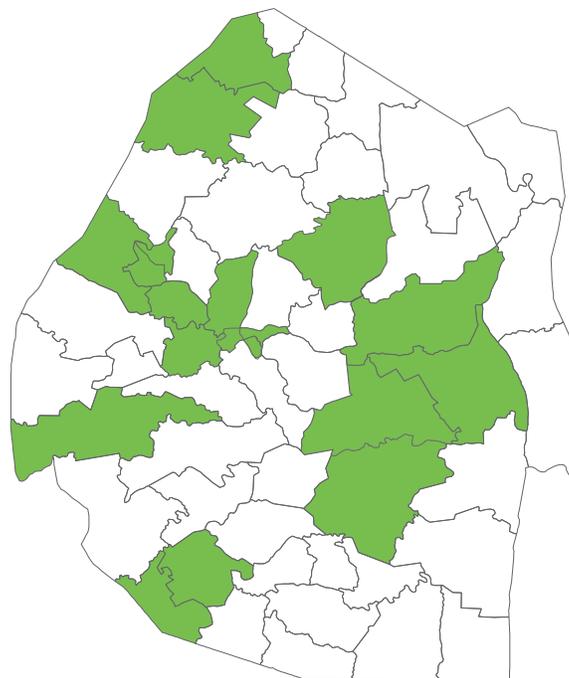
28% were married or cohabiting
(31% R1, 25% R2, $p < 0.01$)

57% employed

Half urban; half rural



Map of the Inkhundla in Eswatini districts, with the 19 included in this study shown in green

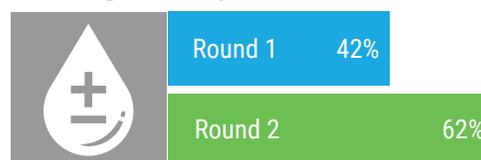


Among the 26 in-depth interview participants, mean age was 27 years (range 20–40). Less than 15 percent of men were married/cohabiting. About one-quarter were HIV-positive.

CHANGE IN HIV SERVICE USE

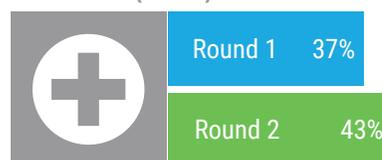
HIV testing, circumcision, and antiretroviral treatment increased

HIV testing in the last year



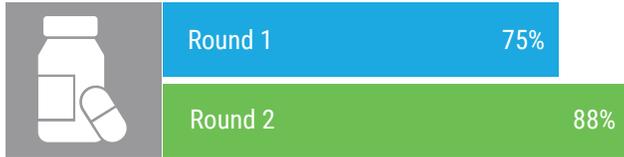
Adjusted odds ratio 2.26 [95% confidence interval 1.74, 2.93], $p < 0.001$

Circumcised (status)



Adjusted odds ratio 1.28 [95% confidence interval 0.94, 1.74], non-significant

Currently taking ART (men living with HIV)



R1 n=23, R2 n=24; note statistical power too low to detect significant difference

Convenient options facilitated routine HIV service use.

Men who participated in in-depth interviews described increasingly convenient and varied options for HIV testing, VMMC, and ART now available. For example, along with facility-based testing, there were mobile, door-to-door, workplace, and self-testing options.

“*Nowadays they provide door to door visits, they provide mobile units talking and calling people to test and know their HIV statuses...it really helps us as men. There is a huge change.*

—Age 24

“*Male circumcision is brought to the communities, unlike before when we had to go elsewhere.*

—Age 29

“*Service delivery has become mobile, where community health workers are the ones that bring the medication to [PLHIV], so it makes life a bit easier.*

—Age 25

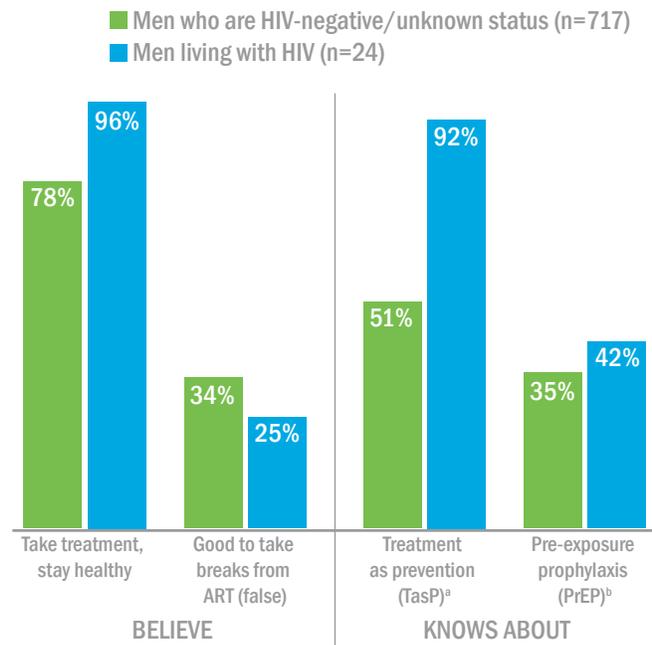
Supportive messaging about the effectiveness of early HIV diagnosis and treatment was critical.

This information/messaging was often communicated to men during pre-HIV test counseling and was consistently described as easing men’s fears around testing for HIV and subsequently linking to care if HIV-positive.

“*...what was important was the fact that they offered counselling once one decided to get tested.... They told us that the results were not a death sentence if you tested positive, that you can take treatment.*

—Age 24, HIV-positive

Treatment literacy was suboptimal.



^aResponded “yes” to “Can taking ART reduce the risk of transmitting the HIV/AIDS virus to another person?”

^bResponded “yes” to “Are there any special drugs an HIV-negative person can take to help avoid getting the virus from an HIV-positive partner?” These items were only included in the Round 2 survey.

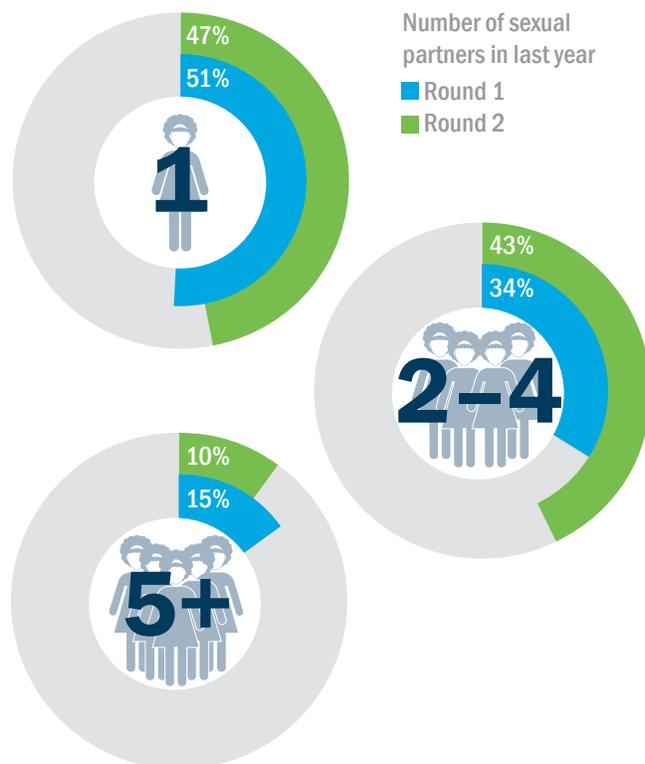
In our qualitative sample, both HIV-negative men and men living with HIV lacked knowledge about TasP (when we asked about this):

“*I only know that [ARVs] keep your immune system strong, I don’t know about the transmission part.*

—Age 28, HIV-positive

CHANGE IN HIV-RELATED RISK BEHAVIORS

Men reported similarly high numbers of sexual partners at Rounds 1 and 2.



There were no changes in age disparity, inconsistent condom use, or intimate partner violence perpetration with these partners.

	Round 1 %	Round 2 %
With last 3 non-marital/non-cohabiting partners:	(n=473)	(n=622)
Age disparate relationships (≥5 years)	35	34
Inconsistent condom use	62	58
With any of last 3 partners:	(n=650)	(n=741)
Intimate partner violence perpetration	15	15

Similarly, there were no changes in hazardous drinking or endorsement of inequitable gender norms.

Hazardous drinking (measured using AUDIT-C³) had a non-significant decline from 53 percent in Round 1 to 46 percent in Round 2.

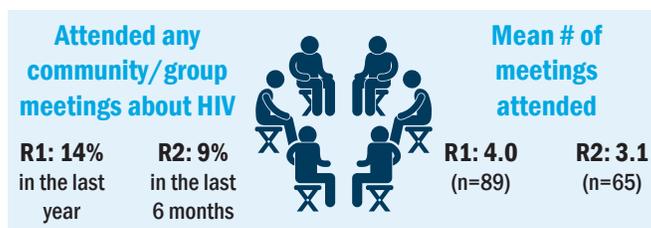
Endorsement of inequitable gender norms (measured using the GEM scale⁴) stayed at 3.5 on scale from 0 to 10.

Transactional relationships were common.

About two-fifths (42 percent) of men surveyed at Round 2 had a transactional relationship in the last year (based on reporting giving at least one item or service “mainly so you could start or stay in a sexual relationship” with a partner⁵). Thirty percent were less resource-intensive transactions (e.g., buying clothes, food, cell phones) while an additional 12 percent involved more resource-intensive transactions, for example, paying for their partners’ school fees or place to live.

MEN’S EXPOSURE TO AND PERCEPTIONS OF HIV PREVENTION PROGRAMMING

HIV program exposure was low.



These low reported levels of participation in HIV prevention meetings in surveys precluded meaningful assessments of associations with HIV risk factors/service use.

HIV prevention programming was eagerly received by men and supported positive behavior change.

Our qualitative research provided a rich understanding of men's experiences participating in HIV prevention programming. Men consistently described welcoming the opportunity to do participate in such programming. Commonly reported effects of prevention programs on men's HIV risk factors were reductions in numbers of sexual partners, improved communication, and reduced violence in relationships. Such programming also provided a foundation of information and support that facilitated engagement in HIV services particularly among those formerly reluctant to do so.

“They teach us a lot about HIV prevention, abuse, respect and a lot more...It made me learn a lot of things from the other young men...it also helps in changing one's behavior from bad to good.

—Age 22

“[They encourage testing by] giving a person hope when we meet as a community. In these meetings there is usually someone who gives out the information to take care and support others.

—Age 25

Certain programming involved regular, curriculum-based men's group meetings, particularly for younger men. These were described as providing opportunities for men to discuss the life challenges they face and learn positive coping strategies, in addition to encouraging HIV risk reduction and linkage to services. This was particularly the case for men at higher risk and/or those reluctant to join sessions they anticipated would be dominated by women.

“...we discussed mostly about life, how to avoid the diseases as young people and how to look after ourselves as men...they looked at the future and helped you according to your needs ...you get to know how other people live their lives.

—Age 25

“...we were talking as men alone...I felt good and comfortable because it was only us guys and we spoke about anything without any reservation, we felt free. We talked about everything ranging from relationships to HIV and how we can help ourselves regarding these things.

—Age 24

RECOMMENDATIONS

- Given high and sustained levels of multiple HIV risk factors, scale-up HIV prevention programming for men that include critical reflection about gender roles and HIV risk. Evidence suggests that such programs should last beyond a few sessions, and engage both men and women (together and/or in separate groups).^{6,7}
- Complement facility-based services for men with a continued emphasis on community-based, client-centered services.
- Implement supportive prevention programming that invites and meaningfully engages men⁸, including in opportunities to discuss life challenges with other men, for supporting uptake of services for hard-to-reach men.
- Prioritize information and messaging around HIV treatment efficacy, including TasP/ Undetectable=Untransmittable (U=U), as part of promoting men's informed decision-making about their own health and preventing transmission to their partners.^{9,10}

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For more information about the DREAMS IS portfolio:

Visit the DREAMS IS special series page: https://knowledgecommons.popcouncil.org/series_dreams/

"How to reduce HIV risk among adolescent girls and young women in sub-Saharan Africa? Implementation science around the DREAMS Initiative," *DREAMS Project Brief*. doi: [10.31899/hiv7.1009](https://doi.org/10.31899/hiv7.1009)

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"Who are the male partners of adolescent girls and young women in Swaziland? Analysis of survey data from community venues across 19 DREAMS districts," *PLoS ONE* 13(9): e0203208. doi: [10.1371/journal.pone.0203208](https://doi.org/10.1371/journal.pone.0203208)

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Suggested citation: Population Council. 2021. "Hearing from men in Eswatini: Shifts in HIV risk and service uptake—findings from DREAMS implementation science research," *Eswatini DREAMS Results Brief*. Washington, DC: Population Council.