



Getting to Zero: Diverse Methods for Male Involvement in HIV Care and Treatment

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Background

Women and girls continue to be disproportionately affected by HIV, representing approximately 60 percent of those living with HIV in sub-Saharan Africa.ⁱ Women and girls are also more likely to be isolated within the domain of the home and to lack decision-making power over their time, finances and movements. As such, healthcare providers must make a special effort to reach them.

While bringing HIV services to women and girls is critical, research shows that interventions are often more meaningful and lasting with the active participation of men and boys.ⁱⁱ Particularly in the context of heterosexual transmission of HIV, failing to get men in for prevention, testing and treatment services hurts women and families and thwarts efforts to contain HIV.

Men may fail to access HIV prevention and treatment services for reasons that include occupation, residence, employment-related migration, social norms and cultural beliefs.ⁱⁱⁱ They often wait longer than women to access treatment and are more likely to be lost to follow-up.^{iv} Outreach to women for care and treatment services has been comparatively more successful. Together, these reasons lead to late HIV diagnosis (including lower CD4 baseline values), the emergence of HIV sequelae and higher crude mortality rates among men.^v

The ambitious UNAIDS goal of “Getting to Zero”^{vi} cannot be achieved by reaching only half of the population; prevention and treatment must reach both sides of the equation – men and women – to get to zero. Increasing men’s involvement in caring for their own health and that of their families requires creative solutions. Catholic Relief Services, through AIDSRelief, has been increasing awareness about the need for men’s involvement and deliberate in its efforts to attract and retain men in its programs.



Emmanuel first brought his wife of 35 years, Angelna, for treatment when she was very sick. Both are receiving treatment and now, he says, “she is so strong, she can push down a tree.”
Karen Kasmauski for CRS.

Catholic Relief Services (CRS) seeks to address the unique roles, relationships, responsibilities and opportunities of men, women, boys and girls to meet their own needs and achieve their full rights, responsibilities and opportunities. Gender considerations are essential to developing strategies and programs for individuals and communities.^{vii} CRS programming is sensitive to the varied roles and responsibilities of men, women, boys and girls in the household and in society, and across many contexts and cultures. Applying a gender lens does not divert from the mission of stopping the impact and spread of HIV, rather it helps to fulfill it.

For more than two decades, CRS has been providing care and support for people affected by HIV. Since 2004, AIDSRelief, a five-member consortium, has provided HIV care and treatment for nearly 700,000 people in poor and underserved communities in ten countries, including more than 220,000 who were on antiretroviral therapy (ART) as of December 2011. AIDSRelief is funded through the U.S. President’s Emergency Plan for AIDS

Relief (PEPFAR) and brings together international expertise in HIV care and treatment: CRS as prime grantee; the University of Maryland School of Medicine Institute of Human Virology as technical lead for clinical care and treatment; Futures Group as lead agency for strategic information; IMA World Health and Catholic Medical Mission Board as implementing partners; and Children’s AIDS Fund as a key sub-grantee operating sites in Uganda and Zambia.

AIDSRelief has provided a flexible environment for testing clinic- and community-based strategies that foster men’s involvement in HIV prevention, care, treatment and support. In seven years of operation, AIDSRelief has greatly expanded gender responsiveness in its programming. This paper shares the strategies used by four AIDSRelief country programs for increasing men’s involvement in HIV treatment and adherence to antiretroviral therapy (ART).

AIDSRelief Strategies for Increasing Male Involvement

Using a gender analysis process to stimulate gender-responsive thinking

AIDSRelief Nigeria took the important, but often neglected, step of conducting a gender analysis of its program. While not exhaustive, the analysis stimulated gender-responsive thinking among staff and created a springboard for future action. Gender analysis can be mistakenly used to identify only missed opportunities for women and girls, but AIDSRelief Nigeria considered the full dimensions of gender—both male and female norms, roles and expectations—and responded to this in their programming.

Findings from the gender analysis included:

- The AIDSRelief Nigeria program responded to the epidemic’s disproportionate effect on women and girls by specifically targeting them with HIV services. Reflecting

the success of an extensive prevention of mother-to-child transmission (PMTCT) program, the number of female clients enrolled in AIDSRelief Nigeria was nearly double the number of males. In AIDSRelief Nigeria's support groups, nearly 80 percent of participants were women.

- Men and boys were under-represented in several care and treatment interventions, pointing to a need for more effective outreach and a focus on improving uptake.
- While the robust monitoring system captured sex- and age-disaggregated data, reports were underutilized as a basis for analyzing the gender implications of the program's structure. The addition of more finely-tuned indicators and/or the use of reflective questions during data analysis were recommended.
- The gender ratios of the AIDSRelief Nigeria and CRS senior staff, with women and men equally represented, were found to be a strength of the program. However, the gender analysis process pushed them further, leading to a gender training that addressed the norms and expectations of both women and men on the staff. AIDSRelief Nigeria plans to extend gender analysis opportunities to partners with the aim of addressing the sex-ratio and gender sensitivity of partner staff and volunteers.

Summary of AIDSRelief Nigeria's strengths and recommendations for improvement

Strengths	Recommendations
Services to women and girls (aged 15+ years)	Increase partners' counseling Increase couples' testing Increase involvement of men and boys in support groups
Sex and age disaggregated data	Include checklist of questions to improve gender analysis of monthly service data
CRS staff and AIDSRelief Nigeria staff include appropriate male/female ratios*	Conduct gender analysis of partner staff and volunteers

* As self-defined by CRS Nigeria staff via group discussion and consensus building.

As an outcome of the gender analysis process, CRS Nigeria conducted a gender awareness workshop for all staff. In the workshop, staff engaged in participatory exercises that explored the basic concepts of gender and fostered increased gender awareness within programming, the workplace and home. The workshop culminated in the development of an action plan which included the formation of a Gender Committee to follow-up on the next steps generated in the workshop.

Both the gender analysis process and the awareness-raising workshop provided a context for re-thinking gender norms and spurring staff creativity and motivation to improve gender responsiveness in AIDSRelief programming.

The successful promotion of voluntary medical male circumcision

AIDSRelief was involved in promoting voluntary medical male circumcision (VMMC) by making it available at the clinics and by promoting it within communities. At the time of writing, two AIDSRelief country programs, Kenya and Zambia, had introduced VMMC in several sites. In Zambia, 11 of 19 local partner treatment facilities provided VMMC through partners like Jhpiego and FHI 360. In Kenya, eight of 29 local partner treatment sites offered VMMC in Nyanza province, where HIV prevalence is the highest in the country (13.9 percent versus the national average of 6.3 percent)^{viii}.

Where VMMC is available, AIDSRelief played a role in promoting uptake of services through multiple provider-initiated clinic-based entry points and via church channels, community health volunteers and health care worker outreach visits. Once they come to the clinic for VMMC, they are introduced to the full range of HIV-related services offered at the clinic including counseling and testing, PMTCT, support groups, etc., that can help to protect them and their partners.

Recognizing the importance of support groups for men

Studies from diverse cultures consistently show that often men do not seek health services until it becomes absolutely necessary to do so. Many studies have confirmed that social constructs of masculinity act as a barrier to accessing HIV services for men.^{ix} In some places, men do not seek services because clinics are considered “women’s spaces”^x and they are placed in the subordinate position of learning from a female health worker which challenges their views of masculinity.^{xi} HIV, in particular, is considered a threat to manhood^{xii} and a sign of a man being unable to control his sexuality or to protect himself.

The formation of support groups specifically for men provides men with dedicated social space to negotiate, question, and re-form their concepts of masculinity. Through these groups, men often maintain their masculine identity as the provider and protector, but they re-define the behaviors necessary to fulfill their role.^{xiii} Support groups also perform a very important role as a safe space in which men can be vulnerable, access peer support and counseling for grief and anger, work through the emotions that come with an HIV diagnosis and share experiences with those in a similar situation.

Within AIDSRelief, men’s support clubs organically developed in five local partner treatment facilities (LPTFs) in Zambia and Kenya. In Zambia, “Men Take Action” groups, made up of both those affected by and those living with HIV, were hosted at LPTFs in Mtendere, Siavonga and Mwandu. In Kenya, a men’s support club started at the Nangina Holy Family treatment facility grew to 24 members. At another Kenyan site, three district support groups, comprised of 70 members and locally registered, formed at the Maua Methodist Hospital. Group members benefit from psychosocial support and access to income generating activities; their families benefit through the participant’s adherence to ART and through being encouraged to participate in counseling and testing and

PMTCT services. The community benefits from these men doing outreach and advocacy; they are invaluable as champions or role models of a redefined masculinity—one which seeks services and takes responsibility for protecting the health of his family.

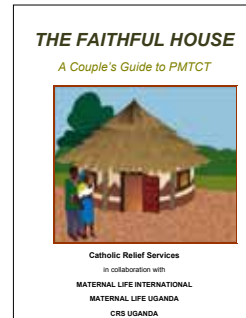
At Maua Methodist Hospital in Kenya, the founder of the Maua male support group was a member of the local community's Meru council of elders called Njuri Ncheke, the highest decision-making body in the community. The Maua men's support group wanted to share their "secret" of "bouncing from the jaws of death and back" with other men who were "hiding and dying needlessly from AIDS as a result of stigma and discrimination." The men felt that they had been rescued from fear and sickness and wanted to rescue others.

-Report from Dr. Subiri Obwogo, Deputy Chief of Party for AIDSRelief Kenya

While Zambia's and Kenya's men's support clubs formed organically, the formation of men's support groups in Uganda was facility-driven and for a specific purpose. In Uganda, staff noted many struggles in getting men to support their partners in PMTCT services—including the abandonment of mothers who were found to be living with HIV. The treatment facility in Kasanga started an active PMTCT support club that wanted to increase men's participation. While initiated at the clinic, the PMTCT support clubs moved into the community, holding meetings on weekends and for shorter periods of time, to attract male members. Male community leaders led the support groups and members shared their experiences. Efforts to make the PMTCT clubs friendly for men resulted in increased support of their female partners in PMTCT services.

Strengthening couples' relationships and encouraging couples' testing

AIDSRelief Uganda established a linkage between antenatal care services and The Faithful House (TFH) program. TFH is a faith-based, skills-building curriculum created collaboratively by CRS and Maternal Life International/Uganda. The goal of the program is to reduce the vulnerability of families to HIV transmission through family strengthening. TFH core curriculum was adapted to address key implementation challenges identified in the PMTCT project, such as HIV couples' testing and counseling, disclosure of HIV status between couples, ART adherence (mother and baby), support for mothers to attend antenatal care and deliver babies at health facilities, and support for feeding options for babies born to mothers living with HIV.



Couples-focused voluntary counseling and testing is effective because the full package of care can be made available to the entire family from the point of diagnosis. Through linkages with TFH, AIDSRelief Uganda established this continuum of care. Women who came to local partner treatment facilities for antenatal care were referred, with their partners, to TFH; through the program, communication and equity in the relationship was improved. An operations research study completed in March 2011 found that half of the couples in Uganda who participated in TFH went on to be tested for HIV, where 6.2 percent of participants learned of their HIV-positive status and were successfully referred into the AIDSRelief program for care, treatment and PMTCT services. The linkage between AIDSRelief Uganda and TFH program ensured a continuum of care by encouraging testing of entire families and enrolling families together in treatment and PMTCT services.



Waswa and Agnes Vincent in Uganda participated in The Faithful House and now have a stronger marriage and a healthy baby girl. Photo by CRS Staff.

Involving men in antenatal care and PMTCT services

HIV-positive women whose partners attend PMTCT services are more likely to adhere to treatment and appropriate infant feeding methods.^{xiv} AIDSRelief programs in Zambia and Uganda actively reached out to partners of women receiving antenatal care or PMTCT services.

AIDSRelief Zambia, through its partners, offered clinic-based incentives and community advocacy to encourage men's greater participation in antenatal care. Women who came for care without their partners were still treated, but were counseled on the importance of bringing their partners for testing. Women who came with their partners were attended to first and offered snacks. Provider-initiated testing and counseling was the standard policy for all Zambia sites, so that each partner accompanying for antenatal care services was also tested and the couple received counseling.

The Siavonga District Hospital in Zambia, where 85 percent of pregnant women are accompanied by their partners for antenatal care visits, is a success story of advocacy and community mobilization. First, AIDSRelief staff conducted community awareness activities in the churches and staff training with the nurses to sensitize them to the importance of men's involvement in women's antenatal care visits. Next, the Maternal Child Health team at the hospital presented the need for men's involvement to the hospital management. The government structures were engaged when hospital management discussed the problem with the District Commissioner. An enabling environment was created when the District Commissioner took the problem to the heads of departments to engage them in appealing to supervisors for men to accompany their wives for care. As a result, 85 percent of pregnant women presenting for care come with their partners, who are then tested for HIV and included in couples' counseling.

In addition to the linkages with The Faithful House, AIDSRelief Uganda has also put in place other activities to encourage men's involvement in antenatal care. The local partner treatment facilities trained on couples' counseling. In addition, the space used for antenatal care services provided a venue for couples' meetings. AIDSRelief Uganda also found success in issuing "love letters" to men inviting their participation in accompanying their partners to antenatal and PMTCT services.

Written invitations increased men's participation in antenatal care and increased uptake of voluntary counseling and testing.^{xv} AIDSRelief Uganda sends out "love letters" from women attending antenatal care and PMTCT and services to invite male partners to follow-up visits. Women and their midwives draft letters using the

words that the women feel will draw her partner to the clinic. Several form letters have been created, so that women can now choose from an existing letter and personalize it with names and dates. The letters include information about upcoming meetings in the community or at the clinic on the topic of healthy pregnancy. The clinician signs and stamps the letters to make them official and the women deliver them to their partners. The greater number of men attending information meetings and being referred for testing is a direct reflection on the success of this activity.

Lessons Learned

While AIDSRelief's mandate for rapid-scale up in poor and remote areas required intense and focused energy, the program also provided a platform for flexible, adaptive, gender-responsive programming. AIDSRelief strategies for improving men's involvement called for a better evaluation of interventions and their outcomes and provided some creative methods for men's involvement.

- Gender analysis of programs and policies and gender training for staff can begin a series of small changes which ripple throughout the program. AIDSRelief Nigeria experienced how even a brief look at gender-responsiveness within their program could lead to a demand for more training, which led to a committee charged with following up on action plans. As AIDSRelief transitions to local partners, partner staff should build on the progress of AIDSRelief Nigeria by engaging in their own gender analysis and gender-responsive policies and programs.
- Futures Group developed strong monitoring and evaluation systems within AIDSRelief. These systems monitored and responded to client adherence and loss to follow-up

through the collection and strategic use of high quality data (disaggregated by sex and age). The gender analysis conducted by AIDSRelief Nigeria revealed the need to take this a step further. As a result, future monitoring may include indicators such as “percentage of female clients accessing antenatal care services with their male partner”; and “number of men and boys participating in healthcare facility outreach.” Staff could develop guiding questions for gender analysis that draw out the implications of the data collected. The gender-responsiveness of ART programs would be strengthened by the inclusion of gender indicators for treatment programs.

- Targeting men with multiple, appropriate services encourages uptake and maximizes the effect of every visit that men make to a clinic. Provider-initiated counseling and testing in AIDSRelief Zambia and Kenya was one standard operating procedure which ensured that all men who crossed the clinic threshold were entered into services. Men who accompany partners for antenatal or PMTCT services should not play a passive role in the waiting room; they should be engaged in counseling and referred for appropriate services. Likewise, men entering the clinic for VMMC, such as those in Kenya or Zambia, are targeted for a range of preventative services.
- For the most effective care, the clinic’s efforts should be complemented by community outreach and wrap-around services. A definite strength of AIDSRelief was its ability to work at both the clinic and community levels with the referral network between AIDSRelief Uganda and The Faithful House program as an outstanding example of this complementarity.
- Men’s involvement in HIV prevention and treatment requires male champions to promote behavior change. Treatment facilities can create an enabling environment

for fostering leadership by encouraging men's support groups. Whether men's support groups develop organically as they did in AIDSRelief Zambia and Kenya, or whether the clinic deliberately establishes men's groups for a specific purpose, they form a space for men to renegotiate their masculine identity and to support one another in creating a new social norm.

- AIDSRelief sites in Uganda and Zambia exhibited their willingness to be innovative and to take risks. The love letters method is a clinic-initiated method of establishing communication between spouses and engaging partners in antenatal and PMTCT care. AIDSRelief Zambia took risks in incentivizing partner participation in care through clinic-based prioritization of couples and through community advocacy with local government and labor leaders. Incentivizing methods need to be carefully monitored for exclusionary results, but may be a positive way to reach the whole family.

Conclusion

Throughout implementation, AIDSRelief took small, gradual steps to increase men's involvement in the HIV response; it is hoped that sharing these experiences will encourage the transition and expansion of these efforts to local partners.

The UNAIDS goal of "getting to zero" requires thoughtful and creative approaches for reaching each member of the population. AIDSRelief has demonstrated flexible programming and innovative approaches which reach out to men and which ultimately improve health outcomes for everyone.

ⁱ UNAIDS, *2011 World AIDS Day Report*. (Geneva: UNAIDS, 2011).

ⁱⁱ Emily Esplan, *Engaging Men in Gender Equality: Positive Strategies and Approaches* (United Kingdom: Institute of Development Studies, 2006).

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^{xiv}SE Msuya, et al., "Low male partner participation in antenatal HIV counseling and testing in northern Tanzania: implications for prevention programs," *AIDS Care* 20 (2008): 700-709.

^{xv}BK Mohlala, et al., "The forgotten half of the equation: randomized controlled trial of a male invitation to attend couple VCT in Khayelitsha, South Africa," *AIDS* 25 (2011): 1535-1541.



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