RIGHTS, ROLES AND RESPONSIBILITIES OF MEN IN FAST-TRACKING THE END OF AIDS.

DRAFT PAPER FOR DISCUSSION

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TABLE OF CONTENTS

A. Glosary
B. Executive Summary
C. Introduction
D. Harmful gender norms and their impacts on men and women
E. Who are the men and adolescent boys affected by HIV, and to what extent are they affected?
F. Global commitments in the HIV response concerning gender equality
G. Between harmful gender norms and inadequate health systems: access and utilization of HIV services among adolescent boys and men
H. WHAT WORKS?: Engaging men for gender equality and better public health outcomes
I. WHAT WORKS?: Ensuring an effective HIV response among men and adolescent boys
J. Conclusions: looking forward

Disclaimer:
This discussion paper was produced through a literature review and with the inputs of several collaborators. It does not necessarily reflect the view and opinions of UNAIDS, or any of the authors or organizations who took part in producing it.
A. Glossary

Adolescent girls and boys: girls and boys aged 10-19 years old.

Comprehensive Sexuality Education (CSE): “seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality — physically and emotionally, individually and in relationships. It views ‘sexuality’ holistically and within the context of emotional and social development. It recognizes that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values.”

Gender: “refers to the socially constructed attributes and roles associated with being male or female. These attributes and roles define what is expected, allowed, and valued in women and men. Because gender is part of the broader socio-cultural context, it is experienced and expressed differently across various social identities, including political status, class, ethnicity, physical and mental disability, age, and other social classifications.”

Gender-Based Violence: any form of violence directed at a person because of their gender or gender expression.

Gender equality: “refers to the equal rights, responsibilities and opportunities of women and men and girls and boys.” Gender equality describes the concept that all human beings, both women and men, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices.

Gender equity: “Gender equity means that women and men are treated fairly according to their respective needs. This may include equal treatment or treatment that is different but considered equivalent in terms of rights, benefits, obligations and opportunities. In the development context, a gender equity goal often requires built-in measures to compensate for the historical and social disadvantages of women.”

Gay: “The term ‘gay’ can refer to same-sex sexual attraction, same-sex sexual behaviour, and same-sex cultural identity in general.”

Gender identity: “Refers to a person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, and other expressions of gender, including dress, speech and mannerisms.”

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5 Ibid.
7 Ibid.
Homophobia: “Fear, rejection, or aversion, often in the form of stigmatizing attitudes or discriminatory behaviour, towards homosexuals and/or homosexuality.”

Intimate-Partner Violence: “behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.”

Masculinity: “is the particular pattern of social behaviors or practices that is associated with ideals about how men should behave and their position within gender relations. Masculinity is a relational concept, defined in opposition to femininity and expectations about how women should behave.”

People engaged in sex work: this report refers to people engaged in sex works as those making an autonomous decision to be in sex work. It does not address those who are forced into sex work or those who are understood to be trafficked.

Reproductive health: “Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.”

Reproductive Rights: “Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.”

Sexuality: “a central aspect of being human throughout life; it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.”

Sexual health: “…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion,

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8 Ibid.
13 ICPD Programme of Action 1994, para 7.3
discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”

**Sexual orientation:** “A person’s capacity for profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender.”

**Sexual Rights:** Sexual rights protect all people’s rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination. The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled.”

**Sexual violence:** “is any sexual act, attempt to obtain a sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.”

**Transgender:** “Transgender describes a person whose gender identity differs from their sex at birth. Transgender people may be male to female (female appearance) or female to male (male appearance). Transgender people may be heterosexual, homosexual, or bisexual.”

**Transphobia:** “Transphobia is fear, rejection, or aversion, often in the form of stigmatizing attitudes or discriminatory behaviour towards transgender people, including transsexuals and transvestites.”

**Unsafe abortion:** “A procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both.”

**Young women and men:** women and men aged 15-24.

**Women’s empowerment:** Women’s empowerment means that women “take control over their lives: set their own agendas, gain skills (or have their own skills and knowledge recognized), increase self-confidence, solve problems, and develop self-reliance. It is both a process and an outcome.”

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20 Ibid.
B. Executive Summary

This discussion paper focusses on men, adolescent boys and HIV, and specific additional actions needed to Fast-Track the End of AIDS to improve the lives of men and women. First, it outlines how gender norms and harmful masculinities increase men’s HIV risk and negatively impact on behavior (to the detriment of women and men) and secondly, looks at the evidence and best practices in addressing these impacts and transforming harmful gender norms.

The paper also examines how current health policy, systems and services could be improved to increase men’s access and improve health outcomes overall.\textsuperscript{6,21,52,56}

The paper begins with the understanding that persistent and pervasive gender inequality is rooted in the structure of society, which accords men disproportionate power and privilege and limits the realization of women’s rights. In most parts of the world, social expectations around acceptable gender roles (or gender norms) reinforce the notion that men are dominant and women subordinate. The paper acknowledges the decades-long groundbreaking work to dismantle the effect of harmful masculinities on women’s vulnerabilities to HIV, poor health outcomes and the impacts of violence. Such efforts are essential.

The paper does not seek to replicate the significant, important work in this area. Rather it focusses on how gender norms and harmful masculinities impact on men’s risk and behavior, and the barriers to service access.

This paper does not suggest that the impacts of gender inequality and harmful gender norms is equally felt by men and women, nor that examining the impacts of harmful gender norms and rigid gender structures on men’s HIV outcomes ought to replace the still-needed attention to women. To the contrary, this paper aims to be both gender sensitive (understanding that gender operates to disadvantage some more than others) and gender inclusive (all people are affected by gender norms). Importantly, gender norms also intersect with other forms of marginalization that increase HIV vulnerability, such as those experienced by gay men and other men who have sex with men and transgender people.

To address the paper’s second main objective – increase men’s access to and use of HIV services by improving policy, health systems, and health services – the paper turns to examining the service access data strategies for overcoming the barriers many men still face. In the last decade, a growing number of studies have drawn attention to men’s low utilization of HIV services and the high morbidity and mortality that accompanies it. There are myriad reasons for men’s low utilization: these include, but are not limited to, the influence of unequal gender norms and the limited availability of HIV services targeting men.\textsuperscript{30} This paper therefore broadly examines how to increase men’s access to and use of HIV services.\textsuperscript{4,15,36,39}

Male-friendly strategies include expanded entry points for care, flexible service hours, workplace testing and counselling, home-based testing, and testing and treatment for couples. Laws and policies that obstruct access for marginalized men such as gay men and other men who have sex with men, and transgender people remain in need of reform. Expanded outreach
to men via traditional and religious leaders, sports, media outlets, and social media are also needed. Based on the preceding analysis, the paper concludes with multi-sectoral recommendations for action.

C. Introduction

The 2030 Agenda for Sustainable Development is a landmark commitment of world leaders aimed to guide global action for people, planet and prosperity. This ambitious development agenda builds on the progress achieved through the Millenium Development Goals (MDGs), and proposes a plan to complete what the MDGs were not able to, including the realization of human rights of all, achieve gender equality and empower all women and girls.

The 2030 Agenda includes 17 integrated and indivisible Sustainable Development Goals and 169 targets, making this Agenda a much broader instrument than the Millenium Development Goals, as it ensures that the economic, social and environmental dimensions to advance peace and prosperity are effectively addressed. Furthermore, the 2030 Agenda applies and benefits from the engagement of all countries, and not only those least-developed, ensuring that progress is sustainable by fostering global solidarity and shared responsibility.

Regarding gender equality, the 2030 Agenda has positioned it as both a standalone goal (Goal 5: Achieve gender equality and empower all women and girls), and included it “as a crucial contribution to progress across all the the goals and targets”.23 This mixed approach provides a unique opportunity to tackle the various determinants that perpetuate gender inequalities, limit women’s and girls’ empowerment and pose obstacles to the realization of their rights.

The End of AIDS is positioned in the 2030 Agenda under Goal 3, focused on ensuring healthy lives and promoting well-being for all, at all ages. “To end the AIDS epidemic by 2030 would mean that AIDS is no longer a public health threat. It means that the spread of HIV has been controlled or contained and that the impact of the virus on societies and on people’s lives has been marginalized and lessened, owing to significant declines in ill health, stigma, deaths and the number of orphans. It means increased life expectancy, unconditional acceptance of people’s diversity and rights, and increased productivity and reduced costs as the impact of AIDS diminishes.”24

To achieve this, the number of HIV infections and AIDS-related deaths will need to decline by 90% compared to 2010, and to do this the next 5 years are critical for the global HIV response. If the world does not step up the pace in the course of the next 5 years, the epidemic could spring back, and we risk losing the unprecedented progress achieved this far in halting and beginning to reverse the epidemic.

However, the gap of where the global HIV response is now, and where it should be, is wide. To ensure that we End AIDS by 2030, UNAIDS has launched the Fast-Track initiative, a location and

23 United Nations. General Assembly Resolution A/RES/70/1
populations-based approach, aimed at ensuring that resources are mobilized and used strategically for interventions that work, in places where the epidemic is affecting the most.

The Fast-Track approach also calls on the HIV response to be more accurate, and creative on how we reach those who need it most. This requires that our understanding of who are those that we need to reach, where are they and what opportunities lay for the HIV response to contribute for more equal and peaceful societies, guide our actions to effectively End AIDS by 2030.

In this sense, the End of AIDS will not be possible if we don’t advance gender equality, and the interconnectedness that gender norms have with HIV risk and vulnerability.

We consider gender transformative approaches to be those that critically examine gender norms for the purpose of building more gender equitable relationships and societies, by transforming unequal power relations.\(^7,^{36}\)

Greater attention now is being given to the startling disparities in HIV prevalence amongst girls and young women, and the structural vulnerabilities that perpetuate their risk in the context of HIV. Packages of programmatic interventions are finally being developed and rolled out, but, (with some notable exceptions) little has been done to develop ambitious programs to engage their male sexual partners to challenge harmful norms and advance gender equality. Moreover, men are not accessing and utilization of HIV services, which misses an opportunity to to work with men and transform norms of masculinity that contribute to new HIV infections among women and men.\(^{121}\) The needs of gay men and other men who have sex with men (MSM) must also be addressed. Too little has been done to reach out to men whose sexual orientation or gender identity does not conform to a heterosexual, masculinized ideal. In addition, men who inject drugs, who migrate for work, who engage in sex work, who are affected by armed conflict, or who are incarcerated also face specific circumstances, which increases their risk of HIV.

Some programmes and policies that do include men typically them as ‘the problem’ (i.e., as vectors of HIV).\(^{66}\) This not only reinforces the dangerous assumption that HIV prevention falls under the domain of women, but it also risks alienating men who might otherwise be open to becoming more engaged in the health and well-being of themselves and their partners.

Failing to ensure men's access to and use of HIV services yields predictable outcomes. Not only do men get sick unnecessarily, but their sexual partners, their families, their communities, and the health systems that serve them are also harmed. For instance, when men do not know their HIV status, they are less likely to practice safer sex, which in turn increases the risk of HIV infections among their partners. They are also less likely to access early treatment and therefore more likely to need ongoing care—both from loved ones (often women) and from health systems over stretched with male patients with dangerously low CD4 counts.

This discussion paper addresses men's under-utilization of HIV services by urging action on two fronts: first, challenging gender norms and public policies that negatively affect men’s and
women’s health, and secondly, improving health system policies and services so as to better reach men.\textsuperscript{4,15,36,39}

The findings and recommendations discussed in this paper are informed by multi-disciplinary literature comprising both peer-reviewed scholarship and publications from nongovernmental organizations and multilateral institutions including UNAIDS Joint Programme, IPPF, UNDP, UNFPA and Sonke Gender Justice. It also benefitted from the input of individuals in institutions such as UNAIDS, USAID, University of California Los Angeles, University of California San Francisco, University of Cape Town, University of North Carolina Chapel Hill, Promundo-US, and others. The paper does not, however, represent the views of the organizations and is developed to inform the discussion for the upcoming meeting.

The next section reviews the state of the HIV pandemic among men and boys, followed by a review of the international instruments and global commitments that are key to engaging men and boys for gender equality and HIV prevention.

D. Harmful gender norms and their impacts on men and women

Gender inequalities remain a global challenge, and manifest as the systematic denial of women’s rights, discrimination and violence, which pose obstacles to the advancement and empowerment of women. Patriarchy, men’s disproportionate power and privilege, sustains gender inequality. In most parts of the world, social expectations around acceptable gender roles (or “gender norms”) reinforce the notion that men are dominant and women subordinate.

Gender norms that make it acceptable for men to use violence, avoid health services, and demonstrate sexual prowess in order to live up to a masculine ideal are among the harmful masculinities fueling the spread of HIV. An extensive body of literature provides clear evidence that gender inequalities and associated gender norms about femininities and masculinities encourage men to act in ways that put themselves and their sexual partners at risk of acquiring HIV.\textsuperscript{20,23,24,47,50} Studies tell us that when men equate manhood with dominance over women, sexual conquest, multiple sex partners, condom refusal, alcohol consumption and substance abuse, and when women are expected to acquiesce to men’s sexual advances, it is difficult for women and girls to protect themselves from HIV.\textsuperscript{32,54,57,75}

The devastating relationship between gender-based violence and HIV has been extensively documented.\textsuperscript{31,70,92,93} Rigid gender norms and notions of what it means to be a man or a woman encourage men to partake in high-risk behaviours and condone and perpetrate violence against women.\textsuperscript{91} In South Africa, where both rates of HIV and gender-based violence are amongst the highest in the world, women attending antenatal clinics who reported a history of physical or sexual violence were 53% more likely to also be living with HIV. High levels of male-female gender power inequality resulted in 56% greater likelihood of testing HIV-positive.\textsuperscript{31}
In addition, gender norms that value a heterosexual ideal put MSM\textsuperscript{25} and transgender people at increased risk. Gay men and other MSM are more likely to acquire HIV at a young age, and they face many barriers to accessing HIV services including stigma, discrimination, and violence as a result of their sexual orientation or gender identity.\textsuperscript{116} Same-sex practices remain criminalized in 78 countries; in seven countries they are punishable by death.\textsuperscript{116}

Early exposure to violence is a strong predicting factor for repeating such behaviour in one’s own adult life.\textsuperscript{91} Breaking the cycle of violence requires addressing harmful and rigid gender norms particularly with men, as well as promoting gender equitable attitudes and behaviours with both men and women, and starting such engagement from an early age.\textsuperscript{35,74}\textsuperscript{4,34,52} Constructively engaging men as active agents of change rather than casting them as only perpetrators or vectors of HIV is critical to affect change.\textsuperscript{4,34,52}

E. Who are the men and adolescent boys affected by HIV, and to what extent are they affected?

\textit{Men and adolescent boys living with HIV}

Globally, there are approximately 36.9 million [34.3 million – 41.4 million] people living with HIV, out of which approximately 16.9 million [15.7 million – 19.5 million] are men and adolescent boys older than 15 years, making up nearly 49% of the global population of people living with HIV aged 15+. Of the total global male population older than 15 living with HIV, approximately 10% (1.3 million – 2.0 million) are adolescent boys and young men aged 15-24, of which 64% are in sub-Saharan Africa, and 20% in Asia and the Pacific.

\textit{New HIV infections among men and adolescent boys aged 15+}

Globally, there are approximately 1.7 million [1.6 million – 1.9 million] new HIV infections among people aged 15-49, out of which approximately 890,000 [810,000 – 970,000] are among men, making up 52% of all new HIV infections among people aged 15-49 globally. Out of the total new HIV infections among men aged 15-49, 30% (approximately 537,000) are among adolescent boys and young men aged 15-24, 27% of which are in Asia and the Pacific, and 54% in sub-Saharan Africa. The modes of transmission and risks among men are highly diverse – with the majority of new infections concentrated among heterosexual men but with incidence rates and overall HIV prevalence much higher in men from key populations.

In sub-Saharan Africa, where the largest epidemic exists, men constituted 44% of new HIV infections. In every other region of the world, however, men made up the majority of new HIV infections in 2014 across all regions.

\textsuperscript{25} In a recent study focused on fourteen higher education institutions across South Africa, for example, survey results from a total of nearly 9,000 students showed that, of the 10% of students who had sex with men, one in five of these students identified as bisexual, heterosexual, or another sexual identity, and half of student MSM had also had at least one female sexual partner in the past year.\textsuperscript{51}
Among young people under 25 years of age, however, the picture shifts to increasing vulnerability among young women. Adolescent boys and young men aged 15-24 made up the majority of new HIV infections in Asia and the Pacific, Latin America and the Middle East and North Africa. However, this picture shifted in the Caribbean, sub-Saharan Africa, and Eastern Europe and Central Asia, where they made up 49%, 36% and 45% of new HIV infections among young people, respectively.

More than half of new global HIV infections among men aged 15+ are concentrated in sub-Saharan Africa (53%), followed by Asia and the Pacific (23%), Eastern Europe and Central Asia (8%), Western and Central Europe and North America (7%), and Latin America (6%).

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**Proportion of new HIV infections among men and adolescent boys 15+, by region**

(Source: UNAIDS HIV Estimates, 2014)

<table>
<thead>
<tr>
<th>Region</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latin America</td>
<td>1.48</td>
</tr>
<tr>
<td>Western and Central Europe and North America</td>
<td>0.75</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>6.3</td>
</tr>
<tr>
<td>Asia and the Pacific</td>
<td>7</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>8.4</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>23</td>
</tr>
<tr>
<td>Caribbean</td>
<td>53</td>
</tr>
</tbody>
</table>

**AIDS-related deaths among men and adolescent boys**

Globally, there were approximately 1.2 million [980,000 – 1.6 million] AIDS-related deaths in 2014, out of which men constituted almost 60%, and made up the majority of AIDS-related deaths in every region of the world. 58% of the global AIDS-related deaths among men occurred in sub-Saharan Africa, followed by Asia and the Pacific (26%), Latin America (5%).


<table>
<thead>
<tr>
<th>Region</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle East and North Africa</td>
<td>29%</td>
<td>71%</td>
</tr>
<tr>
<td>Latin America</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>Asia and the Pacific</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>47%</td>
<td>53%</td>
</tr>
</tbody>
</table>
Men and adolescent boys are not a homogenous population; they have different risks and vulnerabilities

Men and boys have diverse experiences and identities that impact their HIV vulnerability. To address the “blind spot” around men and adolescent boys in the HIV response, it’s imperative to avoid painting men as one monolithic group. Rather, their many diversities should be taken into account, especially those that put men at increased risk for HIV. Here we detail populations of men and adolescent boys in need of particular attention. These include gay men and other men who have sex with men, adolescent boys, transgender men, people who inject drugs, sex workers, migrants, incarcerated persons, and those affected by armed conflict.

Gay men and other men who have sex with men (MSM)

Gay men and other MSM are 19 times more likely to be living with HIV than the general population, and the highest median prevalence among this population resides in sub-Saharan Africa. In Johannesburg, South Africa, the HIV prevalence among MSM is between 13.5% and 49.5%. These populations typically experience extremely challenging barriers to accessing HIV prevention and treatment. Stigma and discrimination, whether legally sanctioned or not, impedes their ability to access HIV services.

Adolescent boys

Adolescents represent the only age group in which AIDS-related deaths rose between 2001 and 2014. This is particularly relevant in much of sub-Saharan Africa, where AIDS is the leading cause of death among adolescents and AIDS-related deaths among this population have increased by 62% since 2005. Young women in sub-Saharan Africa acquire HIV at significantly
higher rates than young men, however young men are twice as likely to die of AIDS-related complications than their female adolescent counterparts.\textsuperscript{27} Unfortunately, adolescents are not well prioritized in strategic plans for scale-up; and when adolescents are mentioned, their gender-specific needs are rarely detailed.\textsuperscript{112,114}

Proportions of young key populations in the context of the HIV epidemic remain unknown, but evidence shows that people start engaging in higher risk behaviours at a young age.\textsuperscript{28} In addition, available age-disaggregated data show higher HIV prevalence rates among young men who have sex with men under the age of 25, than among young males in the general population. Access for young people from key populations is even more difficult because of various factors such as age-related restrictions to HIV and SRH services and the limited availability of youth-friendly services.\textsuperscript{29} So although there are highly vulnerable key populations of adolescent boys and young people, including young men who have sex with men (MSM), transgender youth, young people who inject drugs, and adolescent and young sex workers, data and evidence is still lacking.

**Transgender**

Stigma, discrimination, gender-based violence and a lack of legal recognition of their gender identity, represent the fundamental drivers of HIV vulnerability and risk among transgender women worldwide.\textsuperscript{30} Globally, the chance of acquiring HIV is 49 times higher among transgender women than all adults of reproductive age, with an estimated 19% of transgender women living with HIV.\textsuperscript{31} Violence against transgender people is a global crisis. An international community-based project to monitor killings of transgender people collected 1509 cases of reported killings in 61 countries from 1 January 2008 to 31 March 2014.\textsuperscript{32} Exposure to transphobia is a mental health risk for transgender people and can result in increased levels of depression and suicidal thoughts.\textsuperscript{33} In the United States, 46% of transgender men and 41% of transgender women have attempted suicide. Prevalence of suicide attempts is highest among those who are younger.\textsuperscript{34,35,36} Transgender people remain severely underserved in the response


\textsuperscript{29} Ibid.


\textsuperscript{34} Haas AP, Rodgers PL, Herman JL. Suicide attempts among transgender and gender non-conforming adults: findings of the national transgender discrimination survey. New York: American Foundation for Suicide Prevention; 2014
to HIV, with only 39% of countries reporting in the National Commitment and Policy Instrument 2014 that their national AIDS strategies address transgender people.\(^{37}\)

**People who inject drugs**

People who inject drugs (PWIDs), the majority of whom are men, represent another high-risk group for HIV infection and transmission. Approximately 30% of all new infections among men outside of sub-Saharan Africa occur among PWIDs.\(^{115}\) Other modes of transmission beyond sexual transmission aren’t comprehensively dealt with in this paper.

**Transgender sex work**

Male, female, and transgender sex workers – whether engaging in sex work by choice, by force, or via coercion – have increased vulnerabilities to HIV. Many sex workers are at risk for sexual violence, including by the police.\(^{116}\) Since male sex workers face stigma driven by heterosexism and the criminalization of sex work or prosecution based on the presence of condoms alone, condom usage is low and there are increased risks of HIV acquisition and transmission.\(^{116}\) For example, one Peruvian study, found that male sex workers engage in behaviors that lead to increased exposure to HIV infection.\(^{31,12}\)

**Migrant workers**

Globalization, economic insecurity and the often-elusive promise of better pay elsewhere have resulted in a steadily growing population of migrant or mobile workers worldwide. It is estimated that there are some 214 million international migrant workers and 740 million workers who are mobile within country borders, many of whom are men.\(^{87}\) As a result of unstable working conditions, long hours, and a lack of permanence in one community, migrant workers often struggle to access health care. Away from long-term partners for extended periods of time, they may engage in unprotected sex while traveling, including with sex workers. Migrant workers who are already living with HIV have difficulties adhering to treatment in the absence of rountinized care.

**Incarcerated persons**

Incarcerated persons also lack adequate access to healthcare. Approximately 10.2 million people now live behind bars globally, a 10% population increase from 2004.\(^{42}\) The vast majority - 93.5% - are adult men.\(^{42}\) Incarcerated persons face high risk for HIV, as well as hepatitis C,
other sexually transmitted infections and tuberculosis (TB).\textsuperscript{61} Around the world, HIV prevalence rates in prison are typically several times higher than in the outside community.\textsuperscript{61} Sexual violence, unsafe sex, and needle use for drugs and tattooing place inmates at risk.

\textit{Conflict and Post-conflict settings}

Conflict and post-conflict settings also exacerbate HIV risk. Rates of STIs amongst armed forces—most of whom are men—have been estimated to be two to five times higher than in civilian populations. The HIV prevalence rate among soldiers may range from ten to twenty percent.\textsuperscript{6} In addition, conflict-related turmoil disrupts healthcare services, including HIV-related treatment and care, thereby compounding the challenge.\textsuperscript{6,111}

Sexual violence remains a component of armed conflicts around the world. This form of violence has been deployed for centuries to terrorize women;\textsuperscript{111} less well known is its use to humiliate and terrorize men. The frequency of HIV transmission in this context remains unknown, but many of these abusive acts comprise high risk sexual behaviors. Additionally, traumatized populations must cope with a range of sexual and non-sexual traumas in the wake of conflict, leading to poor physical and mental health outcomes. The normalization of extreme violence during conflict can also lead to ongoing interpersonal violence post-conflict.\textsuperscript{62}

Men vary greatly in their identities and circumstances, and HIV interventions must respond to these varieties in order to be effective. Reaching these key populations will be critical to success.\textsuperscript{45} International human rights commitments have begun to include men and boys in the context of HIV, but as the next section notes, these instruments have yet to comprehensively address their gender-specific health rights.

\textbf{F. Global Commitments in the HIV response concerning gender equality}

Women’s rights were not always central to the HIV agenda, nor were the ways in which unequal gender norms put women at risk immediately apparent. It was not until the 1990s that links between women’s human rights and HIV were articulated in international instruments, as a result of unprecedented mobilization of women’s rights organizations. The imperative to engage men and boys for gender equality also originated during this decade and, while still underdeveloped, can now be found in a wide range of international instruments. This section provides details about these mandates as well as an outline of detailed information on why we need more robust articulation on men’s gender concerns and health rights in the human rights sector.

Building upon successes concerning women’s human rights and health in the 1990s, the 2001 UN Declaration of Commitment on HIV/AIDS brought political attention to gendered topics such as women’s vulnerability to infection, the impact of HIV on women as caretakers, the particular needs of pregnant women, the economic impact of disease on women and families, and the
need to address socio-political realities that diminish a woman’s ability to realize her right to health.\textsuperscript{38,39}

As the global response to HIV evolved, it expanded international human rights norms concerning women’s equality and health. Moreover, findings about the link between women’s empowerment and HIV outcomes helped reinforce the imperative for a human rights-based response to public health crises globally.

In the 2000s, a well articulated set of norms related to the ‘right to health’ more broadly flourished in the international human rights cannon and elsewhere.\textsuperscript{40} Through instruments developed in this decade, the international community recognized that the right to health and the rights of women go hand-in-hand; one cannot be fully realized without the other.

For women, human rights instruments have provided a useful normative framework for addressing gender inequalities in the context of HIV.\textsuperscript{2,123} The deployment of rights-based language now influences the analysis of and approach to the disease at the international policy level: for instance, a UN expert group concluded that the spread of HIV and its detrimental effect (on families, communities and countries) stemmed from women’s lack of equal rights.\textsuperscript{13}

While national and international commitments have been made, implementation remains a worldwide challenge. For this reason, attention to gender inequality continues, and must also broaden. This broadening should expand upon the engagement of men as first articulated in the 1994 International Conference on Population and Development (ICPD) Program of Action, which sought to, ‘promote gender equality in all spheres of life, including family and community life and to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles.’

Since ICPD, a number of other international instruments have provided states with a mandate to develop gender-transformative programs and policies aimed at engaging men and boys. Language has included men and boys in the context of family, reproductive health, violence, and health equity. International commitments include the Programme of Action of the World Summit on Social Development (1995) and its review held in 2000\textsuperscript{41}, the Beijing Platform for Action (1995)\textsuperscript{42}, the twenty-sixth special session of the General Assembly on HIV/AIDS (2001)\textsuperscript{43}, and the United Nations Commission on the Status of Women (CSW) in 2004 and 2009.


\textsuperscript{41} See paragraphs 7, 47 and 56 of the Programme of Action of the World Summit for Social Development, and paragraphs 15, 49, 56 and 80 of the outcome of the twenty-fourth special session of the General Assembly on Further Initiatives for Social Development.

\textsuperscript{42} See paragraphs 1, 3, 40, 72, 83b, 107c, 108e, 120 and 179 of the Beijing Platform for Action.

\textsuperscript{43} See paragraph 47 of the Declaration of Commitment on HIV/AIDS: “Global Crisis – Global Action.”
In addition to moving forward with strengthened language on engaging men in the context of their responsibility to improve women’s access to health and rights, challenging harmful norms and advancing gender equality, we posit that understanding men and boys both as agents of gender transformation and as holders of the right to health themselves is the next step in the evolution of gender-based HIV work. This step should build upon—not supplant—the work with women and girls.

Ensuring men’s right to health and access to services must also include recognition to the needs of men who face challenges by intersecting forms of discrimination (race, ethnicity, nationality, socioeconomic class, sexuality, disability, etc.). Silence in the HIV instruments about the real vulnerabilities that some men face also risks reinforcing problematic notions of men’s invincibility. In many parts of the world, MSM and transgender people have been particularly vulnerable. The 2011 Political Declaration of Commitment on HIV/AIDS, which built on previous declarations from 2001 and 2006, was the first of this trio to mention MSM. It represents an important step, but remains limited in scope, focusing only on the inclusion of MSM in national prevention strategies. As shown in the graph below, in most reporting countries no laws or regulations that protect men who have sex with men exist.

G. Between harmful gender norms and inadequate health systems: access and utilization of HIV services among adolescent boys and men

Studies have consistently shown that men’s testing is lower than women’s in most settings, resulting in lower ART coverage. In 2014, 36% [34-42%] of men aged 15+ living with HIV were
receiving ART. However, even when men do access ART, they are more likely than women to interrupt treatment, and to be lost to ART follow-up. A study in South Africa found that men also start ART at older ages, with more advanced stages of AIDS-related illnesses, thus leading to additional complications.

One recent study found that men reach low immunity after HIV acquisition far more quickly than women, and others found that men have a greater likelihood of death while on treatment.

Harmful gender norms affects all stages in the HIV cascade of care. Data from more than twelve low and middle income countries find that men with less equitable attitudes toward gender are less likely to present for HIV testing. Unequal gender norms fuel these realities in numerous ways. First, socially constructed stereotypes of men as invulnerable misleads potential clients and health providers alike. For some men, the idea that an HIV positive status is a threat to “being a man”, and thus, serves as a deterrent to testing and treatment.

Dovel et al state, “institutional supply-side barriers, and not solely masculinity, contribute to men’s lower rates of testing and treatment.” Men’s engagement with health systems is less likely when health facilities are seen as a woman’s domain and health services reinforce prevailing gender norms and assume men do not need nor will they access services. These leakages in the HIV cascade of care for men result not only in preventable and premature death for many men living with HIV, but unnecessary and far-reaching consequences for male and female partners and family members – and for healthcare systems broadly. Yet according to Cornell and colleagues, “despite this evidence of gender inequity in access to ART, most international and national ART-related policies and programmes in Africa [and elsewhere] remain largely blind to men.”

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H. WHAT WORKS?:

Engaging men for gender equality and better public health outcomes

Many rigorous studies conclude that well-designed interventions can and do change men’s gender related attitudes and practices.

Transformative interventions that engage men to create social and behavioural change through questioning traditional gender norms, roles, and relationships have resulted in increased spousal support, reduced GBV, and strengthened communication and decision-making skills towards safer sex practices and delayed marriage.\(^{45}\)

The evidence base of interventions to prevent violence against women and girls demonstrate that interventions are effective when they address “masculinity; that is they explicitly address the norms, behaviours, and relationships associated with ideals of manhood”\(^{46}\)

Programs that are integrated into the entire community, such as those involving religious or cultural leaders, community organizations, and mass media campaigns are also shown to be more effective in engaging men for gender transformative action.\(^{47,4}\) In the Stepping Stones initiative in South Africa and elsewhere (adapted from the original manual), an HIV prevention


programme aimed at improving sexual health outcomes, including reducing HIV infections through building stronger, more gender-equitable relationships, was found to “significantly improve a number of reported risk behaviours in men, with a lower proportion of men reporting perpetration of intimate partner violence across two years of follow-up, and less transactional sex and problem drinking at 12 months”.  

Other studies have measured the effectiveness of interventions designed to change community norms about violence, working with both men and women, such as the SASA! community mobilization intervention in Uganda, which has proven to reduce men’s use of violence and increase their support for women’s rights.

Interventions specifically targeting men to engage for better public health outcomes have produced mixed results. A review by WHO of 58 programs found that only 29% of programs aimed at engaging men and boys in changing gender-based inequity in health were effective in leading to changes in attitudes and behaviours related to Sexual and Reproductive Health, maternal, newborn and child health, the use of VAW, interactions between the father and children and the men’s health seeking behaviour. However, a study completed in Nairobi, Kenya between 1999 and 2005 found that women whose partner attended PMTCT services had decreased incidence of vertical HIV transmission and lower infant mortality rates.

An ongoing national prevention program to reduce mother-to-child transmission in Rwanda, ‘Going for the Gold’, aims to support a family centered approach with a strong emphasis on male participation and encourages male partners to participate in HIV counselling and testing, led to an increased rate of couple testing from 33% in 2005 to 78% in 2008. A systematic review of interventions on male involvement to improve women’s uptake of PMTCT services, however, notes that further research is necessary to identify the most successful approach to guarantee women’s safe access to healthcare.

In addition, research also affirms that engaging men and boys as beneficiaries as well as partners can advance gender equality and health outcomes for all. In Brazil for example, Promundo’s intervention with young men to promote healthy relationships and HIV/STI prevention showed significant positive shifts in gender norms at 6 and 12 months. In Nicaragua, men who participated in workshops on masculinity and gender equity found significant positive attitudinal and behavioural changes according to partner reports and self

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evaluations. Indicators included: use of psychological and physical violence, shared decision-making, paternal responsibility, and sharing domestic activities. In South Africa, Sonke Gender Justice’s One Man Can Campaign found that 50% of participants reported taking action to address acts of gender-based violence in their community, 25% accessed voluntary HIV counselling and testing services, and 61% reported more frequent condom use. More than 4 out of 5 participants reported having subsequently talked with friends or family members about HIV and AIDS, gender, and human rights.

Research on programs targeting gay men and other men who have sex with men and the complex relationship between masculinity, sexuality, gender, and HIV risk, remain insufficient. Yet, engaging all men and boys in the types of programming described above does at least reduce heterosexist attitudes and discrimination against those who identify or those who are perceived as lesbian, gay, bisexual, transgender, intersex and queer (LGBTI) persons. Mills and colleagues note, “the reality that men are less likely to seek health care is intimately linked to perceptions of masculinity, and is generally considered to be part of the same phenomenon that drives multiple partnering, violence against women, substance use, and homophobia among men.”

While research has found a definitive link between some men’s high-risk sexual behaviours and heterosexist beliefs, greater attention is needed to examine whether and how these beliefs, when widely held in communities, drive men who have sex with men and other sexual minorities away from critical HIV services.

Despite the evidence described in this section, and the international commitments, the majority of interventions with men and boys have, until recently, remained NGO-led, short-term, and far too small in scale to notably alter the course of the HIV pandemic. By not rolling out strategies to effectively engage men, we risk reaffirming the notion that HIV, GBV, other sexual and reproductive health issues, and progress towards gender equality are women’s burdens alone to bear.

I. WHAT WORKS?:

Ensuring an effective HIV response among men and adolescent boys

Creating an enabling environment: advancing gender equality through policies and programming

Men must know their status in order to stay HIV negative, and to initiate ART earlier with less advanced AIDS-related illnesses. Men need to be retained in lifelong care with suppressed viral loads, to reduce their own morbidity and mortality and to reduce the risk of further transmission. The strategies outlined below are particularly valuable because, while they address the specific sexual and reproductive health needs of men, most are also client-friendly and gender appropriate, recognizing that men and women have many overlapping health service needs. Therefore strengthening the HIV cascade of care for men will strengthen effectiveness in tackling the HIV pandemic overall.
Of course, men’s own behavioral factors are only one of the numerous contributing factors that inhibit men from participating in HIV prevention and care. Studies show that the lack of programming aimed at reaching men is a significant impediment to men’s access to services. Male-friendly services, such as clinic after-hours that are accommodating as well as moving services out of clinics represent two examples.

Men’s less frequent health-seeking behavior is exacerbated by poverty. As a result, men may work long hours or in locales far from home with little time left to seek healthcare, even if available.\(^{17}\)

Public policies are also central to changing societal gender norms through clear and specific language reflecting inclusive, rights-respecting approaches. For example, governments can provide comprehensive sexuality education that promotes respect for diversity, challenges harmful gender norms, and aims to reduce stigma and discrimination.\(^{101,106}\)

Governments should also eliminate obstacles in reaching marginalized, high risk populations: UNAIDS estimates that only three-fifths of countries have risk reduction programs for sex workers, 88 countries report fewer than half of men who have sex with men (MSM) know their HIV status, and most countries do not provide opioid substitution therapy or access to sterile needles or syringes for PWID.\(^{114}\) Criminalizing these populations drives them away from needed services, and insufficient anti-discrimination measures fail to offer needed protection. As UNAIDS stipulates in the 90-90-90 targets, “nothing other than zero discrimination is acceptable”.\(^{114}\)

A review performed by Sonke Gender Justice analyzed 13 African countries for the MenEngage Africa Network\(^{54,55,56,57}\) and assessed the extent to which HIV policies, primarily National

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\(^{54}\)In some cases other HIV related policies were also analysed, such as condom or PMTCT policies.

\(^{55}\)See www.menengage.org

Strategic Plans (NSPs), acknowledge the importance of gender transformative strategies to reduce women’s and men’s HIV vulnerabilities.

It found that most NSPs acknowledge the role of gender in the HIV response, but they typically make only cursory mention of male involvement. Moreover, NSP language often assumes that ‘gender’ only concerns women in heterosexual relationships. This framing represents a deterrent to women’s and men’s health in a number of ways: 1) it relegates the burden of HIV prevention to women; 2) it fails to consider diversity among gender identities and sexual orientations; 3) it overlooks men’s health rights to HIV services (few NSPs called for an increase in men’s uptake in care); and 4) it fails to acknowledge the relational aspect of gender; i.e., men and women can be engaged in promoting each others’ health and wellbeing.

In Brazil, governmental policy aimed to take advantage of the fact that 9 out of 10 expectant fathers accompanied their female partner to at least one prenatal visit, creating a unique opportunity for male outreach.5,6 Men’s Prenatal Health Protocol offered these men a full health exam, including STI and HIV testing, as well as information and support on pregnancy and childbirth. The policy alone is a first step; ongoing monitoring of implementation and sensitization of staff are needed.7

Government provision of condoms remains inadequate in many countries with high HIV prevalence in the general population. Only 2 of 15 countries in Eastern and Southern Africa are achieving the regional target of 30 male condoms per man per year. In fact, only eight male condoms on average were available per year per sexually active individual in sub-Saharan Africa; the number is even less for adolescents.8 Because condoms are a primarily male driven prevention method, policies and programs must increase their consistent accessibility and utilization by men. This includes understanding and empowering men as agents in their own selfcare, as well as empowering women to insist on consistent condom adherence. A stronger analysis of male circumcision uptake is needed.

Despite the troublingly high rates of HIV amongst gay men and other MSM, UNAIDS highlights their extremely limited access to HIV-related services and commodities, including condoms, water-based lubricants, safer-sex education, and counselling services.9 These disparities amongst gay men and other MSM are also exacerbated across and within countries depending on socioeconomic status, geographic location, occupation, and other intersecting factors. Stigma and discrimination from health care providers and facilities, dissuade gay men and other MSM from utilizing mainstream services, reducing the number of gay men and other MSM testing for HIV and consequently accessing treatment. Recognition of the rights and health needs of LGBTI persons, national investment, and judgement-free and sensitized HIV services are needed in order to reach gay men and other MSM and improve linkages to care.

Comprehensive sexuality education (CSE) is a crucial component of instilling the knowledge, confidence, and ability in young people to protect themselves by negotiating safer sex.

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57As this research began at the end of 2011, four of the 13 NSPs that were analysed, are now out of date, having ended in 2012 and in the case of Ethiopia, 2011.
throughout their lifecourse. CSE covers a broad range of issues relating to both the physical and biological aspects of sexuality, as well as the emotional and social aspects. It recognizes and accepts all people as sexual beings, concerning more than just health outcomes, such as the prevention of disease or pregnancy. CSE helps young people to acquire accurate information on sexual and reproductive health and rights; to develop life skills such as critical thinking, communication, and negotiation skills; to develop their sense of self-confidence, assertiveness, and ability to take responsibility; to learn to ask questions and seek help; to nurture positive attitudes and values; and to advocate for sexual and reproductive rights as active citizens. Ensuring that young people have access to CSE in safe learning environments—including with quality CSE instructors—must be a global public health and educational priority.

IMAGES found that one of the areas where men are more likely to show up at preventive or primary health care services is when accompanying a partner for prenatal visits. Between 33% to more than 80% of men with children reported having accompanied a partner to a prenatal visit. In most settings studied as part of IMAGES, men were not deliberately targeted as partners or allies of pregnant women. However, the fact that men accompanied their partners offers a window of opportunity that some health systems are beginning to use.

**Strengthening Health Systems**

HIV prevention approaches such as condoms, male circumcision and increasingly PEP remain the cornerstone of the strategic approach for men’s HIV response. However strategies are urgently needed to address the low rates of HIV testing and treatment uptake among men. Services are needed not only for men who have sex with women, but also for key populations such as gay men and other men who have sex with men (MSM), transgender persons, sex workers, incarcerated persons, migrant workers, youth, and people who inject drugs (PWID). It is important to recognize the fluidity of these categories as well as potential for overlap.

Strengthening the linkages between sexual and reproductive health and HIV services has become widely recognized as vital to expanding access for all. For instance, IPPF’s Swaziland affiliate, the Family Life Association of Swaziland (FLAS), integrated voluntary medical male circumcision (VMMC) services into a broader sexual and reproductive health service model, while also increasing the uptake of HIV testing and ART. Ideal services engage men both as clients with their own health rights and as agents of change. Building upon the decades-long human rights imperative to engage men around reproductive health, promising models explicitly promote gender equality and sexual and reproductive rights for everyone.

Linking tuberculosis (TB) and HIV services has also shown promising results. Historically isolated due to siloed funding streams and other logistics, TB and HIV integrated care provides a more effective and cost-efficient approach to addressing this comorbidity. WHO estimates that as many as 1.3 million deaths were averted between 2005 and 2011 as a result of TB/HIV collaborative efforts. Another study found that full HIV/TB integration increased ART uptake and reduced the amount of time to initiate ART, an important improvement for men who are disproportionately likely to get lost to care in the pre-ART phase.
Linkages with primary healthcare should also be considered in order to maximize each entry point opportunity, particularly for hard-to-reach populations. UNAIDS argues that “linking or integrating services can make it easier, less time-consuming and more attractive for people to use them”. In Zambia, opt-out provider-initiated testing and counselling (PITC) was adopted as a standard component of care at nine primary healthcare facilities. Among those who agreed to testing, 44% were male. Among those who tested positive and enrolled in treatment, 41% were male.  

Raising awareness about the availability of male-friendly services at various entry points is also key to success. Such marketing efforts represent yet another opportunity to engage men as rights holders and as agents of gender transformation.

**Strengthening health service delivery**

*Expanded Service hours*

Expanding service hours for clinics that provide testing and treatment represents a critical strategy for expanding access to care. The expansion of service hours allows those who work during the day to access services without risking their employment and reduces long queues that can take people away from daily responsibilities. This strategy is proven to be effective for reaching more men, and would benefit women who need flexible health service hours as well.

*Mobile services*

Research also increasingly shows that getting services out of the clinic and into the local community increases service utilization for all. UNAIDS reports that 95% of HIV service delivery is currently facility-based, and argues that community service delivery—including community-based testing campaigns, provider-initiated testing and counselling as well as self-testing—will improve efficiency and bring services closer to those who need them.

Services in fixed health facilities reach fewer men than other outreach approaches. For example, NIMH Project Accept found that conducting rigorous community mobilization activities to encourage community-based testing resulted in much higher rates of testing compared to facility-based VCT. This intervention was particularly effective at reaching men, finding an overall 13.9% reduction in HIV incidence and 45% increase in HIV testing among men. It demonstrated mobile services delivered at busy, convenient and accessible public spaces can reach men.

This may be especially noteworthy as men who use mobile testing have been shown to have higher HIV prevalence than those accessing fixed clinic facilities. In addition expanding access via mobility, self-testing kits and technologies such as mobile phones used for appointment reminders or support, can also expand access.

As for patient retention, one systematic review of antiretroviral therapy programs in sub-Saharan Africa in 2007-2009, found that only 70% of patients were accessing their treatment from specialty clinics after two years. In contrast, a community-based model of ART
distribution in the Tete province of Mozambique resulted in 98% of patients still accessing treatment after twenty-six months. Other studies have shown that expanding community-based services is critical to increasing HIV prevention, HIV testing, and overall adherence to treatment. Participation in adherence clubs and training for men living with HIV have also been shown to improve retention in care, and should thus be considered as another effective strategy.

**Couples Counseling**

HIV testing and counseling for couples is another key way to get men to seek HIV testing and to decrease transmission amongst couples. A small but growing body of research suggests that couples’ counseling increases testing as well as HIV preventive strategies used within couples, whether discordant or not. It offers a valuable opportunity for couples to communicate and develop skills that allow them to make informed decisions about sexual and reproductive health in their relationship. One systematic review of all couples’ counseling initiatives in sub-Saharan Africa published in the scientific literature from 1990 produced positive results.

Challenges for couples’ counseling include confidentiality, logistics around access, and the navigation of gender dynamics within couples, particularly heterosexual couples. For instance, scholars have noted the need for men to support women’s ability to safely disclose their status within a heterosexual relationship.

In 2012 WHO published a set of guidelines intended to assist with the scale-up of couples’ HIV testing and counseling, including support for mutual status disclosure and Treatment as Prevention (TasP) for serodiscordant couples. As WHO notes, while evidence seems to demonstrate that TasP amongst couples is effective, more research is needed concerning best practices for maximizing its effectiveness.

**Workplace**

Workplace testing is a critical but underutilised. However, the International Labour Organization’s VCT@WORK Initiative has shown impressive results. Launched in over 32 countries, mostly in the global South, the VCT@WORK Initiative builds on five fundamental pillars: 1) a rights-based approach, 2) multi-disease testing to de-stigmatize HIV testing and facilitate increased uptake of VCT, 3) strategic partnerships between the private sector, government and civil society, 4) social mobilization and 5) monitoring and evaluation to capture data and reports from countries. This approach led to nearly three million people being tested for HIV, of whom nearly 60% were men. Additionally, over half of those who accessed treatment were men. This method of outreach is proven to reach large number of men.

Testing CD4 count outside of the clinic is also crucial in creating strong linkages within the HIV cascade of care. For instance, home-based counselling and testing combined with same-day

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58 While this is very true, particularly in low-resource settings were universal access to antiretroviral therapy may be challenging, in the wake of the SMART trial there will be a push to accepting increasingly higher CD4 counts as eligible for treatment. This means that more and more people are going to be eligible to start antiretroviral therapy as soon as they
point of care CD4 testing, has been shown to better facilitate the continuation of care than laboratory-based methods. Because the biggest loss in the HIV cascade of care remains at the pre-ART phase, home-based counseling and testing combined with same-day CD4 testing should be further explored and, if found effective, implemented at scale. 

**Strengthening health workforce**

Key to the success of health system strengthening is expanding the capacity of healthcare providers to fulfill the existing guidelines and services that have been put in place. In this context, strengthening health systems requires gender sensitization of healthcare providers, and provision of services for men in all of their diversities. Healthcare providers are not always sufficiently knowledgeable about services or programs offered for men, nor are they trained to provide sensitized services to all clients accessing them, including MSM, transgender persons, and PWID.

Strengthening of gender-sensitive services sometimes includes addressing problems from misinformed providers. For example, prior to the implementation of a project in Rwanda to increase vasectomy procedures, the healthcare workers aimed to dispel myths among both providers and community members around vasectomy, such as assumed similarities between vasectomies and castration, and myths that it would reduce libido or prevent ejaculation.

**Improving our data**

There is limited access to sex-disaggregated data, although such data are the basis for the identification of national priorities and for the allocation of funds. Compounding this blindness, gender disaggregated data for accountability mechanisms that track progress on enrolling and retaining people in the HIV cascade of care is often lacking.

As stated in both the UNAIDS Fast-Track report and in The Cities report, national targets must be supported by well-designed systems that can collect and use accurate information. These allow problems to be promptly addressed, bottlenecks to be identified and dealt with, and people to be kept accountable. Thus, civil society advocacy—including watchdog organizations as well as those who can support government ministries to develop and use these systems—is critical to maintaining accountability from government ministries and health care facilities. Innovative approaches to build a culture of accountability can also be advantageous.

**Identifying and engaging influencers**

*Traditional and Religious leaders:* Leaders from traditional and faith sectors offer cultural insight, locally relevant knowledge, and social capital that hold potential for reaching a wide constituency. Religious leaders tend to be men, and religious doctrines are often interpreted from a patriarchal perspective, resulting in the capacity for harmful gender norms to continue.
In addition to harmful gender norms from patriarchal systems, same-sex sexual behavior is also condemned by many religions of the world. While gender inequalities and injustices toward sexual minorities are often embedded in religious practice, these same communities can act as conduits for gender equality and human rights.

In African societies, traditional leaders are highly influential, especially in rural areas; effective technical information provided to the HIV response therefore requires the participation of traditional leadership. This approach is recognized by African governments, including Lesotho, Swaziland, Botswana, Ghana, Zambia, Malawi, South Africa and Zimbabwe, whose national strategic plans to fight HIV/AIDS treat traditional leaders and religious groups as key partners.  

**Business Leaders:** Business leaders and employers can play a big role in influencing the health seeking behaviour of working women and men. An ILO research “Effective Responses to HIV and AIDS at Work: A multi-country study in Africa” showed that management commitment played a big role in normalizing HIV testing and increased the demand for HIV testing and other relevant services.

One key lesson emanating from the ILO’s VCT@WORK initiative shows that engaging business leaders in the response can be very effective. The ILO-UNAIDS publication: AIDS is Everyone’s Business!, launched at the African CEO Forum in March 2015 captured the positive messages from business leaders on the need to end HIV-related discrimination and promotion of VCT. For example, Yajith de Silva, General Manager, Watawala Plantations PLC, Sri Lanka says in his messages: “I have taken the HIV test myself and I encourage my employees to do the same. Those who test positive should not worry. Their jobs will be protected and they will be taken care of”.  

**Sports:** There is a clear and urgent need to engage adolescent boys in comprehensive sexuality education and wider HIV prevention measures. One promising platform for engaging adolescent boys is sports, which can act as a non-confrontational, comfortable and playful medium for behavioural change. Interest is growing internationally in the use of well designed sport-based HIV interventions. Grassroot Soccer (GRS), for example, uses games and soccer-based language to promote healthy decisions, reduce stigma and discrimination, increase knowledge about testing and treatment, and advance gender equality. They use team structures to strengthen social support networks and male mentors/educators to deliver programs to adolescent boys. GRS has demonstrated that this approach increases HIV testing as well as voluntary medical male circumcision (VMMC).

**Broadcast media:** Entertainment Education, or ‘edutainment’, can use media like radio and television, to convey HIV-related information, as well as messages about social and behavioral change. MTV’s Kenyan HIV awareness drama, *Shuga*, has shown promising results. A study by John’s Hopkins University found that 60% of young Kenyans polled had seen the show, and of

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these, 80% said the show changed their thinking about having multiple concurrent partners, HIV testing and stigma associated with HIV.\(^9^8\)

*Soul City*, South Africa’s most popular soap opera, constructively grapples with a wide range of social issues and reaches some 34 million South Africans alone. Similarly, the campaign “Brothers for Life” increased men’s utilization of services—particularly HIV testing and VMMC—and increased men’s support for women’s HIV prevention and treatment services, including PMTCT.\(^6^0\) Men exposed to the campaign were found to be 1.4 times more likely to plan on circumcision; knowledge about where to get tested and access VMMC also increased.\(^2^6\)

**Social Media:** As more and more people connect to the Internet around the globe, whether through computer access or smartphones, this technology is a potential strategy to reach vulnerable populations, such as youth and MSM, on issues including HIV prevention and ART adherence.\(^3^, ^8^3\) Online interventions, which are convenient, more anonymous and cost-effective, have shown results similar to traditional in-person interventions.\(^8^3, ^9^7\)

For instance, a chat-room based HIV intervention amongst MSM in the United States reached men who might otherwise have been inaccessible. In the chat room, the health educator answered questions relating to sexual risk reduction strategies, HIV testing, and referrals; self-reported home-based HIV testing subsequently increased.\(^9^7\) The UCLA-based longitudinal study, “Harnessing Online Peer Education” (HOPE), used social media for peer-led HIV prevention amongst MSM from Latin and African American communities. The initial findings show that the use of *Facebook* to facilitate HIV-related outreach increased HIV prevention, knowledge and testing.\(^5^6, ^1^2^8\)

Unfortunately, the evidence base around online and social media-based interventions is thin; especially concerning interventions outside North America or beyond MSM populations. More research is needed to understand the utility of computer and smartphone-based HIV interventions, including the effectiveness of social media to reach a range of populations.
J. Conclusions: looking forward

The End of AIDS will not be possible without advancing gender equality.

Men must be engaged to challenge harmful norms and gender inequalities, which perpetuate the risks, vulnerabilities, and health seeking behaviours of both men and adolescent boys as well as women and girls in the context of HIV. Harmful notions of masculinity also fuel stigma, discrimination and gender-based violence that affects all women and girls and men and boys but specifically impact key populations. Among the male population, adolescent boys and young men are at a particular increased risk of HIV, accentuated among young key populations.

Men and adolescent boys are under-represented in HIV service access and utilization. Health systems are poorly setup to address the needs of men and adolescent boys, and specific structural determinants such as consent laws pose additional challenges to access HIV services.

The gap between the current status of the HIV response, and where it should be to Fast-Track the End of AIDS, is wide. As Mills and colleagues stated: "[E]fforts to understand men’s health-seeking behavior are poorly understood in the AIDS epidemic, and encouraging men to get tested and into treatment is a major challenge, but one that is poorly recognized. Addressing these issues effectively means moving beyond laying blame, and starting to develop interventions to encourage uptake of prevention, testing, and treatment for men—for everyone’s sake." Such efforts must be informed by a human rights approach to health and inclusive of men in all their diversity, with particular attention to those men who are most vulnerable to HIV.

In order to successfully address the blind spot around the HIV burden among men and adolescent boys, it is critical to count on the engagement of multilateral bodies, private sector, donor agencies, national authorities and civil society organizations. Such efforts must be informed by a gender equality and human rights-based approach to health.
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