

MenStar Strategy

As the HIV epidemic gets closer to epidemic control, the clients not being reached have become younger and healthier and have different needs. To reach epidemic control, the HIV response needs to be client-centered – seeking to understand the mindset and circumstances of clients, and meeting them where they are with what they need. Being client-centered therefore necessitates a better understanding of clients’ needs, which can then be adapted to programs and policies that offer more compelling and differentiated messages and treatment services. As a client-centered initiative, MenStar is a coordinated effort to clearly understand and overcome obstacles to testing and treatment for men. Men often make up the largest percentage of people living with HIV who are undiagnosed, not linked to treatment, and virally unsuppressed.^{1, 2} Epidemic control will not be achieved without addressing this gap and reaching men with HIV services. This necessitates planning and implementing strategies that fit the lives of the clients and providing convenient, client-centered services that make it easy for patients to continue treatment. PEPFAR requires implementation of key client-centered, stigma and discrimination-free policies and practices at the site level, including existing policies for optimized treatment and multi-month dispensing, convenient ARV pick up arrangements, community and client participation in design and evaluation of services, and access to trained health workers. Improving these policies and practices within the healthcare system will benefit all clients, including men.

Engaging men is important because men have their own distinct health needs and vulnerabilities and because engaging men can benefit everyone—including women and girls.³ Low male testing and treatment rates increase HIV transmission to female partners and affect their partners, families, and communities. In some countries, more than half of men aged 24-35 years living with HIV infection are unaware of their HIV status and are not on treatment, which imperils their own health as well as increases the risk of transmission among 15-24 year old women⁴.

¹ Test and Treat: Encouraging HIV Testing and Improving Pathways to Care among Young Men in Mpumalanga and KwaZulu Natal, South Africa: Research Protocol (Vol. 3, Tech.). (2017). The Bill and Melinda Gates Foundation.

² Addressing a blind spot in the response to HIV — Reaching out to men and boys (Publication). (2017, November 30). Retrieved http://www.unaids.org/sites/default/files/media_asset/blind_spot_en.pdf

³ “Do’s and Don’ts for Male Engagement”, compiled by the Male Engagement Task Force of the USAID-convened Interagency Gender Working Group

⁴ Addressing a blind spot in the response to HIV — Reaching out to men and boys (Publication). (2017, November 30). Retrieved http://www.unaids.org/sites/default/files/media_asset/blind_spot_en.pdf (2017, November 30). Retrieved http://www.unaids.org/sites/default/files/media_asset/blind_spot_en.pdf

Men's low utilization of services is not just the consequence of individual behavior, but also of structural factors that limit adequate provision of services for men.⁵ In an effort to be client centered, MenStar aims to uncover insights and strategies from a male's perspective. It is equally important to recognize the structural barriers that alienate men and the policy changes that will be required to make this client centricity a reality. The healthcare system has often systematically neglected men's health service needs and driven men from care by being inadequate, inconvenient, time intensive, and not protective of client privacy and confidentiality. Without universal entry points for men's health services, there are very few incentives or non-HIV services that offer a compelling reason for men – particularly young, healthy men – to engage with the healthcare system on a regular basis. These health systems barriers are an important consideration to understanding men's interaction with health services.⁶

While demographic variables like age and geography can provide useful insights into a patient's needs and barriers, psychographic variables like attitudes and aspirations are also essential to understanding why some men are still missing from the HIV cascade and what approaches are likely to be most effective in reaching those that are still missing. This requires a deep understanding of what is meaningful to clients, and then a concentrated focus on adapting these key variables within the healthcare system.

Masculinity and male norms also create both barriers and facilitators to HIV testing and treatment. Barriers include emotional inexpression, gendered communication, social pressures to be strong and self-reliant, and the fear that an HIV positive result would threaten traditional social roles (i.e., husband, father, provider, worker) and reduce sexual success with women.⁷ Facilitators include perceptions that treating HIV could restore masculinity through regained physical strength, greater sense of control, and the ability to re-assume the provider role after accessing treatment.⁸

Below is a framework, based on data from MenStar research⁹, for understanding the obstacles some men face across the HIV care cascade from a man's vantage point, including individual

⁵ Dovel K, Yeatman S, Watkins S, Poulin M. Men's heightened risk of AIDS-related death: the legacy of gendered HIV testing and treatment strategies. *AIDS*. 2015;29(10):1123–1125.

⁶ “Do's and Don'ts for Male Engagement”, compiled by the Male Engagement Task Force of the USAID-convened Interagency Gender Working Group.

⁷ Breaking the Cycle of Transmission Project, funded by the Bill & Melinda Gates Foundation and implemented by PSI, Ipsos, and Matchboxology.

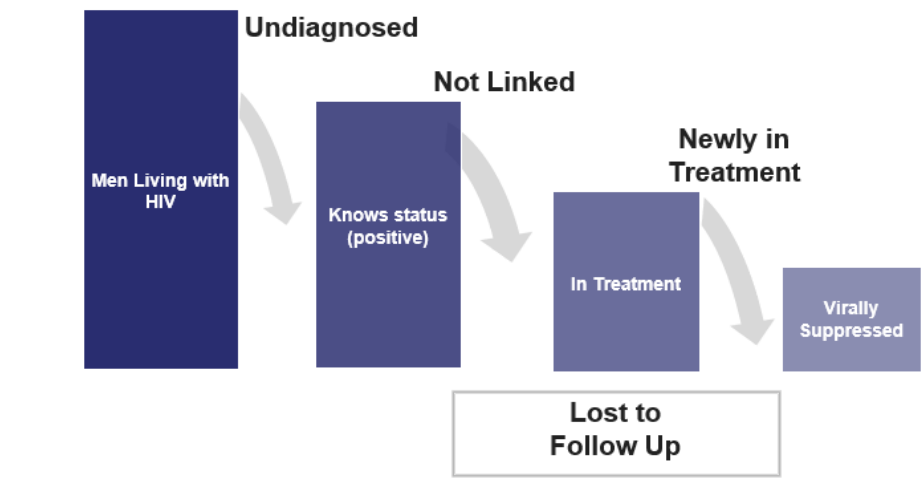
⁸ [Sileo KM, Fielding-Miller R, Dworkin SL, Fleming PJ, https://www.ncbi.nlm.nih.gov/pubmed/29777420.](https://www.ncbi.nlm.nih.gov/pubmed/29777420)

⁹ HIV Testing & Linkage to care: Decision Making and Care-Seeking Behaviors of At-Risk Men in Kenya: A Behavioral Science & Human Centered Design based approach. S Leggewie, A Caravaggio; Johnson & Johnson, R Challapalle, S Sharma; Final Mile 2018; Breaking the Cycle of Transmission Project, funded by the Bill & Melinda Gates Foundation and implemented by PSI, Ipsos, and Matchboxology.

barriers as well as health system barriers. Five categories of men within the HIV care cascade are identified, and the descriptions highlight some of the emotional, psychological, and health systems barriers relevant to each category. The barriers listed are neither exclusive to men, nor are they comprehensive or exhaustive. Additionally, some men may exhibit more than one pattern of behavior. This framework is being proposed to help spur the development of specific interventions aimed to address the obstacles specific to, and spanning across, each stage of the HIV care cascade.

WHO ARE THE CLIENTS AND WHY ARE THEY NOT VIRALLY SUPPRESSED?

Client-Centered Cascade



Descriptor	Who are they?	Key Healthcare System Need	Key Emotional Need
Undiagnosed	Unaware of status/undiagnosed	Confidential and convenient testing options	Increased risk internalization and coping potential, including treatment literacy A reason to believe that the benefit of knowing one’s status outweighs the cost

Not Linked	Aware of HIV status but has not yet started treatment	Improvements to the clinic experience and medication which will be manageable	Increased coping potential, including treatment literacy Feeling of getting back to a self-defined sense of normalcy
Newly in Treatment	Newly initiated on treatment. First 90 days are critical.	A positive healthcare experience from day 1	Support to incorporate treatment into his life
Lost to Follow Up	Lost to follow up, including those who cycle in and out of care: has initiated treatment and has disengaged from services	Proof that the medication and the clinic/system have changed and will now meet his needs	Proof that it's "worth it" to give it another try
Virally Suppressed	Engaged in treatment and virally suppressed	Convenient differentiated service delivery options	Continued access to support and a move towards the feeling that HIV doesn't define him

Undiagnosed

The undiagnosed man does not yet know his status. He may not fully understand his own risk for infection, or see the benefit of getting diagnosed early. The men missing from the cascade are often too scared to learn their status.

The undiagnosed man has limited reasons to interact with the healthcare system, as the system does not offer non-HIV services or other benefits to him. He attends a health facility to seek care for his own illness/injury or the illness/injury of others, but facilities rarely incorporate HIV testing services into acute service delivery, and therefore, he has little opportunity to test. He may not fully internalize his own risk of HIV or think that HIV is relevant to him, because he feels healthy. Stigma and non-disclosure limit his exposure to people openly living with HIV,

and those around him exhibit similar sexual behaviors and do not appear to be HIV positive, further distorting his risk perception. The undiagnosed man may appear indifferent and closed off – but in reality, he may be scared and has not been given the opportunity to test – the health system has missed opportunities to actively engage him. He may also lack the coping potential to deal with a positive HIV diagnosis and therefore puts off dealing with it.¹⁰ His knowledge about HIV may be limited or dated, which leads him to either not think about his own risk or provides him with little compelling rationale to actively seek out testing now, as opposed to delaying until he becomes sick. He may fear the physical and social consequences of a positive result, including: conflict and tension with his partner; disappointment and shame from his family; loss of connection, status, and acceptance from his peers; and loss of respect and reputation in his community. Within the clinic, he may anticipate judgment from healthcare providers, as well as a loss of control/autonomy over his own healthcare decisions. All of this can be compounded by unprocessed childhood grief and trauma of witnessing numerous AIDS deaths and consequent association of HIV and ART with taboos, weakness, and death.

Not Linked

The man who has not yet linked knows his positive HIV status, but has not yet started treatment. He may feel like he cannot cope with HIV as a health condition or the social implications associated with it.

The unlinked man may appear indifferent and closed off – but in reality, he may be scared. Like the undiagnosed man, he may associate an HIV diagnosis with loss of identity; loss of respect and status/social death; loss of fun and pleasure; loss of support and connection; loneliness; and loss of control/autonomy. He may also anticipate the social consequences described above.

Within the clinic, he may anticipate judgment from healthcare providers as well as a loss of control/autonomy over his own healthcare decisions, and automatic disclosure to community members who see him traveling to or attending the health facility.¹¹ He may feel overwhelmed by the monthly health visits and the numerous hours required for ART initiation that may interrupt work and other responsibilities.

¹⁰ HIV Testing & Linkage to care: Decision Making and Care-Seeking Behaviors of At-Risk Men in Kenya: A Behavioral Science & Human Centered Design based approach. S Leggewie, A Caravaggio; Johnson & Johnson, R Challapalle, S Sharma; Final Mile 2018; Breaking the Cycle of Transmission Project, funded by the Bill & Melinda Gates Foundation and implemented by PSI, Ipsos, and Matchboxology.

¹¹ Nhassengo, Pedroso Fabian Cataldo, Amílcar Magaço, Risa Hoffman, Lucas Nuera, José Tique, Mohamed Saide, Aleny Couto, Francisco Mbofana, Eduardo Gudo, Rosa Marlene Cuco, Sérgio Chicumbe, Kathryn Dovel. “Barriers and facilitators to the uptake of universal treatment in Mozambique: a qualitative study on patient and provider perceptions.” *PLoS ONE*. 13(12): e0205919.

All of this can be compounded by unprocessed childhood grief and the trauma of witnessing numerous AIDS deaths and consequent association of HIV and ART with taboos, weakness, and death. In terms of treatment literacy, he may not understand the benefits of early treatment initiation and therefore see little benefit to starting treatment unless sick. He may also have outdated or inaccurate information about HIV transmission – unaware that if he suppresses the virus there is no longer any risk of transmission to his partner(s), as well as the health benefits he will experience from early initiation.

In sum, he sees HIV treatment as all loss and no gain. He faces obstacles across multiple fronts, from emotional/psychological and limited knowledge, to time intensive health care visits that lack privacy. Education and emotional support can help address some of these barriers, as can increasing the supply and access to tailor-made client friendly HIV services.¹²

Newly in Treatment

The man who is newly in treatment recently initiated his treatment, and the first 90 days are critical to keeping him on lifelong treatment. From day 1, he needs a positive clinic experience. If he is well supported through this initial phase of the journey, his likelihood of achieving viral suppression is increased.

The man who is newly in treatment wants to feel like his old self again, but is weighing the pros and cons of being on lifelong treatment. He is struggling with the emotional acceptance of his status, the rational hurdles of being on lifelong treatment, and the immediate barriers to routine clinic visits for the first time in his life. He may feel skeptical and find that the healthcare system is inconvenient or that treatment doesn't fit into his life. He may not see himself in the healthcare system or is experiencing the frequent healthcare visits as too burdensome, disruptive, and risking unwanted disclosure. He anticipates a negative clinic experience, as many facilities are under-resourced and under-staffed, and some healthcare providers have negative attitudes and behaviors towards men. He may experience a loss of privacy and confidentiality and worries that everyone will gossip about him. He may not be sure he can or wants to cope with being HIV positive and the treatment required to stay healthy. He has not been provided with quality information on HIV and the importance of being on treatment, even when healthy. The obstacle here is one of perception and experience and can be overcome with improved and more convenient, confidential healthcare. He needs a positive clinic experience and support to stay on treatment.¹³

¹² Breaking the Cycle of Transmission Project, funded by the Bill & Melinda Gates Foundation and implemented by PSI, Ipsos, and Matchboxology.

¹³ Tibbels NJ, Hendrickson ZM, Naugle DA, Dosso A, Van Lith L, Mallalieu EC, et al. (2019) Men's perceptions of HIV care engagement at the facility- and provider-levels: Experiences in Cote d'Ivoire. PLoS ONE 14(3): e0211385. <https://doi.org/10.1371/journal.pone.0211385>.

Lost to Follow Up

The man who is lost to follow up started treatment, but then stopped, or cycles in and out of care. This man was once newly in treatment and tried out the healthcare system, but has disengaged from it, in part because he didn't like the experience, the medication, or the social stigma and loss he experienced.

He experienced the healthcare system as inconvenient and it may not fit into his life—visits require long waits at inconvenient times. Facilities are overcrowded, under resourced, and understaffed. He may have experienced negative attitudes and behaviors from healthcare providers, and he may have been treated judgmentally or punitively. Economic migration may also be a factor. He may have experienced clinic staff and fellow patients gossiping about him, or perhaps the medication he was taking had side effects and made him feel worse when he was previously feeling fine. In sum, he calculates the cost/benefit ratio and decides that it is not worth it. The benefits of being on treatment appear to be outweighed by the costs. The obstacle here is also one of perception and experience; but because he may have had a negative experience and made up his mind, he may be harder to reach and convince than the man who is newly in treatment. Outreach efforts coupled with counseling and demonstrated improvements in the healthcare system, including differentiated service delivery (DSD), may help reach this category of men.¹⁴ For men previously on ART long enough to work through identity and disclosure barriers, facilitators within the healthcare system are more likely to be central to re-engagement.

Virally Suppressed

The man who is virally suppressed is coping with his HIV diagnosis and is prepared to do what it takes to stay virally suppressed (he feels good about having HIV under control). At the same time, he may need continued, adaptive support to ensure that he remains virally suppressed as the grind of lifelong treatment may become tedious.

The man who is virally suppressed may need sustained engagement, albeit less frequently or intensively, to ensure retention in care and encourage adherence to treatment. He has done the hard work of adjusting to a new routine, coping with the psychological and social implications of his diagnosis, and achieving viral suppression, but he may still face challenges that put him at risk of non-adherence or loss to follow-up. Taking medication every day for the rest of his life is inherently challenging and is compounded by the stigma associated with HIV. His willingness to put up with the challenges of the healthcare system may wane over time if the experience does not adapt to his changing needs. This category of men may find encouragement in messages that portray them as winners, and as part of the collective solution to an important problem. He may

¹⁴ Breaking the Cycle of Transmission Project, funded by the Bill & Melinda Gates Foundation and implemented by PSI, Ipsos, and Matchboxology, available at <http://www.menstarcoalition.org/> or <https://www.psi.org/resource-type/data/>.

also be motivated by the notion of being a responsible caregiver/provider. As with other categories of men, continued promotion of treatment as prevention may be critical for this population. Finding meaning and purpose in living with HIV can bolster motivation to continue being adherent.

One of the key opportunities with the virally suppressed man is to encourage him to become an advocate or champion, thus locking in his commitment to himself and his peers.

WHAT DO THEY NEED?

In order to reach each of these categories of male clients, programs should focus on relevant strategic elements from the following MenStar core package of services:

Core Package of Services

Undiagnosed	Not Linked	Newly in Treatment	Lost to Follow Up	Virally Suppressed
<p>Build coping potential with messages on the new HIV treatment narrative and treatment literacy (A reclaiming of a self-defined sense of normalcy for men through modern treatment options)</p>				
<p>Improve experience and outcomes of testing</p>	<p>Drive demand for treatment services with emphasis on emotional benefits (e.g., “prove that it will meet my needs”): education, counseling and emotional support</p>	<p>Strengthened service delivery with client participation to improve the client experience and make it more convenient, private, and welcoming</p>	<p>Drive demand for return to treatment services with emphasis on clinical benefits: outreach, demonstrable changes to the health care system (e.g., “try me again”)</p>	<p>Support the client throughout the journey with treatment and adherence support mechanisms</p>

		Support the client throughout the journey with linkage and initiation, treatment, and adherence support mechanisms	Offer Differentiated Service Delivery as soon as possible as an incentive	Rapid optimization of ART by offering TLD
		Rapid optimization of ART by offering TLD		Differentiated Service Delivery

HOW TO EXECUTE THE MENSTAR CORE PACKAGE

A more detailed approach to effective implementation of these strategic elements of the MenStar core package is outlined below. Country Teams should review the strategies and prioritize the interventions which are most likely to have impact on the target population group in their country. Items which are **bolded** are Minimum Program Requirements and are not optional. A separate Compendium of examples is also available to showcase specific interventions that have started to effectively deploy the strategies outlined below to reach men and keep them on treatment.

Across all five categories:

BUILD COPING POTENTIAL WITH MESSAGES ON THE NEW HIV TREATMENT NARRATIVE AND TREATMENT LITERACY (A reclaiming of self-defined sense of normalcy for men through modern treatment options)

There is a need to change the narrative around HIV. It should be perceived as a chronic manageable condition, not a death sentence, and people with HIV should not be stigmatized. Like women, men know how they acquire HIV but they often do not know how to live with it. Many men feel they have failed to live up to social expectations as well as their own aspirations, particularly around being a provider and protector.¹⁵ The prospect of HIV can feel like another

¹⁵ Colvin, Cristopher, J. “Strategies for engaging men in HIV services” *Lancet HIV* (2019). p. 2.

looming failure. Counselling and messaging should seek to reframe treatment as an opportunity for men to take charge of their health and future.

Treatment literacy should include information on the clinical benefits of new medications as well as the importance of receiving and understanding the results of viral load testing. It should also include information on how differentiated service delivery options will make healthcare more convenient and less burdensome on an ongoing basis.

Viral suppression should be celebrated as a success / major achievement.¹⁶ The ability to completely suppress HIV such that it cannot be transmitted to anyone else has been proven in numerous trials¹⁷ [HPTN 052, PARTNER, Opposites Attract]. This information could be useful in helping men with HIV to reframe their identity and decrease stigma.¹⁸ Counselling and messaging should not simply instruct men on treatment but explain *why* early treatment is important, including the clinical and lifestyle benefits of treatment, which may connect to men's own internal motivations. Some men may be motivated by the desire to eliminate new HIV transmissions. Others will be motivated by a desire to improve their own well-being and reduce feelings of being infectious.¹⁹ Identifying the motivator upfront can help deliver the right message.

This new messaging has the potential to help men reclaim a positive identity, experience a sense of winning, and feel like they are back to a self-defined sense of normalcy. Treatment as prevention also enables men to be successful caregivers by responsibly taking care of their own health and the health of others. The emphasis should be that HIV is chronic illness that, when treated, has virtually no impact on ability to work or lifespan.

For the Undiagnosed:

1. IMPROVE EXPERIENCE AND OUTCOMES OF TESTING

¹⁶ Breaking the Cycle of Transmission Project, funded by the Bill & Melinda Gates Foundation and implemented by PSI, Ipsos, and Matchboxology, available at <http://www.menstarcoalition.org/> or <https://www.psi.org/resource-type/data/>

¹⁷ Cohen MS, et al. IAS 2015, Vancouver, Canada. Oral # MOAC0101LB; Eshleman S, et al. IAS 2015, Vancouver, Canada. Poster # MOLBPE18; Rodger A, et al. JAMA. 2016;316(2):171-181; Grulich A, et al. IAS 2017. Paris, France. Oral # TUAC0506LB

¹⁸ Mooney, Alyssa C. et al. "Men's Perceptions of Treatment as Prevention in South Africa: Implications for Engagement in HIV Care and Treatment" *AIDS Prevention and Education* 29.3 (2017). p. 274.

¹⁹ Hensen, Bernadette et al. "Systematic review of strategies to increase men's HIV-testing in sub-Saharan Africa" *AIDS* 28.14 (2014).

- More convenient testing to reach men where they are/congregate.^{20, 21} This group is unlikely to proactively seek out testing but may ‘go with the flow’ if testing is easy. Bringing targeted testing to him at times and in places that are convenient for him, is likely to be most meaningful. Examples may include testing in the workplace (formal and/or informal) and moonlight testing in hotspots.
- Efficient HIV services at health facilities (with attention to minimizing wait times) that are confidential and private, in countries where targeted facility and provider-initiated testing and counseling (PITC) testing remains part of the case-finding strategy. Communities often assume HIV status based on where patients wait within the clinic. HIV service departments should have private waiting spaces and confidentiality should be the utmost priority for healthcare providers.
- Targeted HIV self-testing (HIVST), through both primary and secondary distribution as a means of more convenient and private testing.²² Programs should have efficient and effective educational components when distributing self-test kits.
 - HIVST can be used as an option for identified contacts of index clients in antenatal settings, at family planning sites, and STI sites. Any facility attendee who opts to take an HIVST kit should be given the choice to take a second HIVST kit to facilitate couples testing, which importantly, supports disclosure and improves the likelihood of linkage if the partner screens positive.
 - To maximize the probability of a client seeking a confirmation test and linking to treatment, programs should anticipate the barriers and challenges that a client may face and tailor services accordingly.²³ These should be addressed in the communications materials accompanying the test and/or via interpersonal communication with the person distributing and/or assisting with the use of the HIVST kit.
- Facility-based testing, with attention to ensuring confidentiality, in countries where targeted facility and PITC remains part of the case-finding strategy

²⁰ Bukoba Combination Prevention Evaluation: Effective Approaches to Linking People Living with HIV to Care and Treatment Services in Tanzania, PEPFAR Solutions Platform.

²¹ Simwinga M et al. “Reaching men and engaging them in care: Lessons from HPTN 071 POPART Study”. Men & HIV Forum, 2019, Mexico.

²² Journal of the International AIDS Society, “Realizing the potential of HIV self-testing for Africa: lessons learned from the STAR project” Volume 22, Supplement 1, March 2019.

²³ WHO 2019 testing guideline 5.3.3: ‘linkage to appropriate services after HIVST is critical’.

- High among men’s barriers to facility-based testing is the belief that the setting will not be sufficiently private and/or facility staff will not maintain the confidentiality of the result, which sparks fear that upon testing, he will not be in control of who knows or how they are informed. Programs should make every effort to ensure that confidentiality is paramount.
- Include offer of testing for men who are attending health facilities for their own needs or their family’s needs.²⁴
- If the price point for HIVST kits were to fall to \$1 per test or less, PEPFAR would support the targeted use of HIVST in facilities where facility-based testing remains part of the case-finding strategy. There is preliminary evidence that at this price point, if HIVST is appropriately integrated into workstreams, it would increase testing uptake among priority populations such as men and youth, would be cost-effective, and would decrease the burden of health worker time for performing tests.²⁵
- Provider-initiated testing, in countries where targeted facility and PITC remains part of the case-finding strategy
 - While provider-initiated testing can be an effective strategy for reaching men who may not otherwise access testing services, men who do not proactively choose to test may be less likely to link to treatment.²⁶ They may not have had time to contemplate the possibility of an HIV diagnosis, and appear more likely to avoid testing. Provider-initiated testing approaches should therefore ensure particular sensitivity to a man’s mindset and barriers and should make provision for more intensive, personalized counselling and support than may normally be required.
 - There is emerging evidence that men may be accessing health services at higher rates than previously assumed.²⁷ Therefore, facility-based provider-initiated testing for male clients and for men who accompany someone to a health facility

²⁴ ICASA 2019 SATELLITE SESSION "CLOSING THE GAP ON REACHING MEN: TIME FOR ACTION" Differentiated Service Delivery, International AIDS Society.

²⁵ Dovel, Kathryn, Mike Nyirenda, Frackson Shaba*, O. Agatha Offorjebe*, Kelvin Balakasi, Brooke Nichols, Khumbo Phiri*, Khumbo Ngona, Sundeep K Gupta, Risa Hoffman. “Facility-based HIV self-testing for outpatients dramatically increases HIV testing in Malawi: a cluster randomized trial.” *Lancet Global Health*. **To be published Jan 22**

²⁶ Breaking the Cycle of Transmission Project, funded by the Bill & Melinda Gates Foundation and implemented by PSI, Ipsos, and Matchboxology, available at <http://www.menstarcoalition.org/> or <https://www.psi.org/resource-type/data/>.

²⁷ Dovel, K. “Men’s use of facility-based health services in Malawi.” Presentation during ICASA 2019 satellite “Closing the gap on reach men: Time for Action”. December 2019, Rwanda.

should be prioritized in countries where targeted facility and PITC remains part of the case-finding strategy. There appears to be an unmet need in offering testing to men who are at health facilities. Improved HIV service entry points at health services where men frequent can build on existing facility staff and promote linkage to other HIV services as needed.

For the Not Linked and Lost to Follow Up:

2. DRIVE DEMAND FOR TREATMENT SERVICES WITH EMPHASIS ON EMOTIONAL AND HEALTHCARE SYSTEM BENEFITS (IMPROVEMENT OF CLINIC SERVICES)

Proactive interventions are needed to **bring clients back** to the clinic. These efforts should convince clients to try the services again by creating awareness of new medications and effective, convenient, client-centered differentiated service delivery options that are available for men, and address their emotional barriers to HIV treatment.

Many men are not aware of the benefits of testing and treatment. The ability to completely suppress HIV such that it cannot be transmitted to anyone else (U=U) is largely unknown, but potentially powerful in helping men with HIV to recover/reframe their identity.

Demand creation messaging should include information on the improvements to the healthcare system, including differentiated service delivery models, so that clients, particularly those who are not currently in the clinic, are aware that taking treatment will not be logistically burdensome or costly.

Some men may intend to link to treatment in the future but delay because they are still feeling healthy with no symptoms. Previous treatment initiation guidelines based on CD4 count thresholds contributed to the belief that it is fine to wait to start treatment. Counselling and messaging should not simply instruct men but should explain the benefits of treatment and seek to connect them to men's own internal motivations and barriers.

- In consultation with men and the global MenStar Coalition, develop locally appropriate marketing to advertise new clinic standards and new medications.
- These communications should take a consumer marketing approach to demand generation, staying within overarching brand guidelines and targeted messages to reach men in different parts of the client-centered cascade.
- Branding and communications can be used to address emotional barriers and motivators, including men's desires to return to normalcy; be in control of his life and health; be a safe and desirable partner; and earn a living / be a provider.

- Media selection should be guided by effective reach amongst men in the local context.
- A clear targeting strategy should be developed to focus on the most important client-centered care cascade target.
- These efforts could include identification and promotion of “HIV Champions” - generally well-known or well-respected men who can address stigma by advocating for appropriate testing and acceptance/normalization of HIV.

For the Newly in Treatment:

3. STRENGTHEN THE SERVICE DELIVERY EXPERIENCE TO BE MORE CONVENIENT AND WELCOMING

The service delivery experience, including the physical space and the providers, should meet the healthcare system and emotional needs of the clients. As a man assesses whether he can incorporate this new routine into his day-to-day life, convenience factors are likely to be paramount. Setting goals like viral suppression and DSD could be motivational as milestones to strive for. Client satisfaction should be monitored regularly and used for ongoing improvements in areas of convenience, hospitality, responsiveness, and effective support / rapid feedback loops.

A. Convenience

It is critical that men are offered services that allow them to fulfill their obligations, with minimal disruption to their lives. Relevant strategies include:

- Shortened wait times with specific interventions to reduce them to one hour, such as fast-track services and expedited clinic operations for working clients
- Extended clinic hours which meet local needs^{28, 29, 30, 31}
- Transportation support
- Access to differentiated service delivery models as soon as possible, with a minimum offer of 3-6 month supply of medication (multi-month dispensing). For returning men, those who interrupted treatment due to cost, time off work, distance etc., consider immediate access to DSD models to support adherence

- Integration of other health needs into differentiated service delivery models such as TB preventive therapy (TPT) (see COP20 guidance) and non-communicable disease (NCD) treatment supply

B. Welcoming environment responsive to men’s needs

There is abundant evidence that clinics are not spaces where men feel welcome and well-served. Insights suggest men feel clinics are designed for women, and that providers often lack respect for confidentiality and are judgmental towards male clients.³²

- Redesign clinics to be more welcoming to men, including male-only spaces/corners, waiting areas, specific male-only hours, and more male imagery in clinics (e.g., posters)
- Enhanced focus on confidentiality and privacy
- Provide and support training to clinic staff to facilitate a more responsive environment to men’s needs: empathetic, well trained, and well supported providers. This training should emphasize how best to balance engaging men and women³³
- Consistent, affirmative “Welcome Back” messaging that avoids the negative consequences of interruption of care and provides positive reinforcement for re-engagement³⁴
- Having the option of male providers; making efforts to train and hire male nurses, counselors, peer outreach workers, case managers, and other staff³⁵

For the Lost to Follow Up, Newly in Treatment, and the Vially Suppressed:

4. SUPPORT THE CLIENT IN HIS JOURNEY THROUGH LINKAGE AND INITIATION, TREATMENT, AND ADHERENCE SUPPORT MECHANISMS

Clients should have access to responsive support structures and peer networks throughout the entire journey to help them reach and sustain viral suppression. It is especially important to help men realize early in their HIV experience that the burden of care will be manageable and to offer DSD as an incentive to achieve viral suppression.

³² Orr, Neil et al. “Development of a National Campaign Addressing South African Men’s Fears About HIV Counseling and Testing and Antiretroviral Treatment” *Journal of Acquired Immune Deficiency Syndromes* 74.1 (2017): p. S70-S71.

³³ “Do’s and Don’ts for Male Engagement”, compiled by the Male Engagement Task Force of the USAID-convened Interagency Gender Working Group

³⁴ “Technical consultation on HIV linkage”. International AIDS Society Meeting Report, March 2019.

³⁵ Maile L. “Lesotho men’s clinic initiative: Khotla”. Men & HIV Forum, 2019, Mexico.

Linkage and Treatment Support Mechanisms

- Case managers, coaches, or a male peer navigator to orient men to the clinic experience - both within the community and within the clinic - to help men become familiar with the expectations of their treatment experience and the pathway ahead. This may include information about what service delivery options will be available to make ongoing treatment collection and management more convenient (i.e., longer refills closer to home/work or available through after hours fast lane systems, as desired)
- Patient support tools to help navigate the treatment experience
- A service referral and linkage system that seeks to identify and address clients' particular barriers and challenges, which are experienced as supportive rather than coercive
- Support for disclosure, particularly partner disclosure

Adherence Support Mechanisms

- Support/Motivation:
 - a. Peer mentors/champions/expert clients who provide tailored support to clients
- Commitment Tools:
 - a. Case managers, including adherence counselors or clinic coaches, to provide tools and tips for adherence to medication regimen and concerns with stigma
 - b. Adherence clubs/support groups to create community support for continued adherence and viral suppression
- Reminder services
 - a. Digital support tools, including pre-appointment reminders and follow ups for missed appointments

For the Newly in Treatment Man and the Virally Suppressed:

5. RAPID OPTIMIZATION OF ART BY OFFERING TLD

Accelerate use of best in class of new drug regimens: **Clients must have access to TLD**

- Optimal antiretroviral therapy (ART) with minimal or no side-effects is critical to lifelong adherence, and viral load suppression. This is the cornerstone of the PEPFAR program. The World Health Organization (WHO) released updated normative and derivative guidance documents in July 2019³⁶ including updated guidelines for preferred first and second-line ART. The WHO now recommends Dolutegravir (DTG), in combination with a nucleoside reverse-transcriptase inhibitor (NRTI) backbone, as the preferred first-line regimen for all adults.

³⁶ International AIDS Society (2019, July 24) *New drugs and more effective treatment regimens featured at IAS 2019* [Press Release]. Retrieved from <https://mailchi.mp/ias2019/new-drugs-press-release?e=cce6a62396>.

- Some men do not link to treatment because they are still feeling healthy - with no symptoms.³⁷ Previous treatment initiation guidelines based on CD4 count thresholds contributed to the belief that it is ok to wait to start treatment. Counselling should explain the shift to Universal Test and Treat, and the reasons that immediate initiation on treatment is beneficial.

Advanced HIV disease (AHD)

- Men are more likely to present with AHD, have higher HIV-associated mortality, and lower life expectancy than women.³⁸ Ensure access to the AHD package of care, including close follow-up when referred from hospitals to clinics and through the first 3-6 months on ART.

For the Virally Suppressed:

6. DIFFERENTIATED SERVICE DELIVERY

Differentiated service delivery models adapt HIV services by location, provider type, frequency of visits, and package of services depending on individual patient needs. These models can reduce congestion at treatment facilities, make treatment much less burdensome to clients and the healthcare system, and support high rates of client retention and viral load suppression.³⁹

Information on decentralized service delivery should be provided from the time of initiation on treatment, even though a patient may not be eligible until they are stable on ART. Providing this information early in the patient journey can strengthen motivation to adhere by holding out the reward of a more convenient alternative once someone is stable on treatment.

³⁷ Orr, Neil et al. “Development of a National Campaign Addressing South African Men’s Fears About HIV Counseling and Testing and Antiretroviral Treatment” *Journal of Acquired Immune Deficiency Syndromes* 74.1 (2017): p. S72.

³⁸ World Health Organization, Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy, July 2017.

³⁹ Sharma, Monisha et al. “Community-based strategies to strengthen men’s engagement in the HIV care cascade in sub-Saharan Africa” *PLOS Medicine* (2017).

DSD interventions include:^{40, 41, 42, 43, 44, 45, 46, 47}

- Extending ART refills for up to 6 months of medication at one time, with a minimum of 3-month refills
- Decentralized distribution points for medication to convenient locations outside of health facilities, including community venues, pharmacies, workplaces etc.
- Group models of including facility- and community-based adherence and support groups. These can be male only, all genders, or family-orientated depending on men's preferences

Across All Five Categories:

It is equally important to recognize the structural barriers that have kept men out of the healthcare system, and the policy changes that will also be required to make this client centricity a reality.

- A. STRENGTHEN ENTRY POINTS WITH INTEGRATED SERVICES: Promote universal entry points and holistic care for men. HIV is still the only primary health care service relevant to men. Few routine health services are available for young or mid-life men (outside of NCD screening). The availability and promotion of holistic health services for men may increase men's engagement with health systems, provide motivation for

⁴⁰ Decroo et al. "Effect of community ART groups on retention-in-care among patients on ART in Tete province, Mozambique: a cohort study". *BMJ Open*, 2017.

⁴¹ "Improving adherence & retention: Community adherence and support groups in Mozambique". PEPFAR Solutions.

⁴² "Improving patient antiretroviral therapy retention through community adherence groups in Zambia". PEPFAR Solutions.

⁴³ Wilkinson L et al. "Expansion of the adherence club model for stable antiretroviral therapy patients in the Cape metro, South Africa 2011-2015". *TMIH*, 2016.

⁴⁴ Grimsrud A et al. "Community-based adherence clubs for the management of stable antiretroviral therapy patients in Cape Town, South Africa: A cohort study. *JAIDS*, 2016.

⁴⁵ Tsondai, PR et al. "High rates of retention and viral suppression in the scale-up of antiretroviral therapy adherence clubs in Cape Town, South Africa". *JIAS*, 2017.

⁴⁶ Improving retention and viral load suppression rates: Scale-up of adherence clubs for stable antiretroviral patients in Cape Town, South Africa". PEPFAR Solutions.

⁴⁷ "Improving Access to HIV Treatment Services through Community Antiretroviral Therapy Distribution Points in Uganda", PEPFAR Solutions.

facility visits, and reduce fears that HIV treatment utilization is equivalent to automatic disclosure. Currently, the only reason a man would frequent health facilities is for HIV. ANC visits could also be strengthened as an entry point by focusing on family health.

B. INCORPORATE MEN INTO INTERNATIONAL AND NATIONAL POLICIES FOR HIV AND GENERAL HEALTH.

Local programs follow international and national priorities. HIV policies have historically focused on women and the prevention of mother-to-child-transmission.⁴⁸ Men's absence from HIV policy limits the scalability and sustainability of programs essential to engaging men across the HIV care continuum. Men's health and use of HIV services should also be incorporated into national monitoring and evaluation (M&E) systems to allow for routine assessment of and response to gender disparities in HIV services and HIV-related outcomes.

⁴⁸ Poulin, Michelle, Kathryn Dovel and Susan Watkins. 2016. "Men with money and the 'vulnerable women' client category in an AIDS epidemic." *World Development*. 85; 16-30

Mills, E., Beyrer, C., Birungi, J., & Dybul, M. (2012). Engaging men in prevention and care for HIV/AIDS in Africa. *PLoS Med*, 9(2), e1001167.

Higgins JA, Hoffman S, Dworkin SL. Rethinking gender, heterosexual men, and women's vulnerability to HIV/AIDS. *American journal of public health*. 2010 Mar;100(3):435-45.