

Male Engagement in Differentiated HIV Treatment Services

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Presentation Overview

- Overview of male engagement in continuum of HIV Care
- Qualitative study of male engagement in HIV Community-Based Antiretroviral Refill Groups in Zimbabwe

Introduction

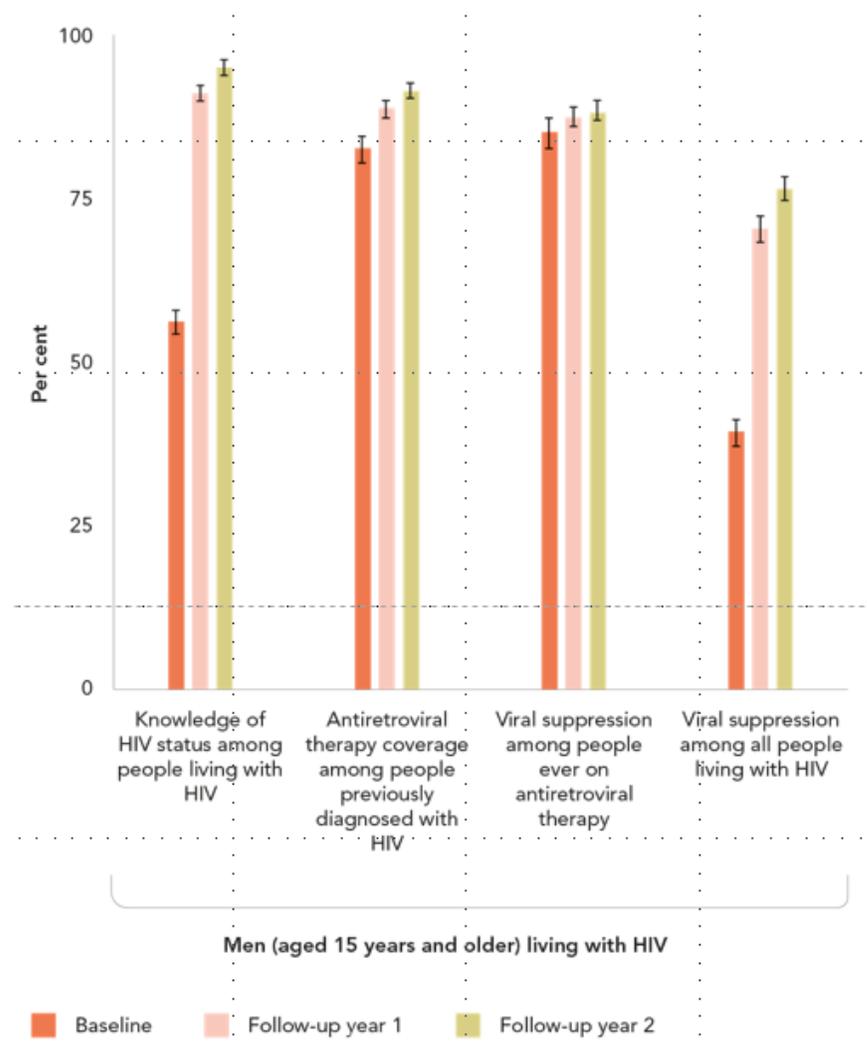
- Remarkable successes of HIV programs in low-resource settings, but global scale-up of HIV services has been uneven.
- One example is the persistent challenge of engaging men in HIV testing, prevention, and treatment.
- In 2017, global antiretroviral therapy (ART) coverage show that men consistently lag behind women in awareness of their HIV status.
- Men are less likely to test for HIV and access antiretroviral therapy and more likely to die of AIDS-related illnesses than women.
- Men diagnosed with HIV are also less likely to link to care, adhere to ART, and maintain viral suppression in some settings.
- Although women and girls are disproportionately affected by HIV, the effective engagement of men and boys is also critical for both equity and effective

Men: The “Blindspot” of HIV Prevention

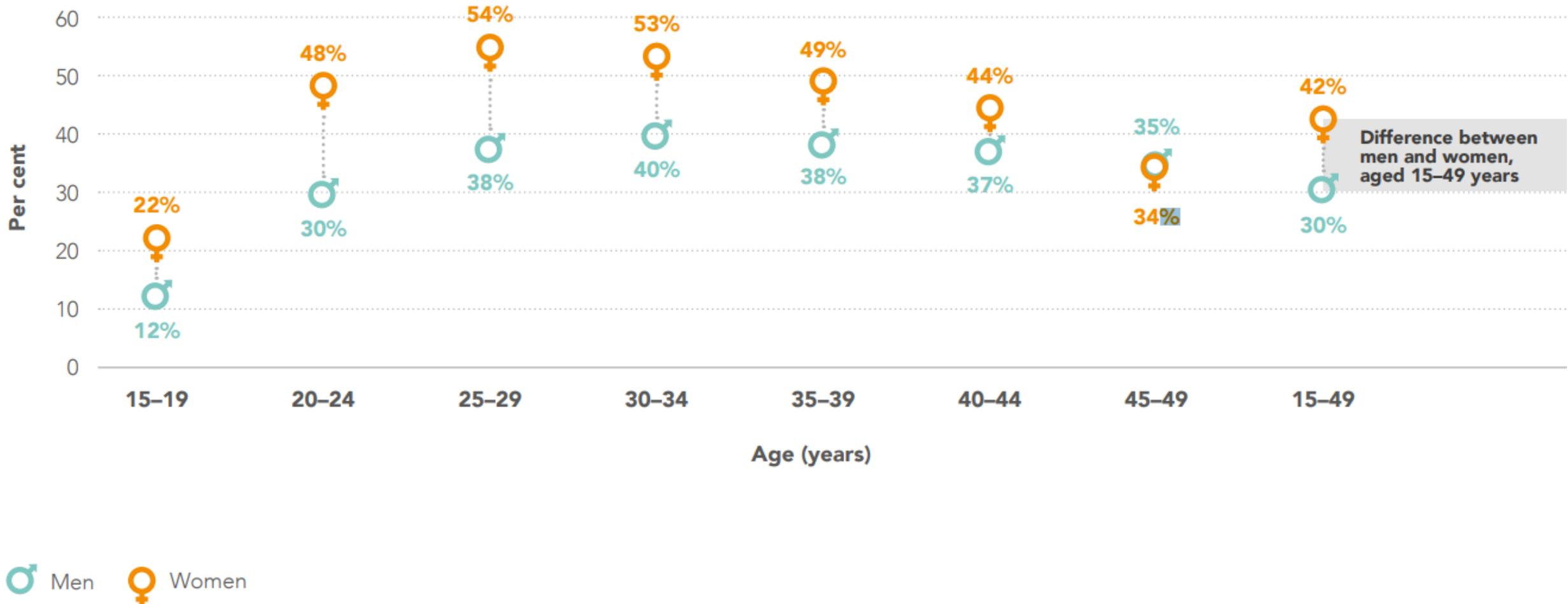


Source: UNAIDS. Blind spot: Reaching out to men and boys. 2017

90–90–90 Among Men Living with HIV Age 15+ in 16 Communities in Rural Uganda and Kenya

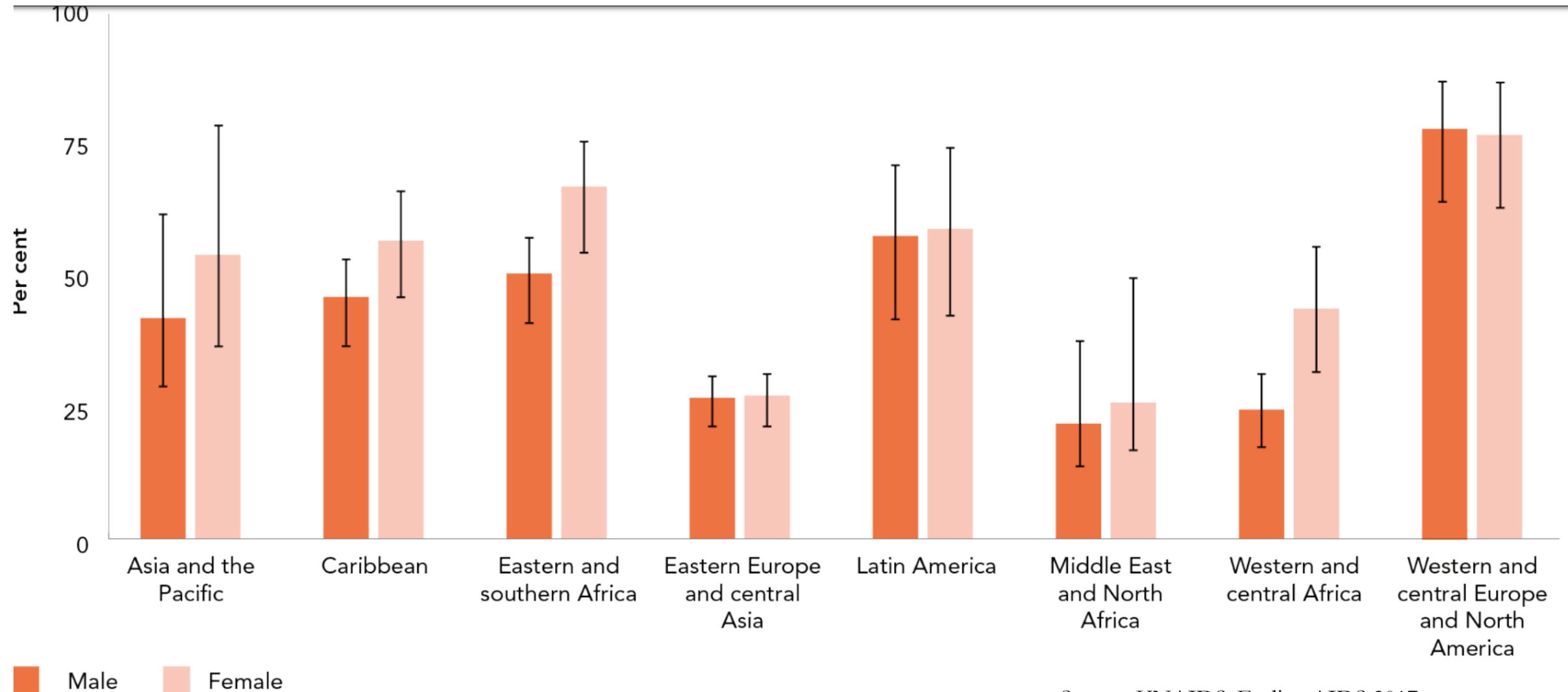


Percentage of Adults Who Have Ever Tested for HIV and Received Result, by Age and Sex, sub-Saharan Africa, 30 Countries, 2011–2016



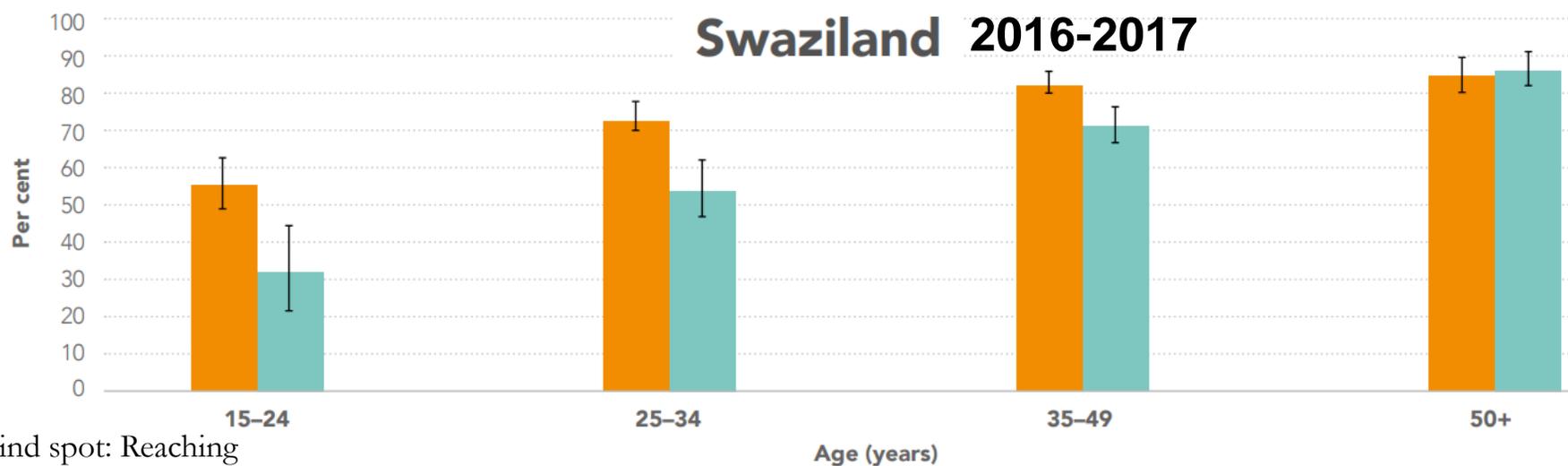
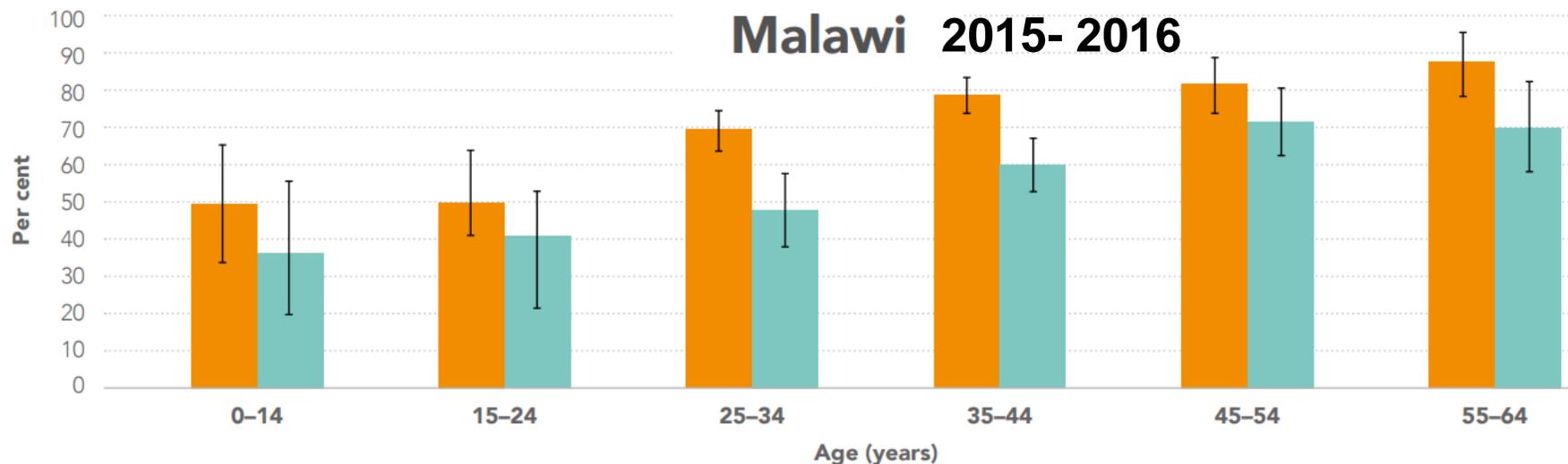
Source: UNAIDS. Blind spot: Reaching out to men and boys 2017

ART Coverage Among Adults Living with HIV Aged ≥ 15 by Sex, by Region, 2016



Source: UNAIDS. Ending AIDS 2017

Viral Suppression among People Living with HIV by Age and Sex



Women Men

Achievement of 90-90-90 in Zimbabwe

- **Aware of HIV Status:** Among people living with HIV (PLHIV) aged 15-64, 68.2% of males and 76.1% of females report knowing their HIV status
- **ARV Use:** Among people living with HIV aged 15-64 who know their HIV status, 86.1% of males and 87.2% of females self-report current use of antiretroviral therapy
- **Viral Suppression:** Among PLHIV aged 15 to 64 who self-report current ART use, 84.4% of males and 87.7% of females are virally suppressed

HIV in Zimbabwe

- ZIMPHIA 2016 population-based survey showed gender disparities among adults 15-64
 - Annual HIV incidence: 0.33% among males and 0.60% among females
 - HIV prevalence: 12.0% among males and 16.0% among females
 - 68% of men were aware of their HIV status *vs.* 76% of women
 - 59% of men aware of their HIV status were on ART *vs.* 66% of women
 - 84% of men on ART were virologically suppressed *vs.* 88% of women

Source: Ministry of Health and Child Care (MOHCC), Zimbabwe. Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) 2015-16: First Report. Harare, MOHCC. July 2017

Suboptimal Male Engagement in HIV Programs

- Men interact with health system less frequently than women, who are more likely to visit health facilities for family planning, antenatal services, and pediatric care
- Male gender norms prompt concerns about compromised masculinity for men who use health services in general, and HIV services in particular
- Stigma
- Engaging men is critical to closing the HIV prevention and treatment gap

HIV Differentiated Service Delivery

- Approach to tailor HIV-related services for specific subsets of persons living with HIV may mitigate some of the barriers to male engagement
- Recognition that one-size-fits-all program designs are unlikely to meet the needs of all populations
- One successful DSDM is the community-based, patient-led group treatment model, broadly known as Community Antiretroviral Groups (CAGs) and in Zimbabwe as Community Antiretroviral Refill Groups (CARGs)

Community-Based Antiretroviral Refill Groups

- Zimbabwe's 2017 national HIV guidelines endorsed CARGs and other differentiated service delivery models, which are being scaled up nationwide as a way to deliver high-quality treatment services to the country's 1.3 million people living with HIV
- CAGs have been implemented in many countries, and early evidence suggests that participants who opt-in voluntarily do as well or better as their peers in conventional clinic-based care

Community Antiretroviral Refill Group Model

Figure 1: Community Antiretroviral Refill Groups (CARGs) in Zimbabwe

CARGs are self-formed groups of clients on ART. Participants meet in the community to share information about their health and ART adherence, and then take turns going to the health facility.

Every three months, one member attends clinic, where s/he receives a clinical check up and appropriate laboratory testing. S/he also reviews the group information with a health care worker and collects three months' worth of medication refills for everyone in the group.

With this system, each member attends clinic for a physical examination and blood tests at least once annually, and receives ART refills in the community from CARG participants.



CARG Eligibility Criteria

- ✓ Age \geq 18 years
- ✓ On current ART regimen for \geq 6 months
- ✓ No current opportunistic infections or acute illness
- ✓ Viral load $<$ 1,000 copies/mL (where available)
- ✓ CD4 $>$ 200 cells/mm³ (where no viral load available)

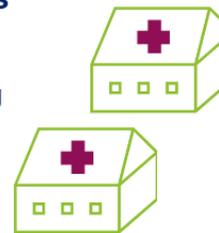
Community-based Services

- Adherence support
- Psychosocial support
- Solidarity
- Medication refills



Facility-based Services

- Clinical examination
- Laboratory monitoring
- Client education



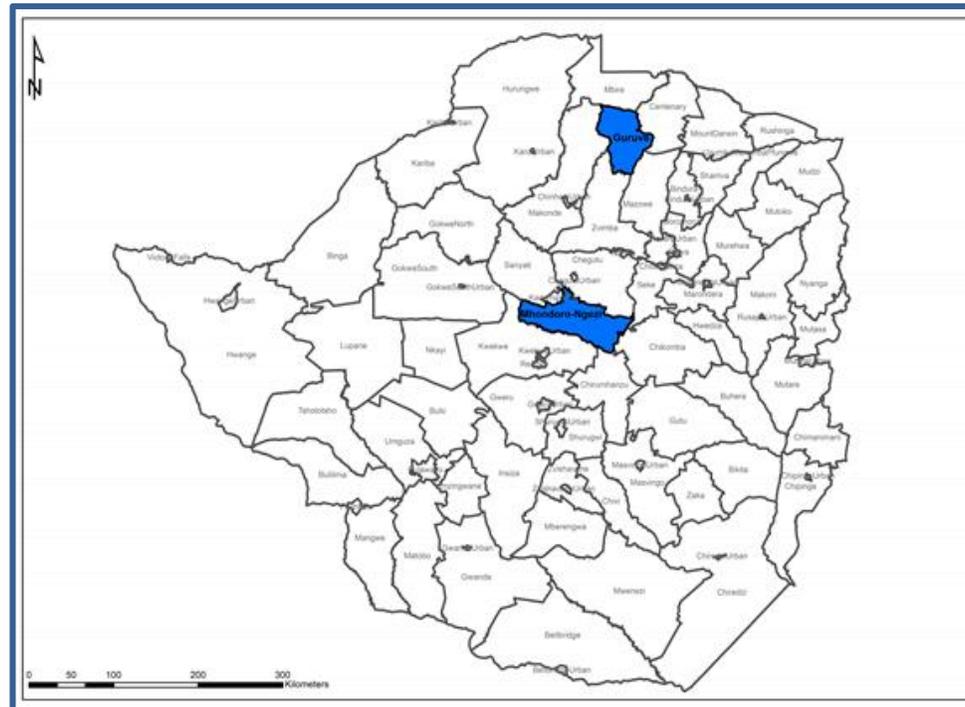
Engaging Men in HIV Programs: A Qualitative Study of Male Engagement in Community-Based Antiretroviral Refill Groups



Methods

Setting

- 3 purposively-selected health facilities (HF) in rural and mining areas, each with more than 1000 patients on ART and at least 200 patients enrolled in CARGs



Participant Sample

- Focus Group Discussions (July – September 2017)
 - Men living with HIV participating and not participating in CARGs, stratified by age (18-35 *vs.* 36+)
 - Women living with HIV in CARGs (≥ 18 years of age)
- In-Depth Interviews
 - Central-level: MoHCC staff, donors, implementing partners, and representatives from community-based, faith-based and PLHIV organizations
 - Facility-level: clinicians, peer educators/counselors
 - Community-level: community leaders, religious leaders, community health workers

Data Collection Strategies

- FGD and IDI guides developed collaboratively by US-Zimbabwe research team in English, translated into Shona, back-translated into English, revised, and piloted for clarity
- FGDs and IDIs were audio-recorded, translated into English when necessary, and transcribed
- IDI duration: 1 hour
- FGD duration: 2 hours

Interview Domains

FGDs and IDIs aimed to understand barriers to and facilitators of participation in CARGs

- Men's reasons for not joining a CARG
- Experience participating in a CARG
- Main challenges and advantages of CARG participation
- Concerns about joining a CARG
- Strategies for encouraging male participation in CARGs

Data Analysis

- Iterative qualitative process: code and analyze data using deductive and inductive approaches
- Constant comparison approach: identify patterns within and across all groups of study participants
- Dedoose, a qualitative software package, used for systematic data management and analysis

Ethical Approval

- The Zimbabwe Ministry of Health and Child Care, Columbia University Medical Center Institutional Review Board (Protocol IRB-AAAR4364), and Medical Research Council of Zimbabwe (Protocol MRCZ/A/2092) approved the study protocol
- All participants completed written informed consent

Results

Sample

- Men Enrolled in CARGs: 57
- Men on ART not Enrolled in CARG: 61
- Women on ART Enrolled in CARG: 29
- Community Leaders: 16
- Health Care Workers: 15
- Zimbabwe Ministry of Health & Child Care, Program Implementers, NGOs, Religious Organizations: 20

Total N = 198 participants

Perceived Benefits of CARGS

- All FGD and KII participants, including men who were *not* CARG members, acknowledged the benefits of CARGs
 - Time- and cost-savings
 - Psychosocial

Perceived Benefits of CARGS

- Healthcare workers (HCW), policymakers and implementers reported that CARGs led to decongested HF
- HCW noted shorter waiting times for other patients and increased ability to prioritize urgent cases
- Community leaders recognized the psychosocial support, decongested HF, and reduced HCW workloads

Perceived Benefits of CARGS

- Facilitated increased openness about HIV and helping to change community attitudes (FGD & KII participants in all groups)
- Reduced stigma was mentioned most frequently by women in CARGs
- Led to increasing ART enrollment and decreasing mortality, helping to de-stigmatize HIV in communities and thus making it easier and more acceptable to be on treatment (HCW)

Perceived Benefits of CARGs

Cost-Savings and Efficiencies

"Right, I am very satisfied and grateful for the formation of CARGs. I am satisfied that it makes things easier for us as we do not have to gather at the hospital. Because one of us goes, I can stay behind doing my chores and he returns and gives me my medication. All who remain behind in the community can focus on their work. So, I see that this has made things really easy." [Men in CARGs]

"We used to spend an entire day here... Sometimes we'd even sleep here... We're seeing things are easier for everyone since the CARG method was introduced." [Men in CARGs]

Decongested Health Facilities

"They reduce workloads at the institution. It may take [time] to provide services to 12 people, but when you consult a single member that has the 15 cards of other members, it could take less than 30 minutes..." [Healthcare Provider]

"They don't have so many patients at the facility... and by so doing you give the health care workers time to really focus or concentrate on the most sick patients." [Implementing Partner]



Figure 2: Benefits of CARGs

Improved Health of Care Recipients

"As for me I'm proud to work with my CARG partners, I no longer see anyone losing weight, feeling sleepy, feeling sick always. They are all healthy and I also found out that there is always someone to share your burden with, someone to open your heart to." [Community Leader]

"Since the CARG groups were formed, members are encouraging each other. They're managing to get those clients who were lost to follow-up and weren't taking their medications." [Healthcare Provider]

Increased Psychosocial Support

"Yes, personally I had some challenges, but when I asked my associate: 'do you at times have cramps on your leg?' they said, 'yes, but it will stop.' That's learning, so it is good when we meet we will be learning, asking and responding to each other what we do not understand; we then ask the nurses... So, it helps, unlike being alone at home thinking. You will end up stressing." [Women in CARGs]

"Eeh what really helps is that, when you are on your own, when you are not in a CARG, if we really analyze this, it will be a very difficult position to be in. You will always be troubled. So, when we meet as a CARG, we do not only meet when we want our medication, we also meet sometimes and share ideas...our challenges. That is when we help each other." [Men in CARGs]

HIV Stigma Reduction

"No one is scorning anyone. We see each other as equals since we are in the same situation. You can certainly see that you are not alone, because many people are in this situation." [Men in CARGs]

"Most people initially looked down upon us when CARGs were introduced and they mocked it, but with time, they saw that CARGs are good...In CARGs I will not lack my tablets." [Women in CARGs]

Perceived Challenges of CARGs

- Overwhelming majority CARG members, community leaders and HCW reported no CARG-related challenges and believed that CARGs had more advantages than disadvantages
- A few HCW and community leaders, however, complained about limited leadership skills of some CARG group leaders
- A minority of HCW reported that some CARGs had to be disbanded because of intra-group conflict, noting that group leader personalities were essential for group cohesion
- Other potential sources of conflict: irregular CARG attendance and failure by some members to contribute toward transportation costs to HF

Perceived Challenges of CARGs

- HCW, more than other participants, expressed concern that CARGs made it harder for them to monitor patients on a regular basis, e.g. CARGs sending same person (often the group leader) to collect medications for members instead of rotating this responsibility as expected
- Most FGD participants preferred self-formed CARGs, i.e., groups of patients who come together and propose themselves as a CARG to HF staff

Perceived Facilitators of Male Participation in CARGs

1. Better marketing of CARGs

- Men who were not CARG members frequently stated that they would join CARGs if they knew more about what they are and how they function
- This perspective was echoed by other groups, who suggested that village health workers, wives, and men already in CARGs could effectively encourage men to join

Perceived Facilitators of Male Participation in CARGs

2. Provision of incentives (monetary and non-monetary)

- All participant groups felt that provision of monetary and/or non-monetary support for CARGs would make them more appealing to men

Perceived Facilitators of Male Participation in CARGs

3. More flexibility in CARG design and implementation

- Diverse opinions about the advantages and disadvantages of men-only CARGs. Some men expressed preference for men-only CARGs, arguing that women could not maintain confidentiality
- Consensus among all groups, however, on the importance of ensuring that CARGs were self-formed rather than having membership assigned by HF staff. They felt this approach built participant ownership, increased the likelihood of amicable groups, and – critically – provided at least partial reassurance that co-members would guard confidentiality

Perceived Barriers to Male Participation in CARGs

1. *Fear of stigma/confidentiality concerns*

- All participant groups mentioned HIV-related stigma as the most important barrier to male enrollment in CARGs. Stigma was mentioned in almost all of the male FGDs, by almost all community leaders, and by more than half of HCW
- Despite acknowledging that CARGs contributed to reduced stigma in their communities, participants noted that significant stigma remained

Perceived Barriers to Male Participation in CARGs

- Fear of HIV-related stigma was deeply entangled with notions of respectability and manhood and this was a substantial concern for men who were not in CARGs
- Many felt that if their HIV-positive status was widely known in their communities they would be treated as “lesser men” and be disrespected. “Being talked about”, “being laughed at” and “being pointed at” were terms used to describe anticipated community reactions

Perceived Barriers to Male Participation in CARGs

2. Information gap

- Lack of awareness of CARGs was the second most common reason given for lack of male engagement. This was mentioned in the majority of FGDs and by the majority of community leaders and HCW
- Men who were not in CARGs also had misconceptions about this model of care

Perceived Barriers to Male Participation in CARGs

3. Few perceived benefits

- Some men did not see any personal benefits to CARG membership because they lived close to HF and thus had easy access to services
- Others preferred having regular and direct contact with their healthcare providers and felt that CARGs could disrupt this connection

Perceived Barriers to Male Participation in CARGs

Stigma & Confidentiality

"If I give [a CARG member] my book...to collect [medication] for me, he will end up having a discussion with his friends about it, saying [so and so] is on medication..." [Men not in CARGs]

"My status is my secret. I don't want it revealed to the public." [Men not in CARGs]

"Some men are still finding it difficult to accept their status and to them it's not easy to mix and mingle with other people in the community, especially in terms of HIV and AIDS issues." [Implementing Partner]



Figure 3: Barriers to Male Participation in CARGs

Eligibility Criteria

"[Someone] was asking what my group was like, and he discovered it was full and he had to look for another one [but] he said how will you know these people, because people like that do not want to expose themselves and have their status known." [Men in CARGs]

"The one challenge is that you cannot join if you have not been on treatment for...six months..." [Community Leader]

CARG Organization

"I don't want to be in a group that has women, but with men I am okay." [Men not in CARGs]

"I think the challenge is that which I mentioned before saying that they might be 2 in a group and not 6 or more. They can't form a group only the 2 of them..." [Healthcare Provider]

Limited Knowledge of CARGs

"The people who brought this program were not transparent. They didn't bring it to the community, community leadership, headsman, counsilors, and so on..." [Men in CARGs]

"It is because it had not reached my ear. You see, with our jobs, we are always away." [Men not in CARGs]

"We assume they are going to invite those who are not in CARGs to come and join...I don't know how it works." [Men not in CARGs]

No Perceived Benefits

"[There is] no need for me to join CARGs because I will be staying very close...I can walk to collect my medication whenever I want." [Men not in CARGs]

"I saw that I am receiving satisfactory service. I did not see the point of bothering people with my medication." [Men not in CARGs]

Limited Patient Monitoring

"Only supplying ARVs to someone can be a disadvantage because you're not observing them. Maybe you want to assess their weight, blood pressure, and other NCDs..." [Implementing Partner]

Summary Points

- Fear of HIV disclosure was the most commonly-reported barrier to CARG participation in Zimbabwe, consistent with reports from other countries
- Secrecy. Men who were not members of CARGs wanted to keep their HIV status secret and perceived CARG membership as a risk, expressing little confidence in the ability of CARG members—particularly women—to maintain their confidentiality

Summary Points

- Study findings underscore that HIV-related stigma—both experienced and perceived—remains deeply entrenched in Zimbabwe’s rural communities, and echoes findings from other studies
- In our study, HIV-related stigma was experienced in very gendered ways

Summary Points

- Study participants noted that CARGs can promote privacy by decreasing HF visit frequency and reducing the risk of being “outed” when seen at the HIV clinic by neighbors or community members
- Men and women enrolled in CARGs also felt that these groups served to *decrease* stigma, and to provide mutual support that can mitigate the impact of discrimination when it occurs

Summary Points

- The second most commonly-reported barrier to male enrollment in CARGs was limited awareness and knowledge of the model
- Lack of information about health services has been cited elsewhere as a common barrier to men's healthcare-utilization behavior globally

Summary Points

- Support for CARG-related income-generating activities and provision of material support for CARG members
 - may directly incentivize participation
 - may also contribute indirectly, by addressing the connection between masculinity and earned income

Conclusion

- Effective gender-specific HIV-stigma reduction initiatives are likely to improve male engagement in HIV services in general and CARGs in particular
- Optimizing the design and implementation of differentiated service delivery models, including CARGs, may also encourage more men to engage in HIV treatment
- Targeted informational, educational and communication programs that clearly explain what CARGs are, how they function, and how one can join are a priority, and bringing this information to men in their workplaces and communities
- Flexibility with regard to CARG design and support for self-forming groups rather than “assigned” groups are likely to address some men’s concerns about privacy and confidentiality; material and in-kind support may also increase enrollment and retention in CARGs
- Providing diverse male-friendly services – not just optimized CARGs – is important to fully engaging men in the HIV response

Pathways to the Future

- Nearly 30 years into the HIV epidemic, we have finally recognized the importance of intervening with men to promote positive health behaviors as well as a key force in helping to control HIV acquisition in adolescent girls and young women
- **Policy and programs:** [UNAIDS publication 2017: “Blind spot. Reaching out to men and boys”](#)
- **Research:** [US National Institutes of Health 2018. “Engaging Men in HIV Testing, Prevention, and Care”](#)
- **Funding:** MenStar Coalition 2018

Men Do Matter!

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