summary brief

Addressing Women's and Men's Gender-specific Needs in HIV Service Delivery

Learnings from Project SOAR

The AIDS epidemic has shed light on the many ways in which harmful gender norms, attitudes, and behaviors increase the risk of HIV transmission, limit access to HIV prevention and treatment services, and at the same time impede gender equality. Conversely, fostering more positive gender dynamics and programming that takes gender into account can help achieve the dual goals of curbing the spread of HIV and creating more equitable societies.

Project SOAR recognizes the key role that gender norms and power dynamics play in HIV service delivery, and whether individuals can access services and practice protective behaviors. By gender norms we mean what society considers appropriate roles and behavior for men and women, and girls and boys. Gender norms influence power dynamics in relationships and interactions between and among these groups. Through our research, we seek to determine how best to address challenges and gaps in the delivery and uptake of HIV treatment and prevention services. Integrating a gender lens into our research activities produces valuable evidence that supports the health of individuals and communities as well as the achievement of UNAIDS' 90-90-90 goals for controlling the epidemic, whereby 90 percent of people living with HIV (PLHIV)—both women and men—know their status, 90 percent of PLHIV are on antiretroviral therapy (ART), and 90 percent of those on ART achieve viral suppression.

SOAR integrates gender into its implementation science research using three approaches:

1. **Characterizing gender-specific, HIV-related needs.** For example, since men access many HIV services less frequently than women, what are their views about and experiences with HIV services, and how can services be structured to better respond to men's needs and preferences?
2. **Determining gender-specific effects of HIV programs and services.** For example, do women and men living with HIV respond differently to community-based ART delivery, and if so, why?

3. **Refining and evaluating gender transformative interventions that address gender power dynamics and HIV outcomes.** For example, what is the impact of a program that seeks to change harmful gender norms on men's and women's relationships and their HIV service uptake?

In this brief we summarize what we have learned so far in applying these gender integration approaches to our research and what we anticipate learning over the coming year.

CHARACTERIZING GENDER-SPECIFIC, HIV-RELATED NEEDS

What can be done to maximize men's uptake of HIV testing services?

Project SOAR, in collaboration with the Kenya National AIDS & STI Control Program (NASCOP), is building needed evidence to improve uptake of HIV testing services among Kenyan men. Although HIV testing has increased in Kenya, men are less likely than women to get tested. Understanding how and why certain men elect to be tested can provide important insights to improve uptake and expansion of HTS among men.

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We conducted an assessment of 124 facilities providing HTS in Nairobi County, **Kenya**, and found that in only one-fourth (27 percent) of facilities did men comprise 45 percent or more of the client load. Facilities with a higher representation of male clients were more likely to:

- Provide HTS for longer hours per day and for six or more days per week
- Provide targeted services to male members of key populations, such as men who have sex with men, male sex workers, and men who inject drugs.

What next?

Better understanding of men's motivations and drivers for getting tested by conducting additional data collection with men seeking HIV testing, HIV-positive men, and HTS counselors.

Together, the research will provide needed information to develop effective strategies for increasing men's uptake of HTS.

What are men's preferences for how HIV services should be delivered?

In **Malawi**, SOAR researchers interviewed 157 male partners of adolescent girls and young women aged 15–24 in Zomba and Machinga districts, about how to better engage men in HIV services. This study is part of our implementation science research portfolio around the DREAMS partnership.[1] HIV service barriers men identified were fear of testing positive, stigma, long waiting times, and lack of privacy and confidentiality. Men want health communication messages and services that:

- Meet their needs and answer their questions (as opposed to those of women and girls).
- Are provided at home or venues they frequent.
- Incorporate mass media and other technologies.

We also interviewed 49 men living with HIV who said they often requested support from health providers, family, friends, and PLHIV support groups for starting or adhering to ART. But many men struggled to meet the demands of taking ART because of stigma, food insecurity, long clinic waiting times that disrupted their livelihoods, and distance to health facilities. To enhance ART service use by men, we recommend:

- Sustaining and expanding support groups of men living with HIV.
- Offering ART refills at community sites.
- Making ART services available at locations easily accessible by men (e.g., community-based settings).
- Integrating programs to reduce stigma and address food insecurity.
- Training health care providers to provide supportive and patient-centered care.

What next?

Refined and improved strategies for engaging men in HIV services that are being incorporated by DREAMS implementing partners and other stakeholders.

What are the fertility needs and desires of female sex workers living with HIV?

Women often face considerable challenges in realizing their reproductive goals. This is particularly true for women who are living with HIV and are also sex workers. In **Tanzania**, there is limited data on female sex workers' need for contraceptives and desire to have children to inform guidance on providing integrated services that meet women's needs and reduce the risk of unintended pregnancy as well as vertical and sexual HIV transmission.

We asked 604 HIV-positive female sex workers about their fertility-related needs and desires. The women were ages 18 to 49 living in Njombe and Mbeya provinces. We found that most women (72 percent) do not want to get pregnant in the next two years, yet nearly a third (30 percent) have an unmet need for contraception. These women are neither consistent condom users nor users of an effective non-barrier method. A sizable minority (21 percent), however, are currently trying to get pregnant and another 20 percent want to have a/nother child someday. Among all participants, few knew about strategies to get pregnant more safely but 43 percent were very interested in learning about safer conception strategies.

What next?

Discussion and dissemination of findings nationally and globally to engage policymakers representing both HIV and reproductive health to formulate policies or guidelines on how services can meet the fertility needs and desires of HIV-positive women, including female sex workers.

[1]DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) is a public-private partnership that aims to significantly reduce HIV infections among adolescent girls and young women.

DETERMINING GENDER-SPECIFIC EFFECTS OF HIV PROGRAMS AND SERVICES

How do women and men living with HIV respond to a depression treatment program integrated into ART clinics?

SOAR is evaluating a depression treatment program implemented by the **Malawi** Ministry of Health at two semi-urban, public health clinics providing ART services in Lilongwe. If unaddressed, depression can lead to poor adherence to ART, HIV treatment failure, and HIV clinical progression.

Results from the screening phase show that 90 percent of more than 1,000 new ART patients (53 percent women) have been appropriately screened for depression. These patients range in age from 18 to 75. Nearly one-fourth (24 percent) have been diagnosed with mild or moderate to severe depression, and of note is that levels of depression and suicidal thoughts were similar for men and women. Depending on the level of depression, clients receive problem-solving counseling by lay health workers and/or medication. Major issues discussed are relationship difficulties, financial problems, and health concerns. The program is being positively received by both male and female clients and clinic staff.

What next?

Critical evidence on the feasibility, effectiveness, and cost-effectiveness of the integrated depression treatment model for improving retention in and adherence to HIV care among both women and men living with HIV. Plus insights about gender differences in the kinds of issues men and women raise with lay counselors (e.g., partner violence) and how they are addressed by the counselors.

How can programs better support youth living with HIV?

Project SOAR is following two cohorts of young people living with HIV in **Zambia**, each participating in an intervention study. In the first study, we are examining how well a community-based program, the Zambia Family (ZAMFAM) project, strengthens households, and community and government structures to meet the needs of adolescents living with HIV (ALHIV). The cohort in this study consists of about 325 ALHIV ages 10–17 years living in Eastern and Central provinces. In the second study based in Ndola, we are testing a peer mentoring approach (Project YES!) in improving HIV outcomes among a cohort of more than 275 youth, ages 15–24 years, as they transition to self-management and adult HIV care. Almost two-thirds of participants in both cohorts are girls and young women.

Among the ALHIV cohort in Eastern and Central provinces we interviewed at baseline, there were no gender differences in a variety of outcomes we measured. For example, both male and female youth were often too sick to participate in daily activities, received little or no psychosocial support to cope with their HIV status, and were not receiving regular CD4 or viral load testing. However fewer adolescent girls were enrolled in school than adolescent boys (77 vs. 87 percent; p=0.02), which has implications for girls' future livelihoods.

In Ndola, early findings from baseline data collection show that more than one-third of adolescents and young adults experienced viral load failure (≥1,000 copies/ml), and there were not statistically significant differences by gender or age band.

What next?

Analysis of gender differences in educational, socioeconomic, psychosocial, and health outcomes among the ALHIV exposed to the ZAMFAM project. Plus gender differences in how well the peer mentoring intervention—Project YES!—supports youth living with HIV, as measured by HIV self-management behaviors, psychosocial factors (stigma, depression), self-reported adherence, and viral suppression.

EVALUATING GENDER TRANSFORMATIVE INTERVENTIONS

Can gender norms be shifted at the community level, and how would this influence uptake of HIV services?

SOAR and partners are exploring this question in a study in **South Africa**. The research team is building a gender and women focus into a cluster randomized controlled trial to evaluate an intervention—the Community Mobilization for Treatment as Prevention

program.[2] The combined aim of the program is to increase uptake of HIV services, including by changing gender norms at the community level.

The team began by working with program partners to integrate more gender transformative elements into the community intervention—such as adding groups specifically tailored to young women's needs, and promotng critical reflection and skill-building around couple communication.

Next, the study team sought to understand the degree to which men and women endorsed common gender norms that may be salient for their use of HIV services. Using data from the study's baseline household survey with about 2,000 women and men aged 18–49 years, we measured four key gender dimensions using the GEM Scale[3] which we theorized were related to HIV outcomes, including HIV testing and treatment:

- Men's violence and control over women (7 items)
- Men as decision-maker in a couple (6 items)
- Men's toughness and avoidance of help-seeking (5 items)
- Women's primary responsibility as family caretaker (5 items)

Notably, both men and women strongly endorsed certain norms in support of men being the main decision-maker in a couple, and women's primary responsibility as family caregiver—but had limited support for norms indicating that a real man avoids seeking healthcare. Strong support was also found for men controlling /disciplining their female partners (although not for outright physical beatings). Supplemental qualitative interviews carried out by the SOAR team reinforced the salience of these specific gender norms topics in the lives of people in these communities.

[2]This is a National Institute of Mental Health-funded randomized controlled trial. For a detailed description of the study protocol, see Lippman et al. 2017. Evaluation of the *Tsima* community mobilization intervention to improve engagement in HIV testing and care in South Africa: study protocol for a cluster randomized trial. *Implementation Science*. 12(1): 9. doi: 10.1186/s13012-016-0541-0

[3]The GEM Scale is a widely used measure of views on gender norms in global health research.

What next?

Intervention impacts on gender norms endorsement and HIV service uptake among women and men participating in this innovative and rigorous community-based trial.

CONCLUSION

SOAR is sharing this evidence with program implementers and policymakers in the countries we work in as well as globally. We are finding our learnings to be particularly relevant as decision-makers grapple with how to address two key issues of concern to the global community, namely gender disparities in:

1. HIV prevalence—with adolescent girls and young women bearing a greater burden than their male counterparts; and
2. Service uptake, whereby men are often less likely to use HIV services than women.

Stay tuned for additional results from our implementation science research that address these and other issues by visiting our website, projsoar.org.

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