



HIV CARE FOR MEN

LESSONS LEARNT FROM MÉDECINS SANS FRONTIÈRES
EXPERIENCES IN RURAL AND PERI-URBAN SOUTH AFRICA

Cover photo: A male client during a consultation with an MSF counselor in Eshowe, KwaZulu Natal. © MSF

TABLE OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
BMI	Body mass index
CHC	Community health center
CoCT	City of Cape Town
DoH	Department of health
HIV	Human immunodeficiency viruses
HTA	High transmission areas
MAHC	Male After Hours Clinic
MMC	Medical male circumcision
MSF	Médecins Sans Frontières
MSM	Men who have sex with men
NCD	Non-communicable diseases
OIM	Outreach initiation and management
OST	Oral self-test
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infection
TAC	Treatment Action Campaign
TB	Tuberculosis
UNAIDS	United Nations Programme on HIV and AIDS
WCDOH	Western Cape Provincial Department of Health

INTRODUCTION

OBJECTIVE OF THIS REPORT

This report details some of the operational conclusions that Médecins Sans Frontières (MSF) has been able to draw from analysing routine data from the programs it has conducted or supported targeting men in Khayelitsha in the Western Cape Province and in Eshowe in KwaZulu-Natal Province.

MSF IN SOUTH AFRICA

MSF has been working with local and national health authorities, as well as civil society organizations, in South Africa for 20 years to pilot, implement and support the scale-up of HIV and tuberculosis (TB) management and care. MSF has supported many HIV related projects and activities in both rural and non-rural contexts since it started its operations in the country. Currently MSF supports large programs to improve the HIV and TB cascade of care in Khayelitsha, Western Cape and Eshowe, KwaZulu-Natal. MSF aims to improve support, treatment and care for people living with HIV (PLHIV) and TB and to advocate for systemic improvements such as policy change and innovative adaptations to care and treatment models, in order to further benefit all PLHIV in South Africa and beyond.

KHAYELITSHA

Khayelitsha is a large peri-urban community located on the outskirts of Cape Town. It has

an estimated population of 500,000 people, with 49% men and 46% of the population between the ages of 15 and 34. According to the 2011 South Africa national census, 55% of household lives in informal housing (shacks), with the remaining percentage living in brick houses [1]. Khayelitsha carries one of the highest burdens of both HIV and TB in South Africa. The adult HIV prevalence rate in 1999 was estimated at 15%, increasing to 30% at the end of 2007 and decreasing to 20.3% at the end of 2010 [2]. Khayelitsha has the largest cohort on antiretroviral therapy (ART) in the Western Cape. As at the end of May 2019, Khayelitsha clinics were providing ART to 45,719 adult patients.

There are two main government health service providers in Khayelitsha: City of Cape Town Health (CoCT) and Western Cape Provincial Department of Health (WCDOH). The CoCT runs ten primary healthcare clinics in Khayelitsha (including two specialized youth clinics: Site B Youth and Site C Youth, and two specialized male clinics: Site B Male and Kuyasa Male) while the WCDOH runs three larger Community Health Centers (CHC). A male clinic now run by Anova Health Institute and supported by the WCDOH is run out of the Site-C taxi rank and focuses on men who have sex with men (MSM). As it is not an MSF supported site, the data is not presented in this report. MSF has been running and supporting HIV and TB related programs in Khayelitsha since 1999.



ESHOWE

Eshowe is in uMlalazi Municipality situated on the KwaZulu-Natal North Coast and forms part of King Cetshwayo District. uMlalazi Municipality has a catchment population of 213,601 of which 46.1% are male [3]. Eshowe, a small market town serving the surrounding peri-urban and rural areas, is situated approximately 140 km north of Durban with Eshowe Hospital as one of the main health facilities. MSF has been running and supporting HIV and TB related programs in ten health facilities including three hospitals in the Eshowe and Mbongolwane areas since 2011.

KwaZulu-Natal's HIV prevalence is among the highest in the world and the highest HIV prevalence of the nine provinces in South Africa: 27.0% [95% CI: 23.9-30.4] among adults aged 15-49 years [4]. The results of the population HIV surveys conducted by MSF in Eshowe and Mbongolwane areas in 2013 showed an HIV prevalence of 25.2% [95% CI: 23.6- 26.9] and 15.9% [95% CI: 14.0- 18.0] among men and recently a repeat survey in 2018 found an overall prevalence of 26.4% [95% CI: 24.9- 27.9], 18.4% [95% CI: 16.3- 20.8] amongst men aged between 15-59 years.



An MSF outreach testing site in Eshowe town centre, KwaZulu Natal © MSF

BURDEN OF HIV AMONGST MEN

FRAMING THE PROBLEM

South Africa is the country with the most people living with HIV. Approximately 7.9 million people of all ages (0+ years) were living with HIV in South Africa in 2017, equivalent to almost 20% of all PLHIV globally [4] and accounts for a third of all new HIV infections in southern Africa[5]. In 2017, there were 270,000 new HIV infections and 110,000 South Africans died from AIDS-related illnesses [6]. HIV prevalence among adults aged 15 to 49 years in South Africa is 20.6%; 26.3% among women and 14.8% among men, although it varies from province to province. HIV annual incidence among adults aged 15 to 49 years in South Africa is 0.79%; 0.93% among women and 0.69% among men. In South Africa women are much more likely to test than men, mostly because of prevention of mother-to-child (PMTCT) programs that facilitate women’s access to HIV testing services during routine prenatal visits[4].

Men represent about 37% of PLHIV but accounted for 52% of AIDS deaths among adults in 2017 [7]. This may be because male HIV diagnosis and ART coverage is much lower compared to women in

South Africa [4] [7-9]. In Khayelitsha just 30% of those on ART are men and in Eshowe MSF/DOH data for 2017 showed that only 27% of patients on ART are men. Table 1 shows the results of the 90-90-90 estimates following the MSF population survey conducted in Eshowe and Mbongolwane areas in 2013 and 2018, showing poorer outcomes across the cascade for men.

This is not unique to South Africa. Research in many African settings has shown that HIV-positive men are less likely to initiate ART, and those who do are more likely to present to clinics later, more ill and have poorer retention and worse clinical outcomes [8-24]. UNAIDS 2018 global AIDS monitoring estimated that there was lower coverage of ART amongst men in Eastern and Southern Africa at 56% compared to women at 72% [25]. Explanations put forward for men’s low attendance and poor outcomes include notions of masculinity that are at odds with illness and ‘good patient’ behavior, public health systems that are historically built around maternal and child health and systematic under-funding of men’s services compared to women’s.

Table 1: 90-90-90 estimates amongst adults aged 15- 59 years stratified by gender

Year	Women			Men		
	1st 90	2nd 90	3rd 90	1st 90	2nd 90	3rd 90
2013	79.0	70.5	93.4	68.3	67.9	92.1
2018	91.9	95.5	95.0	82.5	86.4	92.3

RATIONALE FOR CONTINUED INVOLVEMENT IN HIV CARE FOR MEN TODAY

About 30% of HIV transmission occurs among stable partners [26] and the HIV positive partner among sero-discordant couples is more commonly male than female [27]. This coupled with growing evidence that ART reduces HIV mortality and morbidity more so if treatment is started early [28-30] and potential benefits of viral suppression in reducing transmission[31] make men a critical target population to reduce HIV incidence and mortality. The recently launched MenStar

coalition also identifies male's HIV diagnosis and treatment as a key to breaking the cycle of transmission which when dealt with could ultimately end the AIDS epidemic as a public health problem by 2030 [32]. Targeting specific populations that are most likely to transmit the virus like men and adolescents for ART treatment and care could have important outcomes in preventing transmission to other populations [33].



A Men's March organized by MSF in Khayelitsha, where men marched for equal healthcare and to motivate other men to take more responsibility for their health. © MSF



MSF INTERVENTIONS: RESPONDING TO THE GAPS

Intervention description and objectives¹

- a. **Male Vertical clinics <KHY 2014><ESH 2017>**: These are male only clinics operated by male only staff that offer adaptable services in order to increase medical male circumcision, HIV testing, ART initiation and retention in care, TB screening and early diagnosis, and STI management in sexually active men. Philandoda Male Wellness clinic was set up at the main taxi rank in Eshowe. In Khayelitsha, Site B male was opened very close to a taxi rank and Kuyasa male clinic is situated very close to a bus and train station with the aim of reaching men who are reluctant to access conventional health services currently offered by DoH. Both Khayelitsha clinics are run by CoCT with support from MSF.
- b. **Outreach Initiation and Management (OIM) <KHY 2017>**: OIM is a mobile/outreach service model that functions as an extension to the existing healthcare system to provide a broad set of services accessible to the community in order to encourage access and uptake of basic services such as HIV testing, family planning, STI screening and ART initiation and management closer to the community. It is currently linked to one large CHC, Michael Mapongwana.
- c. **Male after hours clinic (MAHC) <KHA 2016>**: This male-only clinic offered more flexible opening hours (4 pm to 7 pm, one day a week) within a conventional provincial CHC. Male only staff and differentiated models of care were offered and a similar package of care as the one offered at Vertical clinics was provided.
- d. **High transmission areas (HTA) <ESH 2013>**: MSF's High Transmission Areas (HTA) program was specifically designed to provide HIV/ TB screening and management related medical services to farm workers who are mostly men and young students in college.
- e. **Community testing events <ESH 2011> <KHY 2018>**: In Eshowe, this includes testing at fixed sites in the community and door-to-door community testing: community health workers go door to door, providing a package of care, including but not limited to health education, HIV testing and counseling, condom distribution, medical male circumcision (MMC) recruitment, STI screening and TB screening. Fixed sites were set up within the community, providing a similar package of care. Community testing reaches out to people who would not come to a clinic. In Khayelitsha, this includes HIV testing together with screening of Hypertension, Diabetes and Weight at community social events such as taverns, taxi ranks, soccer tournaments, shopping malls, unemployment spots (places where people wait to be picked up for piece work).
- f. **Schools testing and MMC recruitment <ESH 2012>**: Focused on 38 high schools, a team of two lay counselors provided health education, followed by HIV testing and MMC recruitment. On the day of the MMC camp, MSF provided transport to and from the camp, as well as a snack. This has been a highly successful intervention to reach out to young boys and have them medically circumcised.

¹The location of the activity and the year it was established is labeled <KHY year> for Khayelitsha and <ESH year> for Eshowe.



Male vertical clinics

SHINE counselor Zithulele Khanyile conducts an HIV test for a client at the Philandoda Male Services Clinic Eshowe, located at the Eshowe taxi rank.

© MSF



Outreach Initiation and Management (OIM)

MSF male services nurse Cebo Ngobese gets on board the MSF Outreach Intervention Management (OIM) mobile clinic as it visits the community of Edlovini in Khayelitsha.

© MSF



Male after hours clinics

MSF male services counselor Thabo Jim provides a consultation for Moses Tamsanqa in the male services after hours clinic, Site B clinic, Khayelitsha.

© MSF



High transmission areas (HTA)

SHINE male-services counsellor Zithulele Khanyile fills a condomiser container with free condoms in the Eshowe market place, Eshowe.

© MSF



Community testing events

Men queue for HIV testing at an MSF outreach testing event in Khayelitsha.

© MSF



Schools testing and MMC recruitment

A Health Promoter recruits male learners for male medical circumcision camps run by the Provincial Department of Health in Eshowe.

© MSF

Table 2: Building blocks for male targeted interventions

	What?	Where?	When?	Who?
Male Vertical clinics	<ul style="list-style-type: none"> + HIV testing + ART initiation + ART Refill + Adherence support + Clinical visits + Laboratory tests + Referrals + TB screening + STI screening 	<p>Eshowe: Taxi rank</p> <p>Khayelitsha: Taxi rank, Bus station</p>	<p>New/unstable clients – 1 month refills</p> <p>Stable clients – 2 month refills</p> <p>Extended working hours in Eshowe – 8am-5pm(Saturdays)</p>	<ul style="list-style-type: none"> + Male clerk + Male nurse + Male lay counselor
OIM	<ul style="list-style-type: none"> + HIV testing + ART initiation + ART Refill + Adherence support + Clinical visits + Referrals + TB screening + STI screening and management 	In Khayelitsha Community sites identified by community	<p>New/unstable clients – 1 month refills</p> <p>Stable clients – 2 month refills</p> <p>Extended hours – 9am-6pm and Saturdays (male focus)</p>	<ul style="list-style-type: none"> + Lay counselor + Nurse + Community support member
MAHC	<ul style="list-style-type: none"> + HIV testing + ART initiation + ART Refill + Adherence support + Clinical visits + Referrals + TB screening + STI screening and management 	In Khayelitsha within a conventional health facility.	<p>New/unstable clients – 1 month refills</p> <p>Stable clients – 2 month refills</p> <p>Extended hours – 4pm - 7pm</p>	<ul style="list-style-type: none"> + Male clerk + Male nurse + Male lay counselor
HTAs	<ul style="list-style-type: none"> + HIV counseling + HIV testing + ART initiation + ART refill + TB screening + STI screening + PreP provision 	Eshowe: Technical college and farms	<p>New/unstable clients – 1 month refills</p> <p>Stable clients – 2 month refills</p> <p>Normal working hours (7:30am to 16:00pm)</p>	<ul style="list-style-type: none"> + Nurse + Lay counselor + Mobilisers
Community testing events	<ul style="list-style-type: none"> + HIV testing + NCD screening + BMI measurements 	<p>Eshowe: Mobile and fixed community testing sites</p> <p>Khayelitsha: Community social events</p>	Adapted hours at community events (starting at 7 am)	<ul style="list-style-type: none"> + Lay counselor + Community mobilisers
Schools testing and MMC recruitment	<ul style="list-style-type: none"> + HIV testing + MMC 	In schools in Eshowe and Mbongolwane	Adapted to school hours	<ul style="list-style-type: none"> + MMC Mobilisers + Head promoter + Lay counselors

MSF'S EXPERIENCES FROM IMPLEMENTING MALE TARGETED SERVICES

One size does not fit all and targeted efforts that aim for a variety of interventions are needed to reach men. These interventions need to respond to the health system realities and to remain

feasible. The table below outlines options based on resource allocation needed and our experiences from implementing male dedicated services in two different settings in South Africa.

	Increasing Costs		
Services	Light	Medium	High
Opening Hours	Standard hours	Before/ After hours	Before/ After hours, weekend
Additional Salary costs	No additional costs	Before/ After hours	Before/After hours and weekends
Staff	Male staff where feasible	Male nurse/ counselor	All male staff
Service Site	Within HIV clinics	Male only dedicated clinic space/ hours	Dedicated male only site
Clinical Services	Same day ART Rapid access (DMoC*)	Same day ART Rapid access (DMoC*) STIs	Same day ART Rapid access STIs NCDs Erectile dysfunction

*Differentiated Models of Care (DMoC)

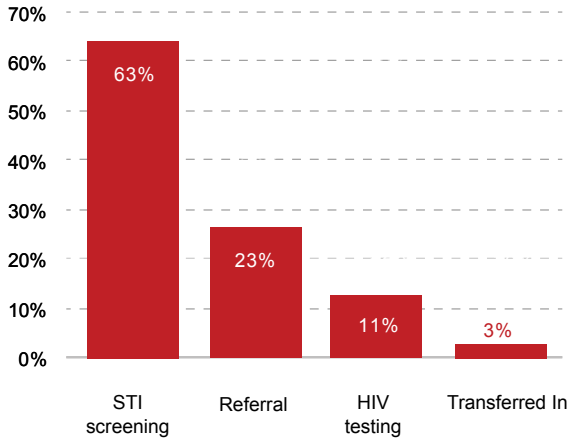


MSF male services counselor Thando Sukanazo gives a health promotion talk in the waiting room of Site B Male Clinic, Khayelitsha © MSF

EVIDENCE CORNER: FINDINGS FROM SOME OF MSF’S INTERVENTIONS TARGETING MEN

FINDING AND TESTING MEN:

Graph 1: Reasons for Initially coming to Site B male clinic amongst a sample of 100 new initiates (Khayelitsha)

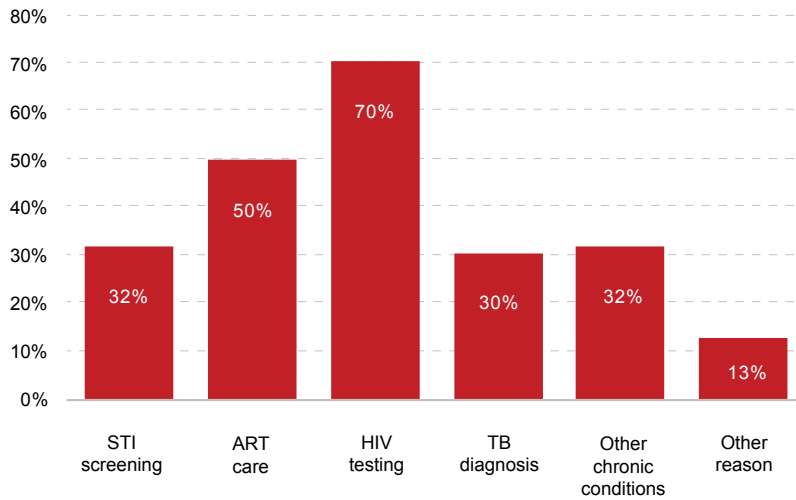


In Khayelitsha, we found that STI screening is the most common reason for men to access male services and the best opportunity to test them for HIV and offer other health related services. Although STI visits are often under-captured in the routine data systems, 46% of those attending Kuyasa Male Clinic and 35% of those attending Site B Male were recorded as receiving STI-related care at their visit. In addition, of those testing positive at these two male vertical clinics, 45% had come to the clinic for an STI visit on the day of their test (also likely and underestimate).



MSF community mobiliser Sphamandla shares news about MSF’s male-only Philandoda Male Services clinic located at the Eshowe taxi rank. © MSF

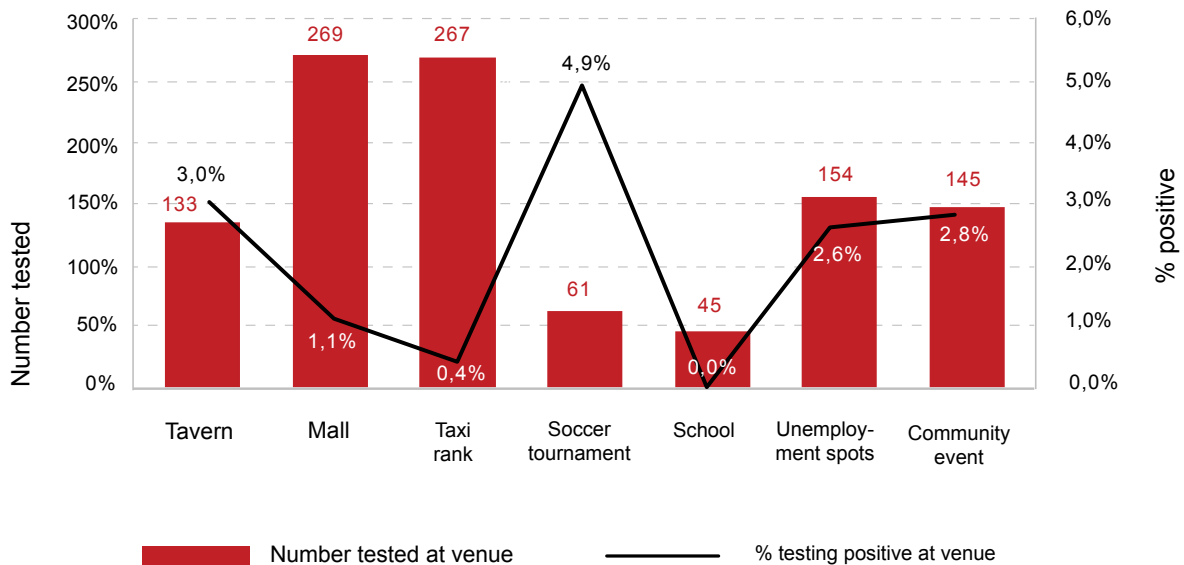
Graph 2: Reasons for coming clinic amongst a sample of males coming to Philandoda male clinic (multiple responses) Eshowe



Among the males interviewed when coming to the Male-only clinic in Eshowe and based on self-

reported answers, the main reason for men to attend the clinic was related to HIV testing and care.

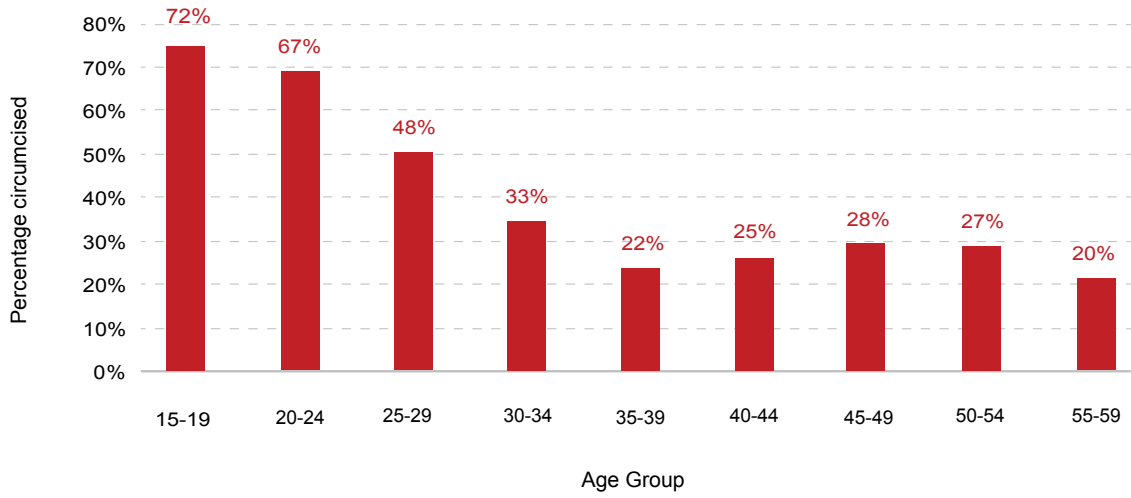
Graph 3: Community outreach testing



Among the different locations tried out, the hotspots identified with a higher positive yield (2.6% - 4.9%) were soccer tournaments, taverns, community

events and unemployment spots (pick up points at highway).

Graph 4: Medical male circumcision in the 2018 Eshowe population survey



Medical male circumcision greatly improved in Eshowe, in the 2013 population survey: 21.7 % of men (median age: 18 years) were circumcised,

increasing to 49.8% (median age: 16 years) in the repeat population survey conducted in Eshowe in 2018.

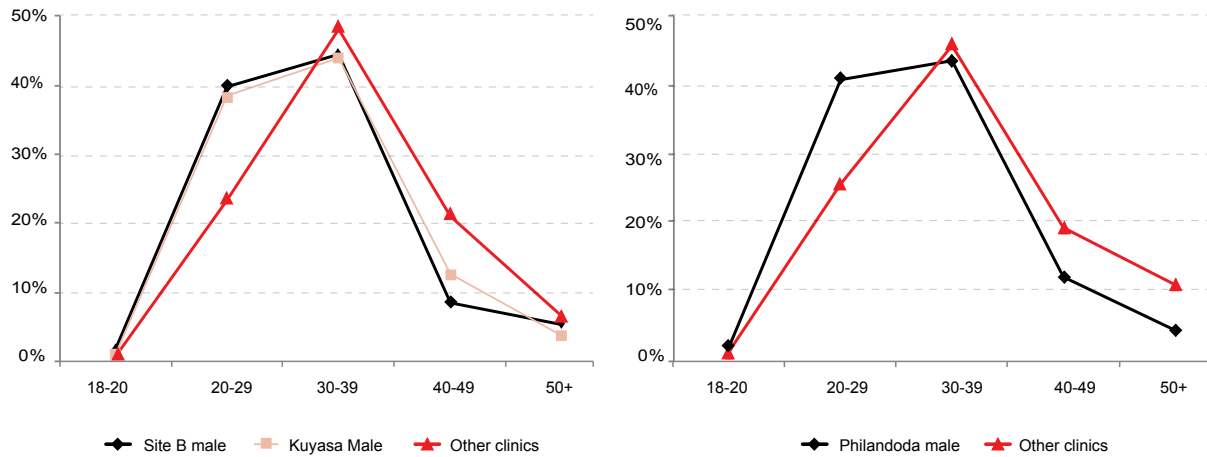


MSF male outreach team members distribute condoms and flyers at traffic lights in Khayelitsha

© MSF

TESTING MEN:

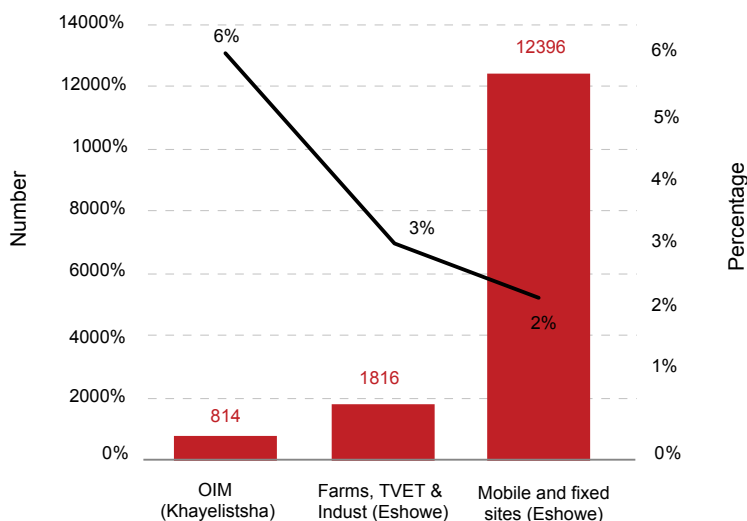
Graph 5: Age of the men testing positive at male clinics compared to other clinics²



Men testing positive at male clinics were younger than men in general clinics in both Khayelitsha and Eshowe. The median age of those testing positive was 31.3 at Kuyasa Male (IQR 27-36), 30.4 at

Site B Male (IQR 27-35) and 34 at general clinics in Khayelitsha (IQR 29-41). In Eshowe it was 32 at Philandoda male clinic (IQR 26-39) and 33 at general clinics (IQR 28-39).

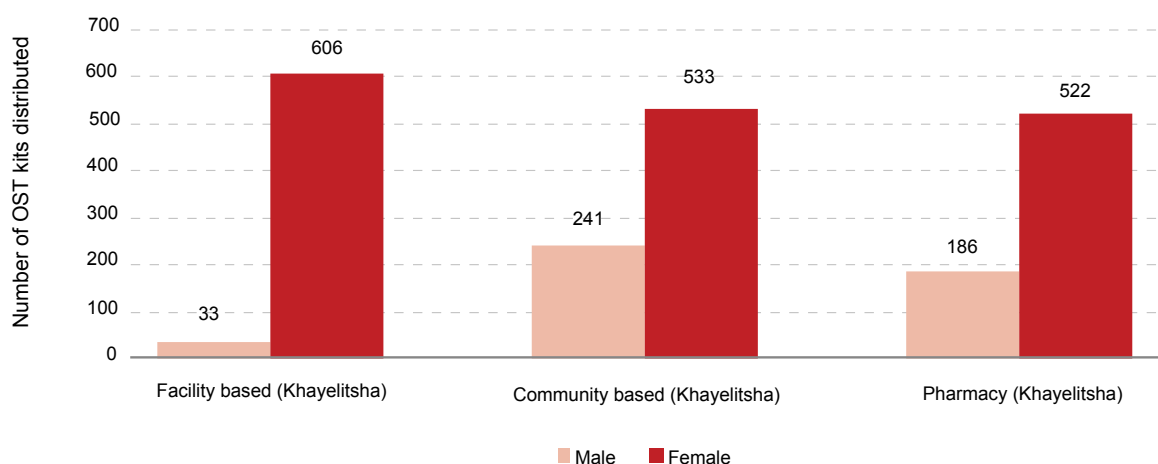
Graph 6: Male attendance for HIV testing and positive yield at community testing venues



Among all the different community testing modalities tried out, the OIM clinic reports the highest positive yield among men (6%). Door to door testing which was performed extensively in Eshowe showed that 6% of men testing positive at the initial stages of the program and became 1% after 4 years of having conducted door to door activities, this suggests we reached testing saturation and the reason why the strategy was changed to mobile and fixed sites in community venues closer to the people to be reached.

² In Khayelitsha, other clinics refer to six other primary healthcare clinics run by the CoCT where males receive ART and in Eshowe, other clinics include 10 other primary healthcare clinics run by KwaZulu-Natal DoH

Graph 7: Oral self-testing kits distributed by gender and distribution point



Different Oral Self-Testing (OST) distribution modalities were tried out in Khayelitsha as part of a study in order to assess uptake and linkage to services. Among the three distribution points, the one with highest proportion of men reached was through community based distribution, while

numbers of women received OST at community points compared with pharmacy and facility distribution, over 50% of male OST recipients received their tests at community points, compared to 40% at a pharmacy and just 7% in a facility setting.

Table 3: Baseline CD4 count comparing males clinics to general clinics

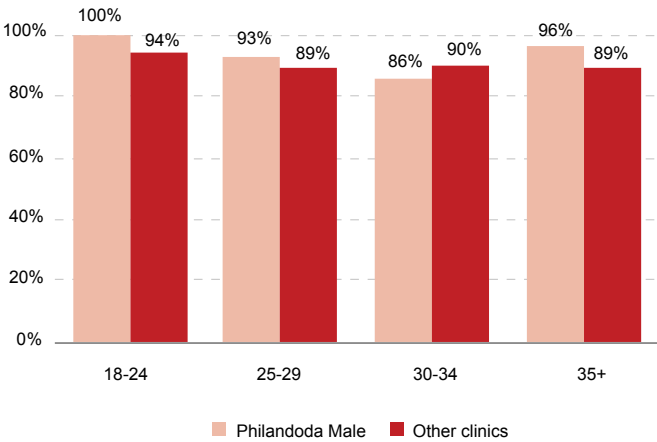
	Eshowe Median (IQR)		Khayelitsha Median (IQR)			
	Philandoda	General clinics	Site B Male	Kuyasa male	MAHC	General clinics
Overall	341 (188 - 533)	376 (219 - 563)	325 (208-424)	359 (258-511)	329 (215-441)	259 (146-399)
<20 years		414 (290 - 606)	353 (171 - 535)	441 (387 - 515)		330 (228 - 404)
20-29	398 (287 - 565)	408 (265 - 595)	329 (247 - 425)	365 (286 - 520)	269 (202 - 371)	295 (191 - 403)
30-39	260 (135 - 441)	343 (187 - 517)	329 (178 - 425)	339 (239 - 483)	346 (211 - 441)	257 (141 - 399)
40-49	352 (171 - 496)	321 (153 - 508)	330 (205 - 420)	363 (255 - 551)	274 (196 - 487)	228 (122 - 383)
50+	334 (164 - 505)	333 (164 - 578)	333 (164 - 578)	474 (170 - 644)	314 (290 - 407)	258 (151 - 427)

In Khayelitsha, based on baseline CD4 count, men coming to the Male-only clinics and male after hours clinics were generally healthier compare with men coming to the general clinics. In Eshowe though, the

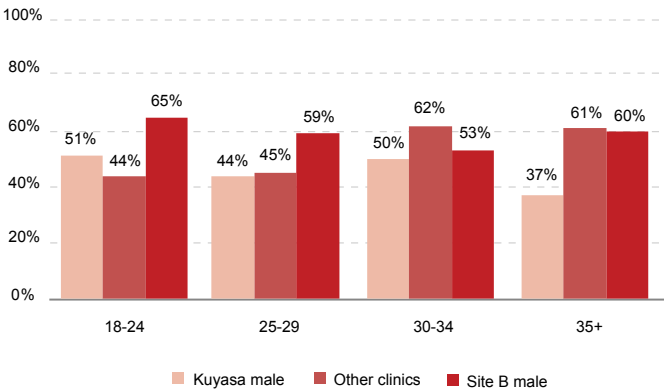
opposite was observed and men with higher CD4 count attended the general clinic, with some small difference for men from 40-49 years old.

STARTING MEN ON TREATMENT

Graph 8: Linkage to care within 30 days of testing by age group and clinic amongst men³



Linkage to care within 30 days by age group and clinic - Eshowe



Linkage to care within 30 days by age group and clinic - Khayelitsha

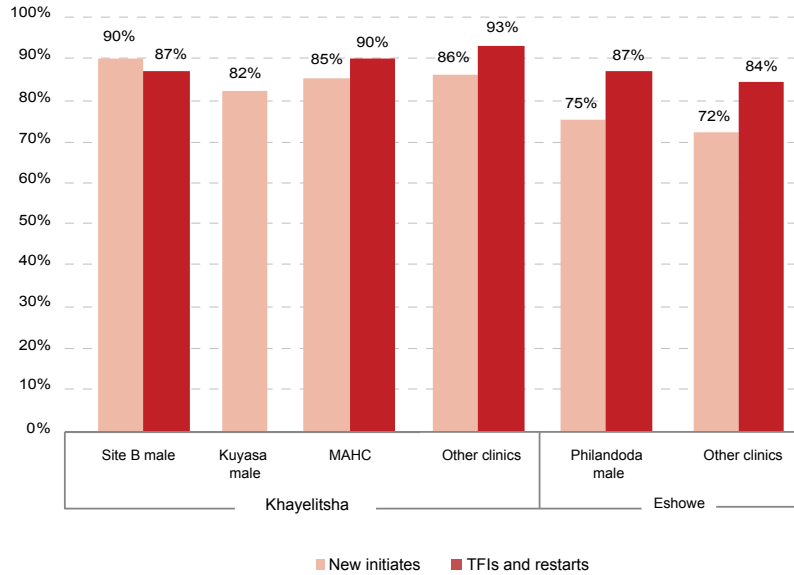
Linkage was high in Eshowe and poor in men throughout Khayelitsha. At first glance, linkage seems worse at the male clinics but that could be influenced by the fact that male clinics attract younger men and linkage is documented to be poorer in that age group. Therefore, when broken down by age, linkage was actually better in male clinics, overall. It is worth noting that 53% of men younger than 30 years of age, who were HIV positive, tested at Site B and Kuyasa Male Clinic, in the period 2014-2017.

Significant differences were found between both settings, highlighting the possible positive influence on linkage to care of same day ART initiation, with 64% of men started ART at same day at the Philandonda clinic compared with 28% at the general clinics, which was only implemented in Eshowe. Another contributing factor for the differences could be due to difficulties of access to health facilities and the fact that Eshowe is a more static population compared with a very mobile population in Khayelitsha and the first being a rural setting versus a peri-urban setting.

³MAHC linkage not included. Due to large proportion of transfers and referrals, the proportion successfully linked at MAHC is artificially high

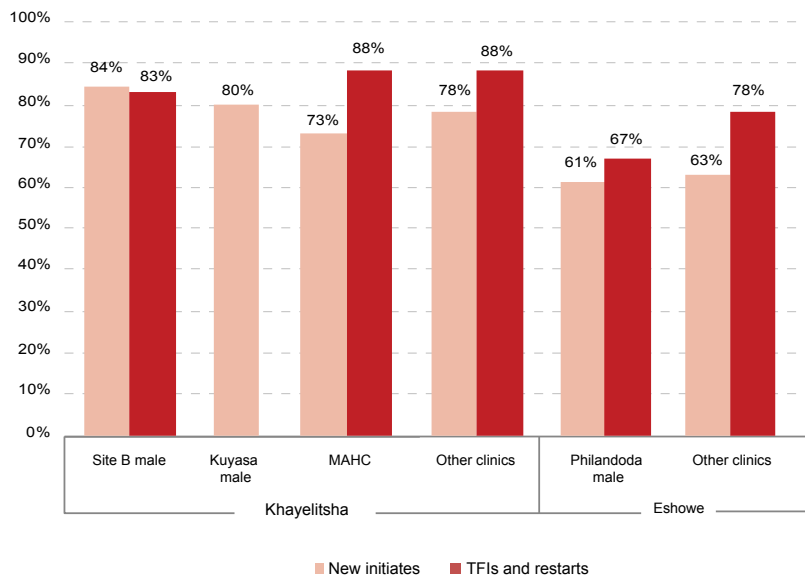
KEEPING MEN IN CARE:

Graph 9: 6 months retention in care at male clinic compared to general clinics



No significant differences were found between Male months retention in care in both settings. services dedicated clinics and general clinics at 6

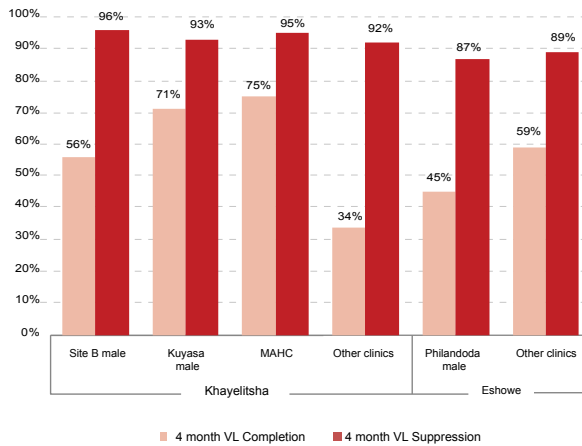
Graph 10: 12 months retention in care at male clinics compared general clinics



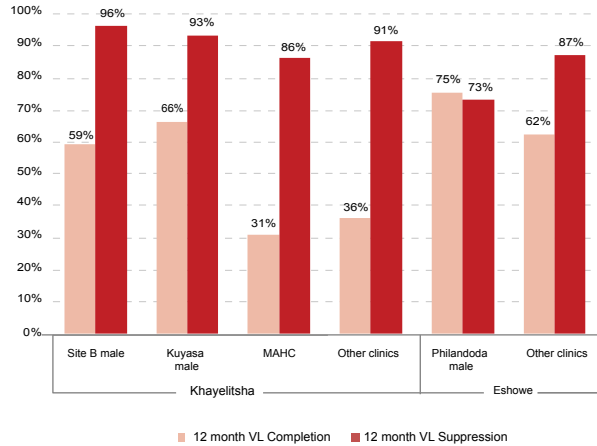
12 months retention in care were as well very similar between male-only services and male after

hour clinics, with even better retention in care in general clinics for Eshowe clients.

Graph 11: 4 Months' viral load completion and suppression at male clinics compared general clinics



Graph 12: 12 Months' viral load completion and suppression at male clinics compared general clinics



Viral load data is poorly captured across facilities: a Khayelitsha study found that while approximately 84% of viral loads were completed, just 55% were captured, but there were no significant differences in suppression rates among those not captured[34]. This therefore makes it seem as if viral load

completion was poorer than it really was. Despite this, suppression remains high across both, male-only and other clinics (with Eshowe's general clinics reporting higher viral load suppression than male-only clinics).

mHEALTH INTERVENTIONS FOR LINKAGE AND RETENTION IN MEN?

Two SMS services were offered at the Site B and Kuyasa Male clinics:

- + Newly diagnosed HIV positive men were offered SMS reminders daily for three days to start antiretroviral care.
- + Men starting antiretrovirals were offered monthly appointment reminders for the first six months of antiretroviral care.
- + 55 men signed up for the linkage reminders out of 357 offered, and 78 for the appointment reminders out of 198 offered.

RESULTS

- + SMSes improved linkage. 55% of those who signed up for the linkage reminders linked to care within 30 days, compared to 35% of those who declined the SMS service over the same period.
- + SMSes had an effect on retention. Retention in care in the SMS group was better at 3 and 6 months (84% and 78% respectively), compared to the decliners (69% and 60% respectively), although this effect was not sustained after the SMS reminders ceased, with retention at 12 months being 50% in the SMS group and 53% in the decliners.

WHAT DO MEN WANT?

A male client satisfaction survey conducted by MSF in 2018 in Eshowe showed that men are often reluctant to visit the health care facilities due to long waiting times, lack of male staff, inconvenient hours and location making access difficult for working individuals. This group reported higher probability of visiting a facility where services are provided quicker, by male staff only and in a location frequented by them on a more regular basis. To understand men's experience and perspective of Philandoda male wellness clinic, men were asked how services could be improved to meet their preferences. More than 50% of the respondents recommended the following:

Offer more services in the evening.

Offer male services in different sites.

Furthermore, participants rated Philandoda services significantly higher than general clinics with regards to interactions with staff, and factors associated with convenience such as opening up to 5:00 PM on weekdays and on Saturdays, location and waiting time for an appointment.

In a 2012 survey conducted by MSF and Anova Health Institute in Khayelitsha it was also shown that men wanted male-only and after hour services[35].

In 2017 in Khayelitsha, a patient survey amongst men who use the Male after hour clinic (MAHC) was conducted. Some of the respondents recommended the following:

“They should increase days of male after hour clinic (MAHC) to Monday-Friday at least.”

“What I like the most about being assisted by males in this clinic is that they treat us with respect and kindness, they do not make me feel guilty for an STI or being HIV+.”

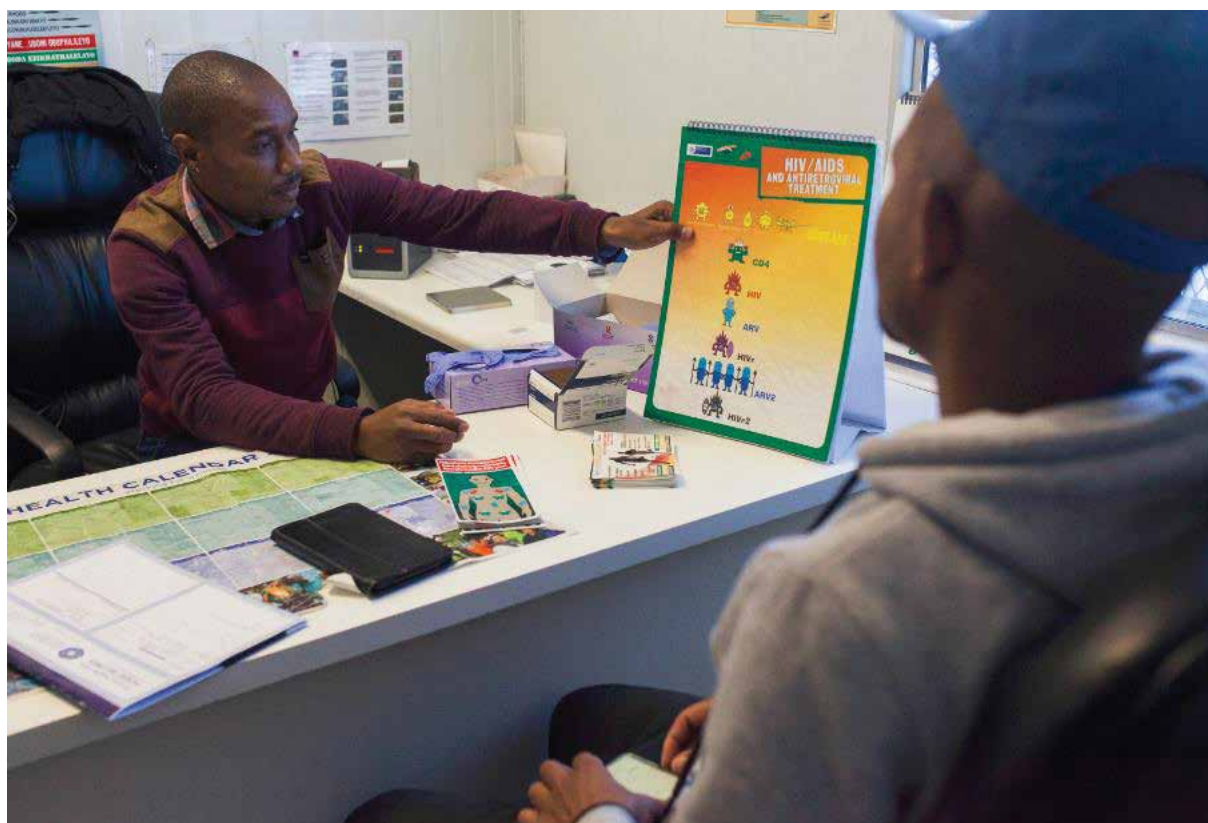
“Thank you for providing the after hour clinic. Now I do not have to choose between going to work and coming to the clinic.”

WHAT DID WE LEARN ABOUT HEALTH PROMOTION ADAPTED TO MEN?

- + We need to mobilize men as leaders within their communities to lead by example and show leadership through their behavior
- + Adapted messages to different age groups and cultural beliefs are important
- + Active search for men means moving to where they socialize, work and rest (homes).
- + Messages to be given by Male Health promoters

LESSONS LEARNT

- + We can reach more men by adapting HIV services that are tailored to their social and medical needs
- + One strategy to reaching HIV positive men earlier and in a healthier state required stepping out of the facility and offering testing in the community. Such approaches included targeting hotspots (including at traditional health practitioners), providing mobile clinics, establishing fixed community sites, testing at education institutions, at home, and offering oral self-testing. However, due to the known difficulty in demonstrating linkage to care, our data provides stronger evidence for testing and linkage at male-friendly services.
- + A large proportion of men attending male clinics came for STI screening and management. This provided an entry point into health services that led to HIV testing and ART initiation of younger, healthier men. Different models of care should therefore take into account clients' ages and needs and offer relevant packages of care.
- + Extended hours integrated into a conventional health center appears to be a feasible adaptation to achieve better linkage and retention to care outcomes compared with male only vertical clinics.
- + Male patients report increased satisfaction because of peer (male to male) support through male only staff, which enhances empathy and understanding.



MSF male services counselor Thabo Jim gives a health promotion talk to a male client at Site B Male Clinic, Khayelitsha © MSF

KEY TAKE HOME MESSAGE

There are no 'quick fixes', but our diverse programs in two different settings suggest that many elements of male-friendly services can make incremental improvements. Further efforts and innovations to continue to understand and address structural and individual factors that affect health-seeking behavior among men are very much needed.

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MSF male services counselor Thabo Jim (left) consults with a colleague at the Site B Male Clinic, Khayelitsha © MSF



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