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Men's heightened risk of AIDS-related death: the legacy of gendered HIV testing and treatment strategies

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Women are frequently depicted as the face of AIDS in sub-Saharan Africa (SAA) [1–3] where they comprise nearly 58% of all reported HIV infections [4]. Donor dollars, policies, and HIV programs have followed suit, resulting in a near-exclusive focus on women [e.g. 5]. Although African women are represented as particularly vulnerable to HIV infection [6], it is men, not women, who are more likely to die of AIDS [7–9]. AIDS prevalence may have the face of a woman, but AIDS mortality has the face of a man.

The data are convincing. Using nationally representative clinic data from South Africa, Bärnighausen et al. [10] found that men were 25% more likely than women to die from AIDS, even though women were more likely to be infected. Of the men who died from an AIDS-related illness, 70% had never sought care for HIV, compared to only 40% of women. Indeed, models predict that by 2015 men will comprise nearly 70% of AIDS-related deaths in certain high prevalence countries of SSA [8]. Men's disproportionate risk of AIDS-related death was first reported in 2006 [11, 12]. Since then studies from across the region show that men are less likely to be tested [13] and less likely to initiate antiretroviral therapy (ART) [14]. Men also start treatment at later stages of disease progression [9], have worse adherence and higher loss-to-follow-up when on treatment [15, 16], and are more likely to die from AIDS than their female counterparts [7, 9, 11].

What has been the public health response to this evidence? Surprisingly little. Despite occasional calls for an increased focus on men's health [3, 8, 17, 18], donor dollars, national strategies, and local programs continue to prioritize women. This focus has been motivated by two factors: first, a desire to reduce new infections by preventing mother-to-child transmission of HIV, a sizeable source of new infections; and second, the view that women, like children, are innocent victims of AIDS. Thus women, and not men, are seen as needing assistance to prevent and manage HIV infection [17]; programs that focus on men typically do so for the benefit of women and children rather than for men's health [e.g. 19].¹

Much of the literature implicitly blames men for their poor use of testing and treatment, focusing on the role of masculinity as the primary explanation [21, 22]. Recent data, however, raise doubt that masculinity is the main culprit. Men are just as likely as *non-pregnant* women to initiate voluntary counseling and testing (VCT) [23, 24]; and once tested positive, men initiate ART at similar rates as women [25, 26]. These findings suggest that institutional supply-side barriers, and not solely masculinity, contribute to men's lower rates of testing and treatment.

Our research in Malawi shows that by prioritizing women, health policies and institutions implicitly sideline men. The prioritization of women is particularly evident in two areas: provider-initiated testing of women in antenatal clinics (ANC), which results in almost universal testing of pregnant women, and the recent and rapid expansion of Option B+.² In contrast to previous treatment protocols that targeted the sickest individuals, male or female, under Option B+ all HIV+ pregnant or breastfeeding women initiate treatment immediately and remain on therapy for life [27]. By targeting pregnant women in high-fertility contexts such as Malawi, where the average woman has almost six children, the two policies effectively ensure regular testing and early access to lifelong treatment for most women at risk of HIV. These policies successfully increase women's use of testing and treatment [27] and reduce mother-to-child transmission; yet men are ignored. Were there to be shortages of test kits or drugs, women would be served first.

Although some policy documents contain statements encouraging men to accompany their partners to antenatal visits under the assumption that they would be tested along with their partners [28], in practice men's inclusion is not widely emphasized by national programs. At the facility level, we found that health workers justify men's attendance in terms of its benefits for their partners, not the men themselves. The few men who attend antenatal services with their partners are ignored in health education talks given before ANC and are given cues that their partner's health is more important than their own [29]. Without question, strategies focused on pregnant women are critical for the elimination of mother-to-child transmission. Such programs, however, should not continue to expand without a critical assessment of how the focus on women in terms of donor dollars, health facilities and health personnel disadvantages men.

¹Notable exceptions include men's health days, such as those initiated by the Swaziland Ministry of Health [20].

²Option B+ was first introduced in Malawi in 2011 and has since expanded to most East African countries with talk of further expansion to other parts of SSA.

In light of the feminization of HIV testing and treatment strategies, what resources are left for men? Provider-initiated testing programs are theoretically available for men who attend health facilities: for example, Malawi's policy is that both men and women who are treated for a non-HIV STI should also be tested for HIV. We found, however, that outside antenatal services, implementation of provider-initiated testing is poor and inconsistent [see also 30, 31]. Men who know they are HIV+ and meet the criteria for ART can initiate treatment, but with the widespread adoption of Option B+ and the associated rapid increase in pregnant women initiating life-long ART, men's representation among new initiators is likely to decline. This has been the case in Malawi, where men dropped from nearly 40% of new initiates in 2011, prior to Option B+, to 35% in 2014 [24, 32].

Given men's burden of AIDS-related mortality and the near exclusive focus of health institutions on women, we argue that HIV positive men represent a new vulnerable population in the AIDS epidemics of SSA. The term vulnerability applies to any individual, group, or community whose circumstances present barriers to obtaining or understanding information or accessing resources [33]. The tacit but systematic exclusion of men from targeted HIV testing and treatment strategies constrain the ability of HIV+ men to manage the risks associated with their infections. Men's vulnerability to AIDS-related death, we propose, is produced not through traditional power inequalities, as is usually assumed for vulnerable populations, but through differential access to HIV testing and treatment services. Specifically, the absence of institutional support for testing men during their peak ages of HIV incidence (as is the case for women via antenatal services), has contributed to the large gender disparities in HIV survival [34].

What will it take for the vulnerability of men to be visible, and taken seriously, by international donors and policy makers? Focusing limited health resources on women is enticing: we acknowledge that women are more likely than men to experience the traditional barriers to care, such as economic constraints and lack of personal autonomy, that have historically motivated donors and policy makers. In light of the abundant evidence showing that men are more likely to die of AIDS, however, attention must be given to men. An important step towards this goal is to recognize how institutional factors create barriers to men's use of care, such that men, but not women, must be proactive to access HIV services. Thus, we suggest that future programs target men and support them. We believe this can be achieved by considering how institutional arrangements are structured for women and not men, especially at the facility level. Could provider-initiated testing be strengthened for services frequented by men? Could male-friendly HIV testing be added to existing outreach services? Could services for men be provided on afternoons or Saturdays when fewer women-focused services are offered? Whatever the solution, it is clear that focused resources are needed to enable men to live longer, healthier lives.

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