

# **FOLLOW UP TO THE THEMATIC SEGMENT**

**HIV and men, in all their diversity:  
how can we get our responses  
back on-track?**

**Additional documents for this item:** N/A

**Action required at this meeting:** The Programme Coordinating Board is invited to:

27. Take note of the background note (UNAIDS/PCB (51)/22.38) and the summary report (UNAIDS/PCB (52)/23.5) of the Programme Coordinating Board thematic segment on “HIV and men, in all their diversity: how can we get our responses back on track?”;
28. Acknowledge that evidence shows that men and boys in all their diversity are lagging behind in access to HIV services across the testing, treatment, and care cascade;
29. Emphasizes that as part of the comprehensive HIV response, equal access to HIV services should be ensured and tailored to all population groups in all their diversity without discrimination;
30. Request Member States, civil society organisations and partners, with the support of the Joint Programme, to:
  - a. Address gaps in research and quality data to inform programming for men and boys, including size estimates of priority and key populations, data on the challenges they face including policy and structural barriers in access to comprehensive, quality HIV and health services, further disaggregated data on gender and sexual violence against men and boys, to ensure inclusion of priority and key populations in all their diversity;
  - b. Ensure that men and boys in all their diversity have equal and safe access to comprehensive HIV services by:
    - i. Strengthening national HIV strategies through specific approaches to reach men in all their diversity, in particular men and boys from key populations and providing differentiated, safe and friendly HIV services to address gaps in testing, prevention and treatment, and in the provision of comprehensive health care;
    - ii. Creating an enabling social, legal and policy environment for the establishment of service access platforms that are suited to reach men in all their diversity promoting more equitable gender norms, and addressing stigma and discrimination in service provision settings;
    - iii. Strengthening the inclusion of communities of men and boys affected by HIV, in all their diversity, in national strategic planning, setting of policies and in monitoring of programmes and service provision;
  - c. Fast-track targeted and measurable actions to end all forms of HIV-related stigma and discrimination and reinforce an enabling social, legal and policy environment for men in all their diversity.

**Cost implications for implementation of decisions:** none

## Introduction

1. Wole Ameyan, focal point for HIV prevention in men in WHO's HIV Prevention Team, introduced the thematic segment, briefly described the agenda and panel topics and welcomed the participants.
2. Yuri Yoursky, human rights coordinator for the Eurasian Coalition on Health, Rights, Gender and Sexual Diversity in Estonia, described his experiences as a gay youth who had been made to feel "imperceptible" and who had to fight and defend his sexual and gender identity. He said it was shocking that, in the 21st century, millions of men of great diversity were still unable to show their true identities and had to submit to toxic masculinities, which had a devastating impact on mental health and public health. Health services should be provided in a spirit of tolerance and respect, Mr Yoursky told the meeting. He called on UNAIDS to facilitate dialogues between civil society and governments so they could develop joint programmes that empower and serve the needs of all men. Narratives and presumptions about men had to change so that they could become more visible in HIV and human rights protection programmes.
3. Winnie Byanyima, Executive Director of UNAIDS, said the recent World AIDS Report had shown the impact of intersecting inequalities on the HIV response. In addition to focusing on adolescent girls and young women, especially in sub-Saharan Africa, it was important to focus on how services often do not meet the needs of men in their diversity and how harmful gender norms also restrict that access. The HIV response had to serve men and boys in their diversity, she said, for their own health and for the sake of their partners, families and communities.
4. Ms Byanyima shared recent HIV estimates showing gaps in men's and boys' access to services for HIV testing and treatment and for achieving viral suppression, which led to poor health outcomes. The gaps reflected people's difficulties in accessing services, limited positive male role models, and harmful social norms. Doing away with structural and economic inequalities, ending stigma and discrimination, and tackling harmful masculinities would benefit all people, she told the meeting. Successful approaches for engaging men existed, she said, citing examples from Promundo in Brazil, the U=U campaign of the Desmond Tutu Foundation in South Africa, and projects in the Buganda Kingdom in Uganda. Those kinds of interventions had to be implemented at scale, while addressing the systemic issues that cause gaps in service access and outcomes, Ms Byanyima said, and services should be tailored for all genders.
5. Adeeba Kamarulzaman, outgoing President of the International AIDS Society, praised the background note and summarized key HIV-related disparities between men and women. Compared with women, there were 740 000 more men living with HIV who still did not know their HIV status, 1.3 million more men who were not on HIV treatment, and 920 000 more men who were not virally suppressed, she said, emphasizing that the figures referred to men of great diversity. Less than 50% of men in Asia-Pacific and sub-Saharan Africa had basic knowledge of HIV, which was a consequence of incomplete or poor-quality comprehensive sexuality education in many countries.
6. Turning to the question of whether men were less likely than women to seek help and health care, Ms Kamarulzaman said sociocultural constructions of masculinities affected health-seeking behaviours. She cited a WHO review of access to mental health services, which showed that, contrary to popular assumptions, men do seek health-related help. The review had found that wider community attitudes, societal and cultural barriers, economic insecurity and limited health and social care provision undermined service access, especially for marginalized groups of men. Similarly, studies in Australia, Malaysia and elsewhere among gay men and other men who have sex with men showed

the impact of internalized stigma even in ostensibly supportive environments, she told the meeting. A study in Malaysia among people who inject drugs highlighted the impact of the criminalization of drug use (including police harassment and arrest, and dismissive attitudes of health workers), which heightened their risk of acquiring HIV and reduced their chances of knowing their HIV status and receiving HIV treatment. She also cited a study showing a clear association between criminalization and lower levels of knowledge of HIV status and lower viral load suppression levels among key populations. People's health-related behaviours were not just a matter of individual choice, she stressed. Men generally were not well-served by sexual and reproductive health services and health systems seldom provided male-focused entry points, she added.

7. Meg Doherty, Director of the Global HIV, Hepatitis and STI Programme at WHO, said the world would only reach its HIV targets and goals if the needs of men were also addressed. She summarized evidence showing poor service access and outcomes for men across the HIV service cascade. She said health systems generally were not designed and structured to engage men. In addition, harmful generalizations (e.g. assumptions and biases of health-care workers regarding men's behaviours) affected men's access to HIV services. Internalized and social stigma and social expectations feed the disparities in service access. Ms Doherty said there had been attempts in WHO guidelines (especially for pre-exposure prophylaxis, or PrEP, and HIV testing and treatment) to address the differentiated needs of men. WHO was looking at new ways to develop and implement more male-centred approaches for men in all their diversity, she told the meeting.

### **Panel 1. Who are we talking about? Why men and HIV? Addressing and changing the narrative about men and health services**

8. The first panel focused on men's diversity, highlighting data showing the gaps in men's access to HIV services across the HIV prevention, testing, treatment and care cascade, and challenging some of the myths regarding men. A short video was screened, which highlighted the evolving conversation around men's need for companionship and intimacy in societies where this would traditionally be considered a "vulnerable" trait and therefore rarely take place.
9. Moagi Kenosi, Programme Planning Manager at the National AIDS and Health Promotion Agency in Botswana, spoke of the need for high-level political engagement. He described the structure of Botswana's HIV response, from national to local levels, as well as elements that focus on mobilizing men. In addition, he said, the First Lady of Botswana was heading a campaign titled "Men and boys, let's talk" to encourage them to use HIV services and address gender-based violence. Another campaign, led by traditional leaders, sought to mobilize men for greater involvement in the HIV response, reduce HIV risk behaviours, challenge negative cultural and social influences and challenge gender inequalities. The involvement of traditional leaders was important to invest these kinds of campaigns with trust and legitimacy, Mr Kenosi said. He also stressed that the government worked with a civil society organization "Men and boys for gender equality" to provide services for men.
10. Josefina Belmonte, Mayor of Quezon City in the Philippines, started by saying that an enabling environment for all people in their diversity to feel comfortable accessing services was fundamental. She described the status of the HIV epidemic nationally and in her city, where 95% of new infections were in gay men and other men who have sex with men. She said a general hesitancy to talk about sex in Filipino society complicated the HIV response. Quezon City had a sizeable budget for HIV activities (it had risen by 780% since 2019). It was improving the collection and use of data, working closely with the national Department of Health, and operating clinics with nontraditional operating

hours to make services more accessible. The service delivery network was being expanded and strong connections had been built with testing hubs and LGBTI+ organizations, Ms Belmonte said. A community-led testing campaign had also been launched. The city was the only local government in the country with a "Zero at 2030" campaign and it was among the first local governments to pass a SOGIE equality ordinance. It also staged the largest pride festival in the country, she said.

11. Vincentius Azvian, from Inti Muda in Indonesia, spoke about the effects of stigma and discrimination on LGBTI+ communities and the difficulties in reaching young gay men and other men who have sex with men with information and services. Referring to a new law passed by the national government, which was expected to drastically complicate the promotion of safer sex, Mr Azvian said he was worried that this might increase the risk of HIV infection. It was important to help men and boys unlearn the notion that they were not vulnerable to HIV, he added, and it was especially important to focus on young men.
12. Nittaya Phanupak of the Tangerine Clinic and the Institute of HIV Research and Innovation in Thailand, told the meeting that there was a lack of recognition in many countries about the need to service men who belong to key populations. Service providers had to abandon binary gender frameworks, she said. Instead, it might be more cost-efficient to deliver services that are friendly for all genders, rather than separating them by categories. She described her involvement in setting up a key population-led health services model, with key population members designing and co-delivering the services. These community-led services had doubled HIV testing rates among key populations and had led to much earlier HIV diagnosis. More than 5,000 transgender women had accepted HIV testing at the Tangerine Clinic, with a high rate of HIV diagnoses and treatment initiation. Similar trans-led health services were being expanded to Myanmar, Nepal, Philippines, Sri Lanka and Viet Nam. Ms Phanupak called for greater trust in the potential of communities to be empowered and to assume responsibility for their health. Trans-centred and -led approaches can be adapted for all groups and genders, she said, adding that she hoped that stereotypes and gender binaries would eventually give way to more people-centred services.
13. Jonathan Mendoza, Fundacion Mavid Carabobo in Venezuela, said that even though effective treatment made it possible to live long healthy lives with HIV, many young people living with HIV were still afraid that the treatment might one day be unavailable, as the government did not purchase sufficient quantities to cover the treatment needs of all young people. Many also struggled to meet their basic needs, such as sufficient food intake, and faced regular violence and violations of their basic rights. They needed support to deal with socioeconomic hardships and protection against institutional and personal violence.
14. From the floor, speakers thanked UNAIDS for arranging the important thematic segment. Praising the background note, they said it was clear that men were being left behind. The thematic segment highlighted the many challenges of serving men in all their diversity and of fully realizing the potential of U=U as a powerful intervention to reach all people, but it crucially also showed the power of community-led interventions while recognizing that there was no single way to reach all men. Speakers also highlighted that the lack of data and research on key populations such as men who have sex with men, sex workers and people who use drugs meant that the AIDS response was operating in the dark, with insufficient information about the challenges faced by some men.
15. Speakers said it was time to bury the myths that men were not vulnerable. The general narrative continued to blame individual men while ignoring the huge differences between

groups of men. That narrative missed the impact of race and class, legacies of colonialism, and the migrant labour system in southern Africa, for example. Speakers called for a new narrative which recognizes that men are vulnerable and which addresses their needs equitably. The background note showed the emergence of a welcome new narrative that could shift from blaming individuals to addressing structural norms and realities, they said.

16. The meeting heard that 93% of the 12 million people in prisons were men and that the vast majority of people who use drugs (who have a 35 times higher risk of HIV infection than the general population) were men. It was therefore vital to have programmes that were geared to serve men, including in prisons. Only 1% of people who need harm reduction services lived in countries that provide those services, with service availability even worse in prisons. Speakers called for the removal of laws that penalize HIV risk behaviours and that criminalize drug use.
17. Speakers emphasized the importance of adopting a life-course approach when dealing with men and HIV, and of using integrated and intersectional approaches that respect all gender identities. Men in their diversity were setting examples on how to navigate poor health services that excluded them. Among the interventions cited was the MenStar strategy, which had been launched in Namibia to support new approaches to improve HIV services for men. Also mentioned was the use of HIV self-testing in workplaces, where uptake was high among men. Workplaces were ideal for reaching men who were being missed and new guidelines were being developed by the International Labour Organization and WHO to make full use of that opportunity, the meeting heard. Citing a new national action plan in the Netherlands that adopts a positive approach to sex, particularly for men who have sex with men, male sex workers and men who use drugs, a speaker said that positive sex approaches can reduce stigma and promote safer sex.
18. However, getting the HIV response on-track would require more than highlighting those experiences, speakers reminded: societal and other barriers had to be removed and affected men had to be involved meaningfully in doing so. They told the meeting that HIV screening methods, for example, tend to prioritize at-risk populations, but in generalized epidemics in sub-Saharan Africa many men were missed because it requires more resources to reach them. Policymakers were urged to reflect on the impact of cost-efficiency measures on the HIV response. Ultimately, resources were needed to close the service gaps.

## **Panel 2. What works in engaging men to enhance HIV services and better health outcomes**

19. This panel focused on good practices for engaging men to enhance uptake of HIV services and obtain better HIV outcomes.
20. Luis Gomes, Director of Collective Amigos Contra el SIDA in Guatemala, described the work of his organization, which serves mainly gay men and other men who have sex with men. It had successfully advocated for including PrEP in the country's Global Fund grant proposal, helped implement the technical protocol, and was using social media to promote this prevention tool. Free, on-demand PrEP was now available, with more than 1,700 people having enrolled on PrEP by end-2021. When research revealed stigma against PrEP users, the organization had started a positive online campaign to counter those attitudes. It was shifting to community-delivered services in the field via peers and hoped to soon provide access to long-acting injectable PrEP.
21. Eboi Ehui, Director of the National AIDS Programme in Côte d'Ivoire, told the meeting that his country had introduced major HIV reforms since 2014 to prevent and counter stigma and discrimination. In 2022, it had relaxed penalties for drug use, shifting the

focus to methadone treatment and psychosocial support, less than ten years after the new law against discrimination and stigmatization. The challenge now was to set up more treatment centres and infrastructure to follow the growing number of people who use drugs, who are especially among young people, he said.

22. Thanduxolo Doro, civil society specialist for PEPFAR-USAID in southern Africa, said it was important to counter the myths around men and HIV. He said many men who struggled to start or stay in care regarded the use of health services and medicines as a sign of weakness and saw health clinics as places designed to serve women. They associated those places with jargon and judgements and a loss of power to make decisions, which left them feeling incompetent and incapable of taking care of themselves. Mr Doro said it was important to change those narratives. The Men for Health campaign was trying to do so by better integrating men in the health system and providing appropriate support. The adapted services were currently available in 531 facilities (about 1/8 of all facilities in South Africa). The campaign was also running on radio and TV stations, and it included a U=U element. The results were good, he said, with retention in HIV treatment increasing dramatically within 18 months. He reminded the meeting that nonadherence to treatment was never simply due to individual behaviour—hence, coaches linked to participating clinics were working in communities to provide tailored support to men on treatment.
23. Professor Twaha Kigongo Kaawaase, First Deputy Premier (Katikkiro) of the Kingdom of Buganda in Uganda, said the authority of the King was being used to address HIV and other health issues among men. This was done, for example, via mass events, like the Kabaka "birthday run" (with 80 000 participants) where health messages were publicized. The theme of the run since 2020 has been "Men Are Stars". HIV prevention and other health messages and information were also publicized at "Fire Place Meetings" (a coming-of-age ritual), at football tournaments, which reach more than 30 000 men, and at other events such as the "King's Canoe Regatta" competition.
24. Mr Kaawaase added that potentially harmful cultural rituals (e.g. ones that carry a risk of infectious disease transmission through the exchange of blood) had been altered to eliminate the risk of HIV infection. Cultures were constantly evolving and changes did not have to risk a loss of identity, he explained. Rituals could be altered slightly without changing their central messages and functions. In a population of 14 million people, comprehensive knowledge of HIV had risen from 89% to 94%, and treatment coverage among people living with HIV had risen from 64% to 92%, he told the meeting.
25. Commenting from the floor, speakers noted that men yearned for safe communities and health-care services, but often found them lacking. This was especially true for people experiencing intersecting inequalities (e.g. indigenous people who experience racism, discrimination, intergenerational trauma and violence, or LGBTBI refugees who were also sex workers). It was important to consider what safe communities and health services meant in such circumstances, how to make them more accessible to those most in need who were not able to benefit from them, and to develop community-driven solutions. More broadly, said speakers, it was important to create a positive social environment, strengthen youth's knowledge of HIV, and use innovative tools like social media interventions and self-testing. They drew attention to neglected groups such as refugees and their difficulties in accessing services, finding employment and protecting their health. While the focus on key populations is important men in the general populations should also be considered. They encouraged UNAIDS and its partners to continue to challenge popular misconceptions about men and their masculinities.

## Conclusions and way forward

26. Eamonn Murphy, Acting Deputy Executive Director at UNAIDS, said the thematic segment was a reminder of the importance of discussing the intersecting vulnerabilities and issues affecting men and HIV. The session had discussed masculinities in different ways, shared examples of how HIV could be linked to other aspects of men's health, and shown how policy barriers can be removed, he said. This did not amount to an "either/or" issue of men versus women, he stressed. HIV and other health services had to be tailored for all genders and that should not be done by shifting resources from one group to another. It was important to understand the varied needs of different groups of men and to challenge stereotypes, he added. Solutions had to match the context and be diverse. The key to success was consultation and collaboration with affected communities, and community-led HIV responses.

**Draft Decision Points:** The PCB is invited to:

27. Takes note of the background note (UNAIDS/PCB (51)/22.38) and the summary report (UNAIDS/PCB (52)/23.5) of the Programme Coordinating Board thematic segment on "HIV and men, in all their diversity: how can we get our responses back on track?";
28. Acknowledges that evidence shows that men and boys in all their diversity are lagging behind in access to HIV services across the testing, treatment, and care cascade;
29. Emphasizes that as part of the comprehensive HIV response, equal access to HIV services should be ensured and tailored to all population groups in all their diversity without discrimination;
30. Requests Member States, civil society organisations and partners, with the support of the Joint Programme, to:
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    - i. Strengthening national HIV strategies through specific approaches to reach men in all their diversity, in particular men and boys from key populations and providing differentiated, safe and friendly HIV services to address gaps in testing, prevention and treatment, and in the provision of comprehensive health care;
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    - iii. Strengthening the inclusion of communities of men and boys affected by HIV, in all their diversity, in national strategic planning, setting of policies and in monitoring of programmes and service provision;



- c. Fast-track targeted and measurable actions to end all forms of HIV-related stigma and discrimination and reinforce an enabling social, legal and policy environment for men in all their diversity.

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