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THEMATIC SEGMENT BACKGROUND NOTE

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

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Executive summary

1. The thematic segment of the 51st PCB meeting is focused on the question: *"HIV and men, in all their diversity, how can we get our responses back on track"*. Why focus on men?

Meaningfully involving men is essential to ending AIDS

2. Men and boys need to be in the picture for their own sake and for the sake of their partners, families and communities. Reducing HIV incidence in men will reduce HIV rates among their sexual and injecting-drug-use partners, lead to further declines in vertical transmission of HIV, and promote healthy child survival. Shifting the structural and economic inequalities, health exclusions, stigma and gender norms that affect men will benefit all excluded communities. Greater attention to the needs of men boys is needed to achieve the 2030 goal of ending AIDS as a public health threat. Crucially, calls to include men have made clear that the resources mobilized for that purpose should be new funds—resources should not be diverted from programmes and activities that focus on women.

Men are vulnerable to HIV

3. Men are vulnerable to HIV in many ways. The annual number of men and boys (aged 15–49 years) who acquire HIV has decreased by only 27% since 2010, compared to 32% among women and girls. This gap has widened in recent years and keeps widening. While more women than men (54% of the total) are living with HIV globally, new infections in men and boys now outnumber those in women and girls.

4. There are gender differences in the treatment and care cascades and in HIV outcomes. Across the testing and treatment cascade, men lag behind: 82% of men living with HIV know their HIV status, compared with 89% of women; 70% of men who know their status are on treatment, compared with 80% of women; and 65% of men on treatment have achieved viral suppression, compared with 74% of women. Men are dying from HIV at disproportionately higher rates.

5. In sub-Saharan Africa, the region most affected by HIV, most men who acquire HIV do so during unprotected heterosexual sex, while in other parts of Africa, as well as in the Middle East, Asia and the Pacific, Latin America and the Caribbean, the Americas and Europe, most new HIV infections in men are among gay men and other men who have sex with men or injecting drug users. Knowledge of HIV among men still tends to be low: in almost all of Asia and the Pacific and sub-Saharan Africa, fewer than half of them have basic knowledge of HIV.

Who are we talking about?

6. Men are a hugely diverse group, who are powerful and powerless in different ways that affect their relationship to HIV. This background note addresses men in all their diversity, whatever their sexual orientation, or their relationship to drug use or sex work. It identifies particular groups that are left behind in the HIV response: poorer men, majority world[1] and indigenous men, heterosexual men, clients of sex workers, male sex workers, gay men and other men who have sex with men, men with disabilities, transgender men, injecting drug users (of whom about 85% are men), and people in prison (of whom 93% are men).

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[1] The group of people in the world who do not consider themselves or are not considered to be white (https://dictionary.cambridge.org/dictionary/english/global-majority)

Busting the myths, changing the narratives

7. Men's lower rates of HIV diagnosis, treatment uptake and adherence are sometimes attributed to men's poor health-seeking behaviours. However, new evidence shows that men do seek health services for themselves and other family members, but that health services often do not meet their needs. Men generally are not well-served by sexual and reproductive health services, which tend to focus mainly on women's reproductive health. Men in key populations face particular challenges in accessing HIV prevention services, including discrimination, harassment and outright denial of health services.

8. Instead of blaming individual men for poor health-seeking behaviour, we would do better to look at the structures that obstruct them from achieving better health. Health systems need to shift from the idea that the "men are missing" to "we are missing the men."[1] Contrary to narratives of strong, dominant men, gender norms can make men vulnerable. Some men endure sexual and gender-based violence. We need to undo the myth that men and women are in competition, where one group's gain necessarily comes at the expense of the other. We should highlight instead the commonalities and complementarities. We need to shift to more accurate narratives that go beyond stereotypes.

What works?

9. There are many things we already know work to reduce HIV and its impacts—such as social protection systems, challenging inequalities, making health services and technologies accessible, creating enabling environments, working with communities, and tackling gender norms. We need to make sure that the intersections with men's experiences are addressed within these broader strategies. Interventions that target men specifically are also needed, and there are increasing examples that they work.

10. In the Philippines, LoveYourself Inc. targeted diverse populations of men, as well as transgender women, with differentiated communications campaigns to generate demand for pre-exposure prophylaxis. Approximately 70% of overall pre-exposure prophylaxis enrolment in the Philippines occurred via the LoveYourself Hubs. The U=U communications campaign in South Africa almost doubled HIV testing by men. Online mentors in Nigeria support men living with HIV, link them to treatment, support adherence, and "make them feel like VIPs". The VCT@WORK initiative tested over 7 million workers (68% of them men) in India, Mozambique, the Russian Federation, Ukraine and beyond.

11. Condoms continue to be as relevant as ever, and the Condomize campaign successfully promotes condom use. Approximately 32.3 million voluntary medical male circumcisions have been conducted in 15 countries in sub-Saharan Africa. Voluntary medical male circumcisions are effective and ethical when offered as a genuinely voluntary choice among the full range of prevention options.

12. Men with pregnant partners are supporting and being involved in the prevention of vertical transmission of HIV and are being offered HIV testing. Clients of sex workers are being reached with harm reduction services, either by sex workers themselves or by targeting highly mobile men who are more likely to pay for sex. Globally in 2021, over 50 countries reported that they provided condoms and lubricants, seven reported that they operated needle and syringe programmes, and 27 reported that they provided opioid agonist therapy to prisoners and other incarcerated people.

13. Communities from key populations provide services and much more. Gay men and other men who have sex with men provide community-based services in the Philippines, Thailand, Viet Nam and beyond. The Partnership to Inspire, Transform and Connect the HIV response (PITCH) supported over 100 community-led organizations and networks in Africa, Asia and eastern Europe, to advocate collectively with gender equality approaches that include marginalized men. United movements have pursued landmark legal cases and convinced governments to shift from punitive to public health policies. Promundo Brazil has developed a programme of activities and campaigns targeted at men that address the links between gender equality, gender diversity and HIV. It has been implemented in 20 countries. Transgender men are mobilizing for inclusion in the HIV response.

Recommendations and action

14. Until quite recently, the HIV response was largely silent on the specific challenges faced by men, besides key populations such as gay men and other men who have sex with men. That is now changing. Research explores entry points into HIV care for men. Guidance is emerging. Global partnerships have been established, such as the Global Men and HIV Technical Working Group and the MenStar Coalition, which has mobilized US$ 1.2 billion and linked more than 3 million men to HIV treatment, 95% of whom have achieved viral suppression.

15. Recommendations for maintaining this momentum include:
    - increase men’s use of health services and make services more easily available to men;
    - provide differentiated health services with men-friendly characteristics and specific approaches to reach populations of men who have been left out;
    - create an enabling legal and policy environment, with public health approaches, decriminalization, community leadership and collective advocacy by key populations, and more equitable gender norms; and
    - address data and research gaps, including on key populations and sexual violence against men, and disaggregate data to include male, female and other genders.

Introduction

16. Every meeting of the UNAIDS Programme Coordinating Board (PCB) features a thematic segment, in addition to the decision-making segment. The thematic segment provides an opportunity for PCB participants to have a policy and programmatic discussion about a specific topic in the context of the broader HIV response. This background note was produced by the UNAIDS Secretariat in consultation with a PCB thematic segment working group to inform the discussion at the thematic segment.

17. The thematic segment of the 51st PCB meeting is focused on the question: “HIV and men, in all their diversity, how can we get our responses back on-track”. Men are a hugely diverse group, and are powerful and powerless in varying ways that affect their relationship to HIV. The background note seeks to include men in all their diversity, whatever their sexual orientation or relationship to drug use or sex work.

Why focus on men?

18. Meaningfully involving men is essential to achieving the 2030 goal of ending AIDS.

19. Men need to be in the picture for their own sake and for the sake of their partners, families and communities. Reducing HIV incidence in men will reduce HIV rates

among their sexual and injecting drug use partners, lead to further declines in the vertical transmission of HIV and promote healthy child survival. Shifting the structural and economic inequalities, gender norms, stigma and health exclusions which men experience will benefit all excluded communities. Crucially, calls for the inclusion of men have emphasized that this must be accomplished without diverting funds and resources from work with other vulnerable populations.[2] [3]

Men’s vulnerabilities to HIV

20. Men are vulnerable to HIV in many ways. The annual number of men and boys (aged 15–49 years) who acquire HIV has declined by only 27% since 2010, compared to 32% among women and girls.[4] This gap has widened in recent years and keeps widening. While more women than men (54% of the total) are living with HIV globally,[5] new infections in men and boys now outnumber those in women and girls.[6]

21. In sub-Saharan Africa, the region most affected by HIV, most men who acquire HIV do so during unprotected heterosexual sex, while in other parts of Africa, the Middle East, Asia and the Pacific, Latin America and the Caribbean, the Americas and Europe, most new HIV infections in men are among gay men and other men who have sex with men or injecting drug users.[7]

22. Knowledge of HIV among men still tends to be low: in almost all of Asia and the Pacific and sub-Saharan Africa, fewer than half of men have basic knowledge of HIV.[8] Men generally are not well-served by sexual and reproductive health services, which tend to focus mainly on women’s reproductive health. Men in key populations face particular challenges in accessing HIV prevention services, including discrimination, harassment and denial of health services.

23. There are gender differences in the treatment and care cascades and in HIV outcomes. Across the testing and treatment cascade, men lag behind: 82% of men living with HIV know their HIV status, compared with 89% of women; 70% of men who know their status are on treatment, compared with 80% of women; and 65% of men on treatment have achieved viral suppression, compared with 74% of women.[9]

24. Several recent studies show that, compared to women, men tend to present to health services with more advanced HIV disease and they are dying from HIV at disproportionately higher rates.[10] Researchers on HIV in Africa have concluded that men inadvertently have been side-lined, contributing to a situation where "AIDS prevalence may have the face of a woman, but AIDS mortality has the face of a man".[11]

Why is progress slow on men and HIV?

25. Why the slow progress on men and HIV? It is sometimes attributed to men’s poor health-seeking behaviours. However, the evidence shows that men do seek health services for themselves and other family members, but health services often do not meet their needs. We would do well to look at the structures and norms that prevent men from reaching better health goals.

26. One of the reasons for the higher HIV testing rates among women is the successful integration of HIV testing services into antenatal services (which also raises questions about gaps in testing for women who are not pregnant). Health systems seldom provide male-focused entry points or health education, and even sexual and reproductive health services are sometimes structured in ways that exclude men.

27. Gender and social norms that expect men to be strong, in control, aggressive, resilient and bold, and stereotypical language around HIV that portrays men as transmitters of disease, may also inhibit men's access to or use of the services they need.

28. Men make up a high proportion of the key populations of clients of sex workers, injecting drug users and gay men and other men who have sex with men. Policies and laws that criminalize and discriminate against people with same-sex sexual orientation or nonconforming gender identities,[2] drug users and people who buy and sell sex make it unsafe to seek health support and services. Health services all too often perpetuate stigma and discrimination against key populations and ignore their specific needs.

29. As identified in the Global AIDS Strategy, social, economic and racial inequalities impede the HIV response. When HIV services require out-of-pocket payments and when social protection systems exclude some groups of people in need, poorer and marginalized people struggle to access the multiple technologies and services that are now available to prevent and treat HIV, imposing a huge burden on them and their families.

Background note structure

30. This paper brings together the latest evidence, guidance, strategies and thinking on men and HIV, and discusses why and how to tackle HIV among men in all their diversity. It considers how socially constructed dimensions of gender shape structures and environments, as well as individual behaviours.

31. The section below introduces narratives that can help us move beyond the stereotypes that hamper efforts to end AIDS. The section after that outlines the gaps in progress towards global targets and outcomes of HIV testing, prevention and treatment in men. The challenges of inequalities, criminalization, harmful gender norms and infringements on human rights are presented and populations of men who face marginalization are identified.

32. The next section discusses approaches that work to address the gaps, challenges and exclusions. Existing strategies, such as more accessible health-care services and technologies, the creation of more enabling policy, legal and social environments, and community mobilization can all have a huge impact. The section considers how such strategies can include men in all their diversity and it presents illustrative case studies. The final section shares existing partnerships and guidance and makes recommendations for ways forward.

Challenging stereotypes and changing narratives

33. Narratives that stereotype men as perpetrators of disease and violence, and women as their victims, appear frequently in both mainstream and alternative cultures and media. Sometimes these narratives are also aired in international development arenas,[12] [13] with "gender-based violence" taken to refer only to violence against women and girls. HIV interventions imply that men's poor health outcomes are due to their lack of efforts to seek services, rather than being due to the fact that health services are inaccessible or inhospitable. Those narratives are inaccurate. They also make it tougher to address real problems, meet the needs of people of all genders,

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[2] Gender nonconforming is commonly used to describe a gender expression different from cultural stereotypes associated with that person's perceived gender or gender assigned at birth. (https://outrightinternational.org/insights/terminology-surrounding-gender-identity-and-expression)

reduce violence and end AIDS. It is time to shift to narratives that are more accurate and more useful for tackling HIV.

It's not a zero-sum game

34. Attention to the realities of men and boys need not detract from the vitally important work focused on women and girls. On the contrary, supporting men to challenge the gender stereotypes that make them and other genders vulnerable can contribute to greater gender equality for all. Supporting men to deal with HIV helps reduce HIV among women too. Many of the ways in which health services need to change in order to be more accessible to men (e.g. longer or flexible opening hours, shorter waiting times, and greater respect from service providers) are good for all users. It's not a zero-sum game.

35. Highlighting the risks and vulnerabilities of men involves some comparison with women. WHO, UNFPA, Equimundo and others have warned against overemphasizing differences between women and men, which underplays what they have in common and ignores the often-larger income and class-related disparities they experience.[14] Reducing inequalities within as well as between genders is vital for ending AIDS.

Gender norms make men and boys vulnerable

36. Gender norms establish expected patterns of behaviour for boys and men, such as bravado and acting strong, knowledgeable and dominant. They face pressures to conform to discriminatory and unhealthy patriarchal behaviours that trap people of all genders in spirals of harmful behaviours and vulnerabilities.[15]

37. In childhood, boys are more likely than girls to experience bullying and harsh and abusive punishment both at home and at school. In several countries, boys experience higher rates of violence than girls.[16] Lesbian, gay, bisexual, transgender and intersex (LGBTI) children are likely to face homophobic bullying at school. In some middle-income countries (e.g. Indonesia, Malaysia, Sri Lanka, South Africa and Thailand) girls on average are now outperforming boys in terms of achievement at school and enrolment in higher education.[17]

38. Adolescent boys may face peer pressure to become sexually active and abstain from using condoms. Stereotypes of masculinity can discourage them from seeking health information and services. Sexual and reproductive health services may exclude boys.

39. Young women are more likely than young men to acquire HIV in some regions. Young transgender people may face the highest rates of HIV infection.[18] Transgender women have 14 times greater risk of acquiring HIV than adult women (15–49 years) in the general population.[19] In sub-Saharan Africa, adolescent girls might acquire HIV in sexual relationships with older men and transmit the infection to same-age male peers. As those women age, they might also transmit HIV to older male peers.[20] Adolescent boys might have better knowledge about HIV than girls, but they tend to be less likely to take an HIV test.[21]

40. Many children, irrespective of their gender, face trauma during childhood, including physical violence, sexual violence or witnessing domestic violence against their mothers and siblings. For many people, traumas continue in adulthood. In Eswatini, Malawi and South Africa, for example, over half of surveyed men reported experiencing two or more such traumas in their lifetimes. The experiences were associated with higher rates of inflicting intimate partner violence, hazardous drinking and depression or anxiety.[22] Yet services to help with adaptive coping are rare.

41. Boys and young men may be recruited into violent male peer groups and gangs. They are also more likely than women to take life-threatening risks. Young men under 25 are three times as likely as young women to die in traffic accidents. Young men have higher rates of smoking, alcohol and drug use, which can also affect their risk of transmitting or contracting HIV, as well as disease progression.[23]

42. Death rates also skew according to gender. Men have higher rates of suicide than women. Globally males account for 82% of homicide victims.[24] In Brazil, there are now five million more women than men, in part due to high homicide rates among men, as well as uneven access to and use of health services.[25] In Mexico, transgender women's life expectancies are on average only 37 to 40 years.[26] In the United States of America (USA), people who die in police custody are disproportionately likely to be African American and male.[27] On average, men living with HIV die younger than women living with HIV.

Men face gender-based violence

43. While women and people with nonconforming gender identities suffer disproportionately from gender-based violence, men are also targeted. Gender norms can increase sexual violence and its impact on people of all genders, as well as generate shame and prevent people from to accessing support. Gender stereotypes of men as being proactive, rather than victims, mean that sexual violence against men can be seen and experienced as an erasure of their masculinity. Sexual violence against women can be seen as destroying their honor and that of their community. Hostility to divergence from gender conformity can drive violence against transgender and gender-nonconforming people.[28]

Sexual violence in the Democratic Republic of Congo conflict

People of all genders endure sexual violence in conflict in the Democratic Republic of Congo conflict. The experiences of male victims include being raped, being forced to watch family members being raped, and being beaten on the genitals.[29] Some of these men fled to Uganda and became activists with the Men of Hope Refugee Association, a nongovernmental organization which supports male victims of conflict-related sexual violence. Compounding the trauma, men who have suffered sexual violence are often seen as not "truly masculine" and face homophobic violence and criminalization, regardless of their sexual orientation. In addition, they face exclusion from survivor support services, some of which assume that only women face sexual violence.[30] All these factors also hinder men from testing for HIV and starting or staying on treatment.

Men actively seek health services

44. A common stereotype is that men have poor health-seeking behaviours and are unreliable at taking care of their own health. Gender stereotypes that teach men not to show weakness may discourage them from seeking health care and information. Criminalization and stigma make it unsafe for key populations to seek health care in some contexts.[31] Generally, though, many men do seek health services, but those services fail to meet their needs.[32]

45. A study in rural Malawi among men older than 15 years who had never taken an HIV test found that 82% of them had been to a health facility in the previous year, mostly to outpatient departments. Almost half of the visits were guardian visits, with men taking other family members to the health facility. Yet only 7% of the men had been offered HIV testing.[33]

46. In-depth interviews with men living with HIV in Malawi showed that where men disengaged from care, it was due in part to fear of stigma, borne out by experiences of rudeness and hostility among health-care providers, and fear of side-effects from antiretrovirals (ARVs). Migration and travel for work was also a big factor. Many of the men had to travel for the sake of economic survival and were required by bosses to travel at short notice. Most men made great efforts to adhere to HIV treatment, for example returning from their travels especially to refill their treatment prescriptions.[34]

47. Qualitative ethnographic research in South Africa has shown a mismatch between perceptions of service providers and the men needing services.[35]

Providers often think…	But men told us…
Men are stubborn and indifferent.	They are anxious and afraid, to the point of paralysis.
Men have plenty of sources of support available to them.	They have no one they trust enough or feel safe with to talk to about HIV.
Men should know that HIV is no longer a death sentence.	They anticipate physical, social and/or sexual death due to HIV, and the latter two are even worse than the first.
Treatment will save your life, so men should embrace it.	They associate treatment with loss, not gain. For many, it is a reminder of failure and a marker of disease.
They are caring and compassionate.	They are intimidated by the clinic and anticipate a negative provider interaction.
They are helping men by being proactive.	They often feel hunted and coerced, and they want to remain in control of decisions about their health.
They are providing counseling and guidance, but men refuse to follow it.	They experience counseling as scripted and didactic, rather than speaking to their personal fears and barriers.

Men are diverse: there are many ways to be a man

48. Men are sometimes stereotyped as perpetrators and women as victims, while gender-nonconforming people are rendered invisible, even in much international development work.[36] The reality is more varied. In Brazil, Promundo's surveys with young men found that many had gender-equitable attitudes due to the influence of peers with those attitudes, positive male role models, and positive personal experiences associated with gender equality.[37] In Nigeria, the Rise programme provides online support to men living with HIV. During prototyping, it found that men consistently preferred and requested tender depictions of support, joy and love, rather than isolating pictures showing men conquering challenges alone through brute strength.[38]

49. Norms around masculinity stigmatize men who are seen not to be "manly" enough, while encouraging homophobia and transphobia.[39] Homophobia and misogyny interact. In Nicaragua, for example, gay men who are seen as more feminine face greater stigma than those who are seen as more masculine.[40] Some organizations working with men promote gender equality and tackle homophobia and transphobia at the same time, such as Promundo Brazil, Puntos de Encuentro in Nicaragua, Sonke Gender Justice in South Africa, and Men of Hope in Uganda.

50. Ideas about what it means to be a man change over time. In Bangladesh, interviews with men of different generations of men found that they had different ideas about what it meant to be a "real man", as well as about sex and acceptance of sex before or outside marriage, attitudes to work, and religious beliefs and practices. Their ideas

were influenced by the historic, social and economic environments in which they had grown up.[41]

51. Although some stereotypes dominate, every society offers more than one model of masculinity, some of which conflict with each other. For example, boyfriends of female sex workers in Kampala, Uganda, face peer pressure to demonstrate their masculinity by being tough, drinking alcohol, having multiple sexual partners, and not using condoms. The more "respectable" model of masculinity of working hard, earning an income and looking after one's family is difficult to achieve for these men, most of whom have grown up in poverty, left school early, lacked family support, and remained socially and economically marginalized. The "Good Health for Women Project" in Uganda has supported sex workers to help reduce barriers to the testing and treatment of their boyfriends. This has strengthened the stability of their relationships and it improved the men's health, with some shifting towards a more "respectable" masculine model.[42]

52. In the USA, the masculinities researcher Michael Kimmel seeks to change violent gender cultures among American soldiers and all-male university fraternities through trainings that appeal to men's ideas of what it is to be a "good man" (which often includes taking responsibility, being respectful and caring for people). Kimmel believes that the characteristics of a "good man" and a "good person" overlap, but that it may be too ambitious to expect the men to abandon their notions of manhood; instead, he uses the idea of being a "good man" as a pragmatic strategy.[43]

Progress towards global targets in men lags behind: Gaps and challenges

53. Including men in all their diversity is key for reaching the Global AIDS Strategy targets of reducing new HIV infections to fewer than 370 000 per year and reducing HIV-related deaths to fewer than 250 000 by 2025, and to realizing the Sustainable Development Goal 3 of ensuring healthy lives and promoting well-being for all. As outlined in the previous sections, inequalities, gender norms and stigma have led to men being left behind in HIV testing, prevention, treatment and outcomes. Gaps also persist in data collection and certain populations of men are being left out. Criminalization and humanitarian crises create additional challenges for people living with HIV and for efforts to reduce HIV transmission.

Criminalization

54. Punitive laws block HIV service access and increase HIV risk. Harmful laws include the criminalization of same-sex sexual relations, transgender people, HIV exposure, nondisclosure and transmission of HIV, drug possession and use, and buying or selling sex.[44] Age-of-consent laws can block young people's access to sexual and reproductive health care. In some cases, the possession of condoms is used by police as grounds for harassment or "evidence" that a person is involved in sex work.[45]

55. Analysis of data from 10 countries collected in 2011–2018 from over 8,000 gay men and other men who have sex with men in sub-Saharan Africa found that those living in countries with severe criminalization of same-sex relations (>10 years imprisonment) were approximately eight times more likely to be living with HIV compared with those living in countries without such criminal penalties.[46] A 2019 systematic review found that African countries with the most severe antigay legislation had substantially lower rates of HIV testing among gay men and other men who have sex with men, compared with countries with less severe legislation.[47]

56. Clients of sex workers, who are mostly male, face criminalization in several developed countries where buying sex is illegal. Criminalizing clients increases risks for both clients and sex workers. A survey of 500 women and men who sell sex (including transgender women and transgender men) in France found that 98% of them opposed criminalizing clients, which they saw as increasing their vulnerability to violence and poverty by pushing the industry underground and discouraging safer clients.[48] Criminalizing the purchase of sex also makes it harder to engage sex workers and their clients with HIV prevention and health care services, and it obstructs public health and harm reduction approaches.

57. Often people have multiple intersecting identities, more than one of which is criminalized. For example, while South Africa's Constitution entrenches the right to housing, some municipal laws effectively criminalize homelessness, exacerbating the impact of stigma and criminalization of other identities. Among homeless individuals reporting police abuse to a community organization, a majority were using drugs, a majority were LGBTI, over one third were living with HIV, and over one third were selling sex. A testimony is cited below.[49]

> *"I sleep on the corner of two streets … the police were waiting there … the constable slapped me … They then started to search me and they found my syringes and crack pipe. They asked what I'm doing with these syringes and I said nothing and they started to beat me … and the other guys. They then took all of our blankets and all documents that they could find. I am scared that they will come back as they have done this for a couple of weeks now … I fear opening a case as they will kill us."* [50]
>
> – Testimony from a homeless person in South Africa.

Humanitarian crises

58. Humanitarian crises are increasing, along with protracted conflicts, food insecurity and climate change events. Global shocks, including the COVID-19 pandemic and the Ukraine war, have exacerbated risks for the HIV response.[51] Humanitarian crises increase existing inequalities, and breakdown social and economic structures. These disruptions can result in a reduction or complete loss of access to HIV prevention, treatment, care and support services in affected areas.[52]

59. Sexual violence against cisgender[3] women is common in humanitarian crises. The experiences of men and transgender people in humanitarian settings are less well-known, even though they, too, face gender-based violence. According to a study by the Peace Research Institute of Oslo, men are more likely to be killed during conflicts, while women are more likely to die of indirect causes after the initial conflict.[53] In the past decade, sexual violence against men and boys has been reported in over 25 conflict-affected countries.[54] Sexual violence against men, boys and people belonging to gender and sexual minorities during humanitarian crises can result in multiple physical and psychological traumas, as well as HIV transmission.

60. A range of trauma responsive medical, psychosocial, and counselling supportive services are needed for people of all genders, including HIV testing and counselling, and post-exposure prophylaxis. While cisgender women and girls may not be well-

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[3] Cisgender is commonly used to refer to people who identify exclusively with the gender assigned at birth. (https://outrightinternational.org/insights/terminology-surrounding-gender-identity-and-expression)

enough served in humanitarian responses, needs assessments may overlook men, boys and sexual and gender minority groups.[55]

Research and data gaps

61. Most countries lack research and data on key populations, a large proportion of whom are men. Stigma and, in some cases, criminalization hinder data collection on populations of clients, transgender people, drug users, gay men and other men who have sex with men, and sex workers. In general, there is even less data available on sex workers who are men or transgender, compared with those who are cisgender women.[56] Not enough is known about the sizes of key populations and the challenges they face. Data on key populations is lacking, particularly in countries with generalized epidemics.

62. There are several other research gaps. Data on sexual violence against men and boys may not be collected due to assumptions that they do not face this kind of violence. In research on pre-exposure prophylaxis (PrEP), evidence on the feasibility of community-based approaches and task-sharing disproportionately represent cisgender gay men and other men who have sex with men, as well as adolescent girls and young women from a few countries. There is a need for additional evidence across multiple geographies and populations.[57]

63. While huge progress has been made collecting sex-disaggregated data related to HIV, often only two sex categories are included. The experiences of people who do not fit the categories may be missed. Data collection needs to move towards more inclusive practices to accurately reflect diverse populations.[58]

Who is left out?

64. Many male populations that are affected by HIV are not sufficiently included in the HIV response and many of them intersect with each other: for example, men of all sexual orientations may buy and sell sex, or may inject drugs. Some gay men and other men who have sex with men identify as "straight" and may be presumed to be heterosexual. Like other men, transgender men and men with disabilities may have diverse sexual orientations and have sex with people of different genders.

65. **Poorer men.** Marked inequalities within and between countries are stalling progress in the HIV response, and HIV is further widening those inequalities.[59] Income inequality, lack of social protection, and economic barriers to health care remain key drivers of HIV. The lower people's social and economic status is, the poorer their health is likely to be. Even in the richest countries, health systems fail people in ways that are related to gender, race, income status and other intersecting factors. In the USA, for example, states with lower spending per person on social services and public health tend to have higher rates of HIV diagnoses and HIV-related deaths.[60] Other research from the USA has found that about 9.5% of people living with HIV experienced homelessness in 2018, the majority of them men.[61]

66. **Majority world and indigenous men.**[4] The HIV epidemic worldwide intersects with geography, ethnicity and indigenous or settler status. Globally, sub-Saharan Africa has the heaviest HIV burden and is home to two-thirds of all people living with HIV.[62] Eastern Europe and central Asia, the Middle East and North Africa, and Latin America have all experienced increases in annual HIV infections over the past decade.[63] In the

[4] The group of people in the world who do not consider themselves or are not considered to be white (https://dictionary.cambridge.org/dictionary/english/global-majority)

United Kingdom (UK) and North America, ethnic minorities account for disproportionately large numbers of new HIV diagnoses.[64] In the USA, African American people comprise a larger proportion of new HIV diagnoses[65] and people living with HIV, followed by Hispanic and Latinx people, compared with people of other races and ethnicities. Racism, HIV stigma, homophobia, transphobia and other barriers to health care drive these disparities.[66]

67. In some countries there are now substantial disparities in HIV rates between indigenous and non-indigenous peoples.[67] A comprehensive literature review on indigenous peoples and HIV in Australia, Canada, New Zealand and the USA has documented high levels of domestic violence, injecting drug use, and stigma and discrimination in those populations—factors that increase the risk of HIV infection. Racism, colonialism and histories of exploitation by medical and other government services contribute to mistrust of health services among both indigenous peoples and ethnic minorities, which in turn contributes to poor HIV and health outcomes.[68]

68. **Heterosexual men**. Heterosexual men are sometimes neglected in the HIV response.[69] Historically, the global response to HIV in large, generalized epidemics has focused more on women of reproductive age and children. Over time, this has grown to include, appropriately, key populations such as gay men and other men who have sex with men, sex workers, adolescent girls, and others. However, heterosexual men have remained largely invisible, particularly black heterosexual men of low socio-economic status living in sub-Saharan Africa.[70]

69. **Clients of sex workers.** Men who pay for sex constitute a distinct population which is at high risk of HIV acquisition and transmission. Research in South Africa has shown that sex between sex workers and clients contributed to about 7% of new HIV infections recorded in that country between 2010 and 2019. Sex between clients and their nonpaying partners accounted for about 42% of new infections over the same period.[71] However, clients have not been fully recognized as a priority population for HIV prevention. In 2021, the largest meta-analysis to date of men who have paid for sex analysed 87 population-based surveys in sub-Saharan Africa.[72] It found that up to 1 in 10 sexually-active men reported ever paying for sex and about 68% of them reported using condoms in recent paid sex encounters. Men who had paid for sex were more likely to have tested for HIV, but were also 50% more likely to have acquired HIV than men who had not paid for sex.[73]

70. **Male sex workers.** Data on men selling sex are scarce, even though men (both cisgender and transgender men) do sell sex to women and men, and make up a significant part of the population offering transactional sex. Men who sell sex are highly vulnerable to HIV. A recent study in Tianjin, China, found that HIV rates among men who sell sex to men were significantly higher than among other men who have sex with men.[74] In westernx Africa, men selling sex were found to be less likely to use condoms than other men who have sex with men.[75] Yet, HIV responses that target sex workers often focus on women, sometimes including transgender women, but rarely include men. Responses targeted at gay men and other men who have sex with men often miss the specific experiences of men who sell sex. Male sex workers can face double stigma and criminalization because they sell sex and have same-sex relations.[76]

71. **Gay men and other men who have sex with men.** Gay men and other men who have sex with men have been central to building the HIV response globally, and are targeted by many interventions. Nevertheless, they are among the most frequently omitted or poorly served groups: their risk of acquiring HIV is 28 times higher than that of other men.[77] They also face persistent criminalization in some countries, as well as

ongoing stigma and discrimination, which marginalizes them in HIV responses. For example, in Peru, HIV incidence and HIV-related mortality are increasing. The country's epidemic is concentrated largely among gay men and other men who have sex with men. Only about 14% of the men who test HIV-positive and start antiretroviral therapy (ART) adhere to the treatment, despite free national provision. Qualitative research with HIV-positive gay men and other men who have sex with men and with health-care providers has noted numerous barriers to care, including discrimination, shame, depression, travel cost/times, a preference for traditional plant-based medicine, and concerns about the side-effects of ART.[78]

72. **Drug users**. In the HIV response, people who inject drugs are among the most frequently omitted or poorly-served populations. Beyond sub-Saharan Africa, most new HIV infections in men are among gay men and other men who have sex with men, and men who inject drugs. Among users of opioids, the most commonly injected drugs, 85% are men.[79] It may be that men's greater likelihood to inject drugs is related to gender norms and peer pressure which encourages risk-taking. An estimated 11.2 million people worldwide injected drugs in 2020 and those numbers are increasing. It is estimated that one in every 8 people who inject drugs is living with HIV (approximately 1.4 million people).[80] The risk of acquiring HIV is 35 times higher among people who inject drugs than among those who do not inject drugs.[81] Yet, criminalization predominates over public health approaches for these populations.

73. **Transgender men.** Transgender men are often marginalized in HIV responses.[82] Precise data are lacking,[83] but it is clear that this population faces high risks of acquiring HIV.[84] Transgender men are as diverse as other men. Their sexual orientations are diverse, they may have anal or vaginal sex with people of various genders, with or without condoms. Stigma and discrimination can exacerbate their risk of acquiring HIV and other sexual health complications. Mental health issues, social isolation, substance use and low self-esteem are highly prevalent among transgender men. Those factors, along with a perceived need for gender affirmation (seeking social recognition and support for one's gender identity or expression), may make it more difficult for transgender men to negotiate safer sex practices with their partners.[85]

74. **Men with disabilities**. Due to discrimination and exclusion, people with disabilities have a higher risk of HIV than other people.[86] HIV can also increase the risk of impairment. Data from sub-Saharan Africa suggest that men with disabilities are 1.5 times and women with disabilities are 2.2 times more likely to acquire HIV, compared with men without disabilities.[87] However, HIV and sexual health and education programmes often neglect out people with disabilities.[88] This may be connected to misleading stereotypes of people with disabilities as being asexual. Some initiatives are addressing these issues, including the Disability, HIV and AIDS Trust network in southern Africa, the innovative online sexuality education resource "sexualityanddisability.org" in India, and Undressing Disability Hub[89] in the UK.

75. **Prisoners and people in closed settings.** Approximately 12 million people are held in prisons worldwide, 93% of them men. Incarcerated people are five times more likely to be living with HIV than adults in the general population. On average, more than 3% of the global prison population is living with HIV.[90] High-risk sex and rape, as well as drug injecting, can be common in prisons. In South African prisons, for example, high-risk sex is commonplace, usually in the form of unprotected anal sex, as well as rape and sexual assault, much of it intertwined with gang violence. Anecdotal evidence indicates that prison rape fuels a cycle of victimization and perpetration and contributes to the rape of women, men and children, and to the transmission of HIV in communities once inmates are released.[91]

What works?

76. The interventions and approaches that help reduce HIV infections are well-known. They include social protection systems, challenging inequalities, making health services and technologies accessible, creating enabling environments, and working with communities. We need to make sure that the intersections with men's experiences are addressed in these approaches and strategies. Interventions that target men specifically are also needed, and there are increasing examples of their success.

Making health systems more accessible to men

Communications targeting men

77. Communication campaigns are effective for preventing, testing and treating HIV in men. Campaigns that tackle stigma and target men with non-judgmental and easy-to-understand narratives about love, intimacy and support are effective. Key to their success are consultations and co-creation with target audiences.

Differentiated communications tailored to diverse groups of men and transgender women increase PrEP use in the Philippines[92]

Love Yourself Inc., one of the leading HIV awareness, advocacy and response organizations in the Philippines, was started by and for young people, lesbian, gay, bisexual and transgender people, and gay men and other men who have sex with men. It now has 1,100 volunteers.

Its recent campaign promoting PrEP uses messages that are tailored to diverse groups of men and transgender women. The #Men of PrEP campaign for "Men who love men" features photos of social media influencers/ambassadors who are athletic, muscular young men and use slogans such as "Sex without fear, PrEP is here." The #Queens of PrEP, "A PrEP campaign to unleash the queen in you", features photos of drag queens, and transgender and cisgender women beauty queens, with slogans such as "Hiiiiiieeee! My new happy pill is here!". The #SummerFunCollab, "a PrEP campaign for the sexually adventurous" targets men who engage in anonymous sex, as well as online male sex workers.

Complementing those campaigns is #FREEdomwithPrEP, which is aimed more broadly at gay, bisexual and other men who have sex with men, and which publicizes the fact that PrEP is available free of charge. Between June 17 and October 2022, more than 6,200 people had started PrEP through LoveYourself hubs (comprising about 70% of all PrEP enrollment in the Philippines).

U=U messaging in South Africa with a focus on men[93]

In a randomized trial in South Africa, HIV testing uptake among men exposed to a specially designed communications project was almost twice as high as among men receiving standard HIV messaging. The Desmond Tutu Health Foundation[5] ran workshops with target audiences to develop messages centering on Undetectable = Untransmittable (U=U). Three main insights emerged: the benefits of ARVs must be conveyed accurately

[5] In collaboration with Penn University, UCLA and the Bill and Melinda Gates Foundation.

(e.g. "You're not cured, but they are so defeated they can't be seen"); men who take ARVs must be portrayed positively (i.e. undo the stereotype of "the bad guy"); and the benefits of ART should be reframed so they are easy to understand.

"Make him feel like a VIP"—online mentors support men living with HIV in Nigeria[94]

RISE-Valor seeks to strengthen HIV case-finding, prevention, treatment and viral load suppression services for men in Nigeria. The approach is to provide support to men prior to testing, by using online "VIP guides" mentoring, providing information, and answering questions in WhatsApp and Facebook messaging. The mentors help link men who test HIV-positive to services, support them with dynamic case management, and encourage their personal growth as they experience the "ups and downs" of living with HIV.

The project aims to help men break with trauma, normalize fears, envision happy futures, destigmatize risk, and validate themselves. Slogans used include "Claim courage—you are not alone, because our VIP guides will be with you at every step"; "You will have love because new treatment means you can't pass it on to anyone else"; "You can enjoy life because the new treatment is so easy: just one pill a day". Social media support is combined with radio shows and in-person community support. The impact includes increased uptake of PrEP and testing, and increased linkage to ART services.

More accessible prevention, testing, treatment and support

78. There are effective strategies to increase men's use of health services and make the services more easily available, including by reducing economic barriers (via free or affordable services with full insurance coverage, and access to social protection systems). Strategies also include using differentiated and targeted modes of delivery, extending clinic operating hours, reaching men in their places of work and leisure, providing respectful, nonjudgmental and nonstigmatizing services, and using new communications technologies.[95]

79. Evidence suggests that men do take HIV tests when offered, but that opportunities are often missed to offer testing when they attend clinics.[96] Testing male partners of pregnant women can be important for increasing HIV testing among men.[97] Some studies show that men are as likely to test for HIV as nonpregnant women.[98] Provider-initiated testing at antenatal clinics has been hugely effective for reaching women and reducing vertical transmission of HIV. This needs to be extended to male partners of pregnant women and should be framed as being for the benefit of men's health and that of their partners and children.[99] Testing and counselling as couples, with support for partner notification, has been found to be effective.[100] There are fears that disclosure of HIV status within couples could lead to increases in intimate partner violence, though several studies have found this is not the case.[101] [102]

80. Offering HIV testing at work, community and home-based testing, self-testing and couples testing can help men and others test for HIV. However, while these approaches can help reach people, they still need to travel to clinics, sometimes repeatedly, and wait to be linked to ART and care. Test-and-treat strategies that offer immediate initiation of ART after diagnosis can help overcome this hindrance.

Reaching men through voluntary counselling and testing, including HIV self-testing, at work (VCT@WORK)

The International Labour Organization (ILO), UNAIDS and other partners launched the VCT@WORK Initiative in 2013 to provide adults with HIV testing services where they spend much of their daily lives: at work.[103] By end-2019, the VCT@WORK Initiative had tested close to 7 million workers (68% males and 31% females), including their families and dependents. The fact that the majority of people tested were men shows the potential for reaching men with HIV testing services in their places of work.

Workplaces with nondiscriminatory HIV work policies were prioritized to protect workers' rights and confidentiality and ensure they were not discriminated against. A variety of approaches were used. Testing services were integrated into multidisease and health screening campaigns in Mozambique, led by the Business Coalition ECOSIDA. Miners were reached through large public sector companies in India and the Russian Federation. Seafarers were reached via seafarer unions in Ukraine. Peer educators played key roles promoting testing and linking workers to treatment when necessary. HIV self-testing was introduced in VCT@WORK in 2018. Between 2019 and 2022, nearly 380 000 workers and their family members used HIV self-testing that had been provided through their workplaces; 62% of them were male, including a significant proportion of first-time testers.[104]

81. Treatment adherence is strongest when services address privacy, confidentiality and stigma concerns, minimize travel and waiting times, develop trusting relationships with patients, and when patients recognize the positive impact of treatment on their health and ability to provide for families. Awareness training for health-care workers about men’s concerns, streamlined referral processes and convenient pick-up arrangements for medicines are particularly effective at increasing adherence among men. Reducing costs (out-of-pocket payments, transport expenses and opportunity costs) helps people of all genders access the health care they need. Home, workplace or mobile pick-up site for medicines, home visits by community health-care workers and mobile phone message reminders also show good results among men. Community health workers and peer navigators can help retain men in care.

82. Targeted interventions are needed to reach prisoners and people in closed settings. A small but increasing number of countries provide at least some HIV-related services in places of incarceration: between 2017 and 2022, 52 countries reported providing condoms and lubricants, seven had needle and syringe programmes, and 27 provided opioid agonist therapy to prisoners and other incarcerated people. Many of these services rely heavily on donor funding and support. They are also unevenly distributed across prisons and tend to be poorly linked to national HIV, public health or occupational health and safety programmes. A lack of political will is the biggest underlying barrier. However, there is some progress. For example, in the Republic of Moldova, the national prison administration provided 142 000 needles and syringes in prisons in 2021, and five civil society organizations teamed up to offer HIV testing in prisons. Fifteen of 17 prisons have now been certified as offering the same level of health-care services as in the wider community.[105]

83. Vertical training and provision of services at country level needs to shift to more horizontal approaches which integrate STI and HIV prevention, testing and treatment with broader health services. Efforts are being made to integrate HIV testing into clinical services that reach many men, such as tuberculosis (TB), viral hepatitis and

sexually transmitted infection (STI) services, or services that reach men exclusively, in particular voluntary medical male circumcision (VMMC).

Multidisease health screening campaigns to increase men's uptake of HIV testing and other health services in the Democratic Republic of the Congo.[106]

This intervention was offered to people in the general population aged 15 years and older, with a particular focus on males, especially those in the 20–39-year range, since young men tended to lack awareness of their HIV status. Community health workers conducted sensitization campaigns in the areas surrounding eight health facilities and disseminated tailored messaging to raise awareness about free multidisease screenings that were available at the facilities. Individuals interested in the screenings were given appointment slips to return for a free consultation and screening outside working hours. Facility-based providers offered free screenings for hypertension, hyperglycemia, STIs, pneumonia and dermatitis, based on client eligibility and preference.

Following screening, the person's HIV risk was assessed, using the national HIV risk assessment tool, and he was offered HIV testing, if appropriate. Men who screened or tested positive for any of the infections were linked to follow-on care and treatment services at the facility, including same-day ART initiation for those confirmed to be HIV-positive.

Almost 3,000 individuals participated in the multidisease screening campaign, among whom 57% (1,629) were male; 210 were confirmed HIV-positive (a 12% positivity rate), and 192 (91% of those testing positive) were enrolled on ART. This approach was offered under the Integrated HIV/AIDS Project in Haut-Katanga (2017-2023), with funding from PEPFAR through the United States Agency for International Development.

Making services available to male victims/survivors of sexual violence

84. Data are lacking on the experiences of men and boys who are subjected to sexual violence. Some organizations are gaining experience, however, and lessons are emerging, including from the Refugee Law Project in Uganda, Médecins Sans Frontières, the Centre for Victims of Torture and some of their local partners. UNICEF[107] and the Women's Refugee Commission[108] have developed guidance for supporting survivors.

85. Male survivors are more likely to present and seek care at clinics that provide integrated care (medical, mental health and psychosocial) for survivors of violence and that do not make disclosure of sexual violence a precondition for accessing care, compared with stand-alone sexual violence clinics or clinics that are integrated into maternal and child health units.[109] Service providers need to know how to engage and sensitively respond to men, for example men who have been subjected to forced sexual encounters, without making assumptions about the survivor's sexual orientation.[110] Training and sensitization can help them respond appropriately. Offers of HIV testing and post-exposure prophylaxis need to be part of the response.

Reaching men with HIV prevention technologies

Condoms

86. Condom use has had an enormous impact on the global HIV pandemic: modelled simulations show that increased condom use since 1990 has averted an estimated 117 million new HIV infections.[111] In India and Thailand, for example, increased

condom distribution to sex workers and their clients, combined with other prevention interventions, were associated with reductions of transmission of both HIV and other STIs. South Africa and Zimbabwe are two high-prevalence countries where increased condom use has been shown to have contributed to reductions in HIV incidence.[112]

87. To increase condom use, the gendered aspects of condoms must be considered. Condoms are the main contraceptive choice for sexually active adolescents. Fewer young women than young men report using condoms—possibly due mainly to young women's reduced decision-making power to negotiate safer sex. These power relations must be changed, including by working to transform gender norms among men. Concerns about the impact of condoms on sexual pleasure inhibit their use among people of all genders, and in some contexts ideas about "flesh-on-flesh" sex are closely tied to ideas about masculinities and pleasure.[113] This can be addressed with targeted messaging about pleasure with condoms,[114] [115] as well as efforts to improve technologies of production.[116] Condoms must also be available in humanitarian crises situations, and in prisons and closed settings, where men are in the majority.[117]

88. Demand creation for male and female condoms is essential to motivate and sustain their use. Many initiatives promote condom use, including UNFPA's CONDOMIZE! Since 2014, this innovative campaign has been destigmatizing condoms through "edutainment", the high-level involvement of policy-makers and media (including social media and influencers), and with inputs from key and vulnerable populations.

Voluntary medical male circumcision

89. The evidence shows that medical male circumcision reduces a male's risk of acquiring HIV through vaginal sex by 50–60%.[118] VMMC has to to be offered safely by competent health service providers, in combination with other interventions. The latter include safer sex education, condom promotion, the offer of HIV testing and other services, and STI screening and management, including referral to treatment. From 2008 to 2021, approximately 32.3 million men and boys underwent VMMC in 15 focus countries in sub-Saharan Africa.[119] Efforts to reach men with targeted interventions can learn a great deal from the successes of VMMC programmes in reaching men at scale.

90. Ethical VMMC needs to be truly voluntary. Communications encouraging men to circumcise must not stigmatize uncircumcised men as spreaders of disease.[120] WHO recommends that, while financial compensation is effective at mobilizing men's participation in these programmes, it should not be offered as an incentive, but rather as compensation for travel costs and time spent. It also should not be conditional on undergoing circumcision, but rather for taking part in programmes that offer the option of VMMC without pressure.[121] Particular attention should be paid to issues of consent for children younger than 15 years who are being asked to make decisions about an invasive and irreversible nonessential surgery which carries higher risks of adverse events for less mature genitalia.[122] Access to information, counselling and other preventative health services must not be conditional on undergoing VMMC.

91. VMMC should be offered as one option among the full range of HIV prevention options, and service providers should take full advantage of men's contact with health services by offering them other sexual and reproductive health services, as well as comprehensive health care such as hypertension and TB screening, malaria management and tetanus toxoid-containing boosters.[6] In South Africa, for example,

[6] Differentiated and simplified pre-exposure prophylaxis for HIV prevention: update to WHO implementation guidance. Technical Brief. Geneva: WHO; 2022 (https://www.who.int/publications/i/item/9789240053694).

the Integrated National Men's Health Strategy aims to build on investments in male medical circumcision sites by turning them into "one-stop-shops" for comprehensive health services. Ultimately, male medical circumcision will be subsumed within a broader package of men's health services.[123]

Needles, syringes and opiod substitution therapy[124]

92. Harm reduction for injecting drug users is particularly relevant to men, who make up 85% of users of opioids, the most commonly injected drug.[125] Less than 1% of people who inject drugs live in countries that have achieved the UN-recommended coverage of needles, syringes and opioid substitution therapy, and the funding gap for harm reduction in low- and middle-income countries is large. Substantial evidence shows that harm reduction, condoms and PrEP outreach can reduce HIV incidence But these programmes are too rarely brought to an impactful scale. If governments shift resources from punishing drug users and instead devote them to harm reduction therapies and ARVs, they could greatly reduce HIV transmission without increasing costs.[126] Political will is needed for effective action.

93. Drug users and their allies can play a key role in bringing about a shift to public health approaches. In Uganda, for example, drug users were supported to represent their community in policy fora, where they exchanged information directly with policy-makers. This contributed to the introduction of medically assisted treatment for drug users in Uganda. In Viet Nam,[127] community organizations and networks modelled voluntary community-based substitution treatment for drug users at local health centres, in contrast to the previous approaches of detention and forced detoxification. The Government has contributed funding to continue the intervention.

Health-on-bike targeting drug users in rural India[128]

Since October 2021, the Health-on-bike initiative has been targeting people who inject drug, the vast majority of them male, and other adult men and their children in a rural Christian area of 38 villages in Noklak district, India. Since the area is inaccessible by car, two "bike outreach coordinators" use motorbikes to visit the district, offering screening for HIV, STI and TB, as well as harm reduction services, ARV delivery and viral load sample collection to residents in the 38 villages.

The bike outreach coordinators connect with local health facility staff and affiliated peer educators, who provide them with information and logistical support. When the bike outreach coordinators are unable to travel back to their base location due to unfavorable weather or poor road conditions, they overnight in the villages with support from the local churches. The churches have played an important role creating an enabling environment for the communities to access the services. A total of 344 men and boys have tested for HIV, of whom 15 tested HIV-positive and were successfully linked to ART. Two-hundred-and-four injecting drug users were linked to opioid substitution therapy and 128 were linked to needle exchange programming.

Health-on-Bike was implemented by PATH and I-TECH India under Project Sunshine, funded by the U.S. President's Emergency Plan for AIDS Relief through the U.S. Centers for Disease Control and Prevention, and with logistical and technical support from the Nagaland State AIDS Control Society.

Pre-exposure prophylaxis

94. By 2015, twelve trials on the effectiveness of oral PrEP had been conducted among diverse populations: serodiscordant couples, heterosexual men, women, gay men and other men who have sex with men, people who inject drugs and transgender women. The trials took place in Africa, Asia, Europe, South America and the USA. A systematic review and meta-analysis of the trials using TDF[7] has confirmed that PrEP is effective for preventing acquisition of HIV infection. The level of protection did not differ by age, gender, ARV regimen or mode of acquiring HIV (rectal or penile/vaginal). PrEP has maximum impact when used by or with people who are at high risk of acquiring or transmitting HIV. These include some gay men and other men who have sex with men, people who use drugs and people who sell sex. It may also be important for sero-discordant couples, especially during pregnancy or before the HIV-positive partner has achieved viral suppression.

95. A range of ways for delivering PrEP and supporting adherence have been used. For example, in Brazil, telehealth approaches were implemented during COVID-19 to maintain PrEP services for adolescent and adult gay men and other men who have sex with men, and for transgender women. Similar levels of PrEP persistence were maintained during COVID-19 compared with entirely clinic-based approaches before COVID-19, while reducing the average time spent at PrEP services by clients. These adaptations show how digital and home-based PrEP services could improve access to and persistence on PrEP. However, some clients prefer in-person services, so telehealth approaches should be offered alongside facility-based services.[129]

Post-exposure prophylaxis

96. Post-exposure prophylaxis (PEP) is effective in preventing acquisition of HIV after a person has been exposed to HIV. It may be used in cases of exposure in health settings, risky sex, sexual assault or sharing needles or other drug injecting equipment.

97. A systematic review of studies of awareness and use of PEP by gay men and other men who have sex with men has found that they tend to have modest awareness of PEP, but low rates of use after risky sex. Criminalization, homophobia, racism and HIV stigma all discourage use of PEP, as do requirements of contacting an emergency physician in an HIV or sexually transmitted infection clinic to gain access. Cost was a barrier in Thailand and in some cities in the USA, for example, where PEP is not free. The review concluded that PEP is under-used and that gay men and other men who have sex with men are willing to use PEP, if supported to overcome barriers to access, and to adhere to the full 28-day course of treatment.[130]

98. PEP is not intended to be used repeatedly. In Brazil, studies found that PEP was being used repeatedly at higher rates by cisgender men and transgender women than by cisgender women, and more often by gay men and other men who have sex with men than by heterosexual men. Strategies are needed to target repeat PEP users with other HIV prevention technologies.[131]

Creating enabling environments

Decriminalization, destigmatization and human rights support

99. As discussed above, stigma and criminalization obstruct access to services and correlate with higher rates of HIV infection. To reduce HIV and its impact, a shift is needed from criminalization to harm reduction and public health responses, and from

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[7] Oral PrEP containing tenofovir disoproxil fumarate

stigmatization to respect and rights. There must be an end to impunity for unlawful policing practices and other human rights violations by state actors. Punitive laws targeting people living with HIV and key populations must be repealed. Community-led monitoring and evidence-based advocacy can help bring about these changes.[132]

100. The People Living with HIV Stigma Index provides a standardized tool to gather evidence on how stigma and discrimination affects the lives of people living with HIV.[133] Launched in 2008, it was developed by and for people living with HIV. A new version is now available. More than 100 countries have completed the study and over 100 000 people living with HIV have been interviewed. Networks of people living with HIV implement the surveys, building capacity among other groups of people living with HIV. They have committed to a proactive gender equality and diversity approach that includes all key populations. Evidence is gathered to inform advocacy.[134]

101. The Partnership to Inspire, Transform and Connect the HIV response (PITCH) focuses on supporting marginalized people to change the services, laws, policies, practices and mindsets that affect their everyday lives.[135] PITCH has supported over 100 community-led organizations, networks and platforms, including regional partners in nine low- and middle-income countries: Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Uganda, Ukraine, Viet Nam and Zimbabwe. PITCH has encouraged diverse key population groups to form coalitions and set joint agendas at regional and global levels. This helps build solidarity, promote more equitable gender approaches and include marginalized men, as well as people of other genders. United movements have pursued landmark legal cases[136] and persuaded governments to shift from punitive to supportive policies. Marginalized communities have created more enabling environments with improved access to HIV, sexual and reproductive health and rights, and harm reduction services.

102. PITCH supported partners to identify and address the often-overlooked gender-related needs of key populations, including marginalized men such as male sex workers and drug users. For example, PITCH supported Mozambique's National Platform of Sex Workers' Rights, which was formed by sex worker groups led by men and women, including transgender people, to build relationships with police and the health sector. Its work includes establishing sex worker focal points in each province to help sectors deal with issues as they arise and to liaise between the police and communities.

Community-led responses

103. Grassroots movements have been central in responding to the HIV epidemic by improving uptake of HIV testing and counselling, negotiating access to treatment, helping lower drug prices, and reducing stigma and discrimination.[137] The 2021 Political Declaration on HIV and AIDS[138] sets targets for the involvement by affected communities in the HIV response.[8]

104. In 2012, an extensive and in-depth review was carried out on the participation gay men and other men who have sex with men in the HIV response.[139] It included consultations in China, Ethiopia, Guyana, India, Mozambique, Nigeria, Ukraine and Viet Nam; outreach to thought leaders and representatives in Asia, Africa, eastern Europe and central Asia, and the Americas; and an extensive literature review. The review found that HIV had disproportionately affected gay men and other men who have sex with men since the beginning of the pandemic, and that this population group

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[8] By 2025, community-led organizations should deliver 30% of testing and treatment services, 80% of HIV prevention services for populations at high risk of HIV infection; and 60% of programmes to support the achievement of societal enablers, including protection of human rights, reduction of stigma and discrimination and law reform.

had responded by making major contributions to the HIV response. Since the beginning, gay men and other men who have sex with men have led and participated through advocacy, education, research, and design and delivery of prevention, treatment, and care programmes that have benefited everyone affected by HIV. In stigmatizing environments, gay men and other men who have sex with men, as well as LGBTI community groups, are often the only groups willing to advocate for the recognition and rights of gay men and other men who have sex with men, and for HIV services that meet their needs.

Community outreach in Thailand increases testing by gay men and other men who have sex with men, transgender women, and male and transgender sex workers and drug users[140]

This initiative targeted gay men and other men who have sex with men, transgender women, and male and transgender sex workers, aged 18–32 years, including drug users and people who have chemsex. It reached people through online outreach, social media and in person events. Fun memes with "bite-size" information were circulated and were linked to further information. “Party packs” were distributed (condoms and water-based lubricants, along with HIV prevention information resources catering to high-risk key populations). Testing was encouraged through the TESTBKK website and the “Testmenow” online booking platform, provision of self-test kits and links to clinic partners. Information about U=U, innovative interventions and clinic partners helped retain people on HIV treatment. The project sparked a substantial huge increase in testing. It is implemented by APCOM, which works to improve the health and rights of gay men and other men who have sex with men across Asia and the Pacific. Similar initiatives are being implemented by APCOM and linked organizations in Indonesia, Laos and Mongolia.

From HIV testing to comprehensive primary health care: Fostering peer-led, community-driven, and integrated care models for gay men and other men who have sex with men in Viet Nam[141]

Despite a significant decline in newly reported HIV cases in Viet Nam in the early 2010s, the HIV burden among young men was on the rise, with most new HIV infections concentrated among gay men and other men who have sex with men. A multilayered approach was adopted to increase the number and types of entry points for those men to receive HIV prevention (condoms and lubricants, and PrEP); testing (HIV lay provider testing, self-testing, and index testing); ART and adherence counseling.

The work centered on three strategies: (1) expanding the role of key population-led organizations in delivering HIV-related services through client-centered design; (2) reforming HIV communications by using innovative digital tools and unique community engagement; and (3) prototyping and scaling up a community-led, integrated care model that holistically responds to the distinct needs and preferences of gay men and other men who have sex with men, including subgroups such as chemsex users. This has provided an effective platform for comprehensively meeting the spectrum of health-care needs of these men and retaining them in care.

Gay men and other men who have sex with men were engaged in every step of the design, implementation and scale-up of the interventions. This included partnering with service providers and peer counselors to pilot and scale-up community-based testing and PrEP models, and working with clinics to design and implement the comprehensive integrated care model and differentiated service delivery models, such as mobile PrEP

service delivery. In addition, the project's partnership with community influencers was essential for developing and implementing effective HIV demand generation activities, including joint behaviour change communication campaigns and peer-led offline events. From December 2015 to October 2021, over 126 000 gay men and other men who have sex with men received lay HIV testing. Among them 5,673 tested HIV-positive (4.5% positivity) and 5,515 (97%) were enrolled in ART. This work was initiated under the USAID/PATH Healthy Markets (2014–2021) project and continued by USAID/PATH STEPS (2021–2026) with funding from the US President's Emergency Plan for AIDS Relief (PEPFAR).

105. Transgender men are mobilizing for their inclusion in HIV research and responses. In 2019, the International Working Group on Transmasculine People & HIV was established, comprising transmasculine activists, researchers and public health experts from 19 different countries across all continents, including people living with HIV and PrEP users. They seek to build capacity in their community and support the global HIV response to include transgender men and transmasculine people.[142]

106. A 2010 consultation with (male, female and transgender) sex worker organizations[143] yielded a clear message that has been echoed by key populations generally: Don't just fund HIV, give core funds and support for rights work. Building organizing capacity to create an enabling environment is essential for reducing new HIV infections. Male sex worker organizations are contributing to the HIV response. In 2013 in Macedonia, for example, the sex worker organization Star-Star launched a project designed by male and transgender sex workers. Male and transgender sex workers lead trainings for health workers, while sensitized outreach advisors offer male sex workers and their clients HIV counselling and rapid testing.[144] Star-Star has created an online register of "friendly health centers" which offer HIV-related services for sex workers in a respectful manner. Star-Star's work has contributed to keep HIV rates in Macedonia low.[145]

Shifting gender norms and inequalities, and tackling stigma and discrimination

107. Gender inequality contributes to the transmission of HIV and exacerbates its impact.[146] Strategies that challenge gender norms and stereotypes can contribute to reducing stigma and HIV infections. Comprehensive sexuality education that addresses gender and power relations is strongly associated with significant reductions in rates of STIs and unwanted pregnancy.[147] A peer education programme and social marketing campaign with young men in informal settlements in India, for example, also found a strong association between inequitable gender attitudes and HIV risk. By the end of that programme, participants reported more equitable gender attitudes, better communication with partners and less violence, less stigmatizing attitudes to people with HIV, and higher rates of condom use.[148]

Program H supporting men to challenge gender norms

Promundo Brazil has lengthy experience of working with men to promote gender equality. Aimed at young men, its Program H initiative encourages men to question rigid norms of masculinity and promotes the transformation of gender attitudes that generate inequities. Launched in 2002, the programme has been adapted in more than 20 countries. It is based on several surveys carried out with young men in Brazil with gender-equitable attitudes, which revealed that the adoption of these attitudes had been influenced by the presence of peers who supported gender equality, successful personal experiences associated with gender equality, and the existence of positive male role models.

Program H combines educational workshops with awareness campaigns that are developed, conceived and implemented by young people. In 2014, it launched the HMD Program manual, which includes addressing links between negative gender norms and HIV prevention and stigma, and promoting understanding of sexual diversity. When organizations use Program H in their communities, they can use the Gender-Equitable Men (GEM) scale to analyse changes before and after interventions and campaigns and thus assess their effectiveness. The GEM scale is a validated attitude scale, which has been adapted and applied in more than 20 contexts and which is recognized as an effective instrument for assessing attitudes about gender.

Men who participated in Program H activities reported positive changes, including increased use of contraceptives, improved relationships, greater willingness to do household and caregiving tasks, and a lower incidence of sexual harassment and violence against women. Program H has been officially adopted by the Ministries of Health in Brazil, Chile, Croatia, Mexico and elsewhere. Schools have played a central role in the implementation of the programme. In India, Program H approaches were incorporated at the government level, reaching 25 000 schools.[149]

Involving men in preventing vertical transmission of HIV and supporting parenting

108. Men's involvement in preventing vertical transmission of HIV can contribute to better health outcomes for men and their families. Men help prevent HIV transmission to children through financial support, accompanying partners to antenatal clinics visits, practising safer sex, open communication, and by learning how to administer HIV medicines to new-borns.[150] The multiple barriers to involvement include having to pay for antenatal clinic services, believing in unequal gender roles, male-unfriendly antenatal services, providers' hostile attitudes toward men,[151] clinic hours that clash with men's working hours, perceptions of antenatal care services as being female spaces, and men's fear of HIV testing.[152]

109. Strategies that increase male engagement include sensitizing men about HIV and pregnancy, engaging leaders and employers, providing services outside working hours, and providing incentives.[153] Fathers have a vital parenting role for children irrespective of their HIV status. Many men have a strong desire to parent, and for men living with HIV, having a baby can help normalize their lives.[154]

110. Some programmes have successfully supported fathers with active parenting. Initiated by Promundo Brazil with partners, Program P has been adapted in Brazil, Indonesia, Rwanda and South Africa in urban and rural contexts, under the program MenCare+(+Father, in Brazil). The programme includes activities for men and partners, guidance for health professionals on how to involve men in antenatal consultations, as well as in health facilities and community campaigns. Qualitative results from the implementation of Program P have shown positive changes in the lives of men and their families. In Nicaragua, young parents reported improvements in relationships with their sons, daughters and partners, as well as greater participation in household and child-care tasks.

Harm reduction for clients of sex workers

111. Clients of sex workers are a hugely diverse group and are not easy to target with interventions. Programmes have tried to reach them via sex workers, for example by distributing HIV self-test kits to sex workers, who can distribute the tests to peers, clients and partners.[155] In such interventions, sex worker participation must be

voluntary: their buy-in is essential to success. Programmes need to learn and take the lead from sex workers on potential risks.

112. Another route to reach clients is targeting men who are more likely to buy sex, for example facilitating treatment access for migrant workers, long-distance truck drivers, mine workers, and other men who travel for work.[156] There is little evidence that programmes that seek to deter men from buying sex are effective.[157] However, evidence from client programmes in the global South suggests that health-related sex worker and peer-led programmes can influence clients' awareness, knowledge and behaviours around sexual health risks and safer sex practices.[158]

113. Even when key populations remain criminalized, harm reduction approaches may still be possible. In South Africa, for example, sex work remains criminalized. However, based on a review of evidence, Sonke Gender Justice adopts principles for practical client interventions, including clear definitions of sex work, challenging stigma and judgement, emphasizing elements of sexual consent and considering risk perception and emotional distress. Sonke has developed a curriculum on sex work,[159] which can be used for trainings with men generally, and which addresses sex work as well as issues of gender, consent, respect, condoms, violence and HIV. They have also produced a booklet for clients, titled “Secret guide to the business of sex”.[160]

Working with religious and traditional leaders

114. Religious and traditional leaders can play a significant role in community HIV services. The Global AIDS Strategy[161] emphasizes the role of faith-based organizations, religious leaders and faith communities. Their positions of trust and their missions to serve make them ideal for supporting their constituencies and tackling stigma.

Harnessing traditional leadership to increase uptake of HIV services by men and boys in Uganda[162]

His Majesty Mutebi II, the King (also known as Kabaka) of the Buganda region in Uganda, has the power to influence people and transform cultural norms, beliefs and customs that impact on the communities in the region. Kabaka has also been able to attract financial support from private sector partners such as Airtel Uganda, DFCU Bank, Nile Breweries to contribute to health promotion campaigns. From 2017–2022, the King engaged in the campaign on “Good Health for Men and Ending AIDS by 2030”. Kabaka spoke on radio television and social media platforms. Kabaka birthday runs and marathons, campfires and a football cup were held. The costs were largely covered by private sector sponsors.

The campaign contributed to significantly improved HIV-related outcomes in the Buganda region between 2017 and 2020, including a 52% decrease in new HIV infections, which contributed to Uganda reaching the 90–90–90 targets in 2020. Building on the campaign, Buganda Kingdom plans a similar HIV advocacy campaign (Men are Stars, or “Abaami Munyenye) to mobilize a critical mass of men and boys in this region and in Uganda overall to access HIV and other health services and fight stigma and discrimination.

Partnerships and guidance

115. Up to five years ago, the HIV response was largely silent on men’s specific challenges, outside of key populations such as gay men and other men who have sex with men. That situation is changing: studies are exploring new possible entry points into HIV

care for men, partnerships have been established, and guidance is emerging. Someof the initiatives are outlined below.

The Global Men and HIV Technical Working Group

116. UNAIDS and WHO coordinate the Global Men and HIV Working Group (MENHT), a standing body of stakeholders and partners to support global and country engagement and to galvanize action around men and HIV. UNAIDS, WHO, ILO, the International AIDS Society and Population Services International co-chair the group. It coordinates activities to improve outcomes for men across the HIV cascade and supports advocacy efforts. It also supports the development of operational guidance for improving HIV services for men, including identifying interventions; reviewing technical documents; identifying, collecting, and sharing best practices, case examples and tools for reaching men; disseminating guidance, briefs and lessons learned; and supporting scale-up of effective interventions (including technical assistance). Information is shared through a series of thematic webinars coordinated by UNAIDS and WHO.

Male engagement in HIV testing, treatment and prevention in eastern and southern Africa: A framework for action

117. UNAIDS in collaboration with Sonke Gender Justice, the WHO, UN Women and Sweden Sverige 2gether 4SRHR, launched a framework in 2022 to improve male engagement across the continuum of HIV services.[163] The framework provides a foundation for country-led action to achieve the targets in the Global AIDS Strategy 2021–2026 within a broader gender equality agenda. The focus is on transforming social, economic, legal and policy structures, addressing supply- and demand-side factors and transforming gender norms.[164] A resource hub on men and HIV,[9] linked to the framework, was launched to provide a platform for data on men and HIV, as well as for sharing best practices in the region.

MenStar Coalition

118. MenStar[165] is a coalition of public and private sector partners founded to address the needs of men in the HIV epidemic particularly in sub-Saharan Africa. The US$ 1.2 billion coalition was launched by Elton John and Prince Harry at the AIDS Conference in Amsterdam in 2018. It is reconstructing men's relationships with health care by developing insight-driven, innovative programmes to improve health care for men at each stage of the HIV treatment cascade. The programmes are guided by a global Menstar Strategy[166] and core package of services that are designed to ensure that programming reflects the insights gleaned from the research. To date, through the Coalition's efforts, more than 3 million men have started HIV treatment, 95% of them have achieved viral suppression. However, some men continue to drop out of care, and it is challenging for them to remain on treatment.

Guidance on men, HIV and related issues

119. Important guidance on men and HIV has been developed, as outlined below. Several other policies, guidance, frameworks and implementation tools are being developed. For example, WHO and UNAIDS are producing "Men and HIV: A review and synthesis of evidence-based approaches to reaching men in sub-Saharan Africa", as well as a framework for VMMC and sustaining men's services.

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[9] https://menandhiv.org/

120. **Guidance and resources already available:**

- *HIV self-testing at workplaces: approaches to implementation and sustainable financing*, WHO and ILO, 2022;[167]
- *Technical brief: Transgender people and HIV in prisons and other closed settings,* UNODC, WHO, UNAIDS, UNDP, PRI, 2022[168] (includes transgender men);
- *"That never happens here": Sexual and gender-based violence against men, boys and/including LGBTIQ+ people in humanitarian settings*, International Committee of the Red Cross, Norwegian Red Cross, 2022;[169]
- *Addressing sexual violence against men, boys, and LGBTIQ+ persons in humanitarian settings: a field-friendly guidance note by sector,* Women's Refugee Commission, 2021;[170]
- *Supporting young male refugees and migrants who are survivors or at risk of sexual violence: a field guide for frontline workers in Europe*, UNICEF's Regional Office for Europe and Central Asia and the Women's Refugee Commission's, 2021;[171]
- *Improving men's uptake of HIV testing and linkage to services*, World Health Organization, 2021;[172]
- *HIV prevention, testing, treatment, care and support in prisons and other closed settings: a comprehensive package of interventions*, UNODC, ILO, WHO, UNFPA and UNAIDS, 2020;[173]
- *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations*, WHO;[174]
- *Blind Spot: Reaching out to men and boys*, UNAIDS, 2017;[175]
- *Adolescent boys and young men*, UNFPA, 2016;[176]

Recommendations

121. Recommendations for ways forward are outlined below. These are based on the evidence reviewed for this background note, the gaps identified, the available guidance, and the experiences of successful approaches and interventions.

122. **Increase men's use of health services and make services more easily available to men**

- Strengthen national HIV strategies by elaborating specific approaches to reach men in all their diversity. Specific attention is needed for men who are often left out by HIV responses: poorer men, ethnic and racial minorities and indigenous people, heterosexual men, clients of sex workers, male sex workers, gay men and other men who have sex with men, men with disabilities, transgender men, drug users, prisoners and other people in closed settings.
- Provide differentiated health services with men-friendly characteristics—regarding who provides the services and when, where and which services are provided—to address gaps in testing, prevention and treatment, and in the provision of comprehensive health care.
- Reach men through their sexual partners and spouses, and engage them more systematically in maternal and child health services and sexual and reproductive health services, including through strategies such as couples HIV testing and partner-assisted notification.
- Use communications that are targeted at men to increase HIV testing, treatment and adherence, and prevent transmission.

- Ensure that VMMC is truly voluntary and ethical, and that it is offered at scale in all priority locations as one option within a combination of HIV prevention measures and broader health support.
- Recognize that men and boys also face gender-based violence and ensure that they can access support services.
- Address stigma and discrimination in health-care settings and develop trusted service access platforms that are suited to reach men from key populations with HIV prevention, testing and treatment.
- Engage communities of men in all their diversity in all phases of the development of HIV programmes that are focused on men. Expand community-led HIV service delivery in the areas of HIV prevention, testing and treatment.

123. **Create an enabling social, legal and policy environment**

- Adopt a solid public health approach to health and HIV service access among key populations, including comprehensive harm reduction, and remove policies and laws that criminalize key populations or sanction their harassment and discrimination.
- Support organizations led by key populations to undertake collective advocacy as well as provide HIV-related services. Donors need to support community organizations with core funding.
- Challenge stereotypes of masculinity throughout the life cycle. Accommodate the diverse needs and realities of men. Remove gender inequalities and promote more equitable gender norms and institutional arrangements to the benefit of all genders.
- Enlist religious and community leaders and other figures of respect to dispel misconceptions and promote equitable gender norms and access to HIV prevention, testing and treatment for all people who need services, regardless of gender.

124. **Address data and research gaps**

- Address data and research gaps on the size of key populations and the challenges they face, particularly in countries with generalized epidemics. Ensure inclusion of men who are often left out of the picture, such as male sex workers and men who pay for sex.
- Collect data on gender and sexual violence against men and boys.
- Further disaggregate data beyond male and female categories to ensure inclusion of people with nonstereotypical gender identities, such as transgender men and people with nonconforming gender identities.

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