

USAID DISCOVER-Health Project

CHARACTERIZING THE MALE SEXUAL PARTNERS OF ADOLESCENT GIRLS AND YOUNG WOMEN IN DREAMS DISTRICTS IN ZAMBIA

The Barriers and Facilitators for HIV Service Access
and Utilization by Males 20 – 34

JSI Research & Training Institute, August 2020



THE MALE CHARACTERIZATION STUDY

AUTHORS

Muka Chikuba-McLeod (JSI)

Mercy Chisashi (JSI)

Peter Chungulo (JSI)

Luigi Ciccio (JSI)

Andrew Fullem (JSI)

Sarah Illingworth (USAID)

Caitlin Madevu-Matson (JSI)

Musonda Musonda (USAID)

Mwansa Njelesani (JSI)

Heidi O'Bra (USAID)

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CONTACT INFORMATION

JSI Research & Training Institute, Inc.
(JSI)

USAID DISCOVER-Health Project

45 Warthog Road, Kabulonga

P.O. Box 51186

Lusaka, Zambia

<https://www.jsi.com/project/usaiddiscover-health-project/>

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ABSTRACT

The “Characterizing the Male Sexual Partners of Adolescent Girls and Young Women in DREAMS Districts in Zambia” Study (herein referred to as the Male Characterization Study or MCS) was conducted by the USAID DISCOVER-Health Project, implemented by JSI Research & Training Institute, Inc. conducted in 2017 and 2018.

The mixed methods sequential study was designed to generate information about the male sexual partners of adolescent girls and young women (AGYW) most at risk of HIV infection and those already living with HIV, in order to: understand where they meet their sexual partners; identify key features of their social and sexual networks; understand and define their health seeking behaviors; and highlight the opportunities and barriers for increasing their access to health services and increasing their engagement in health and HIV prevention programs.

The ultimate goal of the MCS was to generate recommendations for improving programs and services in order to meet the needs of men and facilitate their uptake of HIV services primarily for their own health outcomes, but also to reduce HIV transmission among AGYW. Addressing and responding to the health seeking barriers faced by this population of men is critical to achieving HIV epidemic control in Zambia, by the country’s stated goal of 2020.

The study was conducted in two phases. First, a quantitative survey among AGYW characterized their male sexual partners. The second phase consisted of a qualitative survey among males who fit that AGYW sexual-partner profile. The focus group discussions and in-depth interviews conducted with the male participants revealed both the barriers and facilitators to men’s health-seeking behaviors, and the interventions and actions required to increase their access to and use of HIV services.



ACRONYMS AND ABBREVIATIONS

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
DISCOVER-Health	District Coverage of Health Services Project
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-based Violence
GRZ	Government of Zambia
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IDI	In Depth Interview
MCS	Male Characterization Study
MNCH	Maternal, Neonatal, and Child Health
MOH	Ministry of Health
NZP+	Network of Zambian People Living with HIV
PEPFAR	President's Emergency Plan for HIV/AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision

A photograph of a group of men in a room. In the foreground, a man wearing a white jacket, a blue shirt, and a grey cap sits on the floor, looking upwards with a thoughtful expression. His hands are clasped in front of him. Behind him, several other men are seated on benches or the floor, looking in various directions. The room has a yellow wall and a wooden bench. A blue semi-transparent banner is overlaid on the left side of the image, containing the text 'SUMMARY AND RECOMMENDATIONS' in white capital letters.

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

WHY DID WE DO THE STUDY?

The Problem:

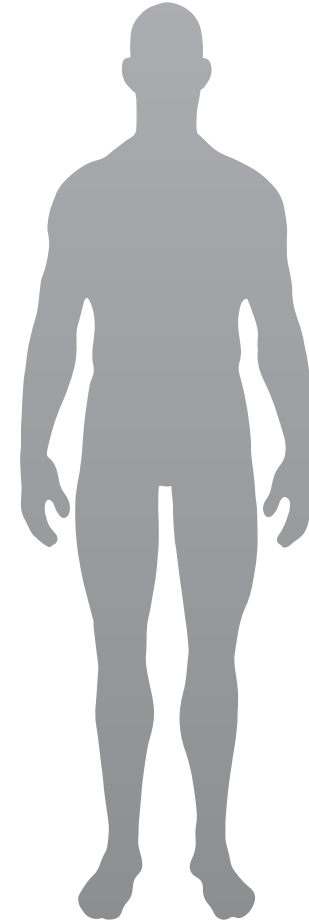
Findings from the 2016 ZAMPHIA study showed that the adult HIV prevalence rate in Zambia was **11.6%**, with the prevalence in women higher at **14.5%** compared to men at **8.6%**. HIV incidence among adolescent girls and young women (AGYW) 15-24, stood at **1.06%**, 14 times higher than the incidence in males (**0.07%**) of the same age group.

The higher infection rates among AGYW were thought to be a result of a cycle of transmission in which older men (25-34) who have high HIV rates transmit HIV to AGYW. In turn, as these girls and young women age up, they begin to infect their longer-term partners (men 25-34) who are HIV negative.

A key aspect to this transmission cycle is that both men 25-34 and AGYW had poor viral load suppression rates (under 40%) and were thus able to transmit HIV to their sexual partners.

To break the transmission cycle, there was a need to engage both AGYW and their sexual partners in HIV prevention.

However, lack of information and research regarding the characteristics of men who are the sexual partners of AGYW, and the barriers and facilitators they face in accessing and utilizing HIV services, hindered implementation of informed and effective HIV prevention interventions.



Lack of information regarding the characteristics of the male sexual partners of AGYW and the barriers and facilitators they face in accessing and utilizing HIV services, hindered implementation of informed and effective HIV prevention interventions.

INTRODUCTION

WHY DID WE DO THE STUDY?

Study Aim

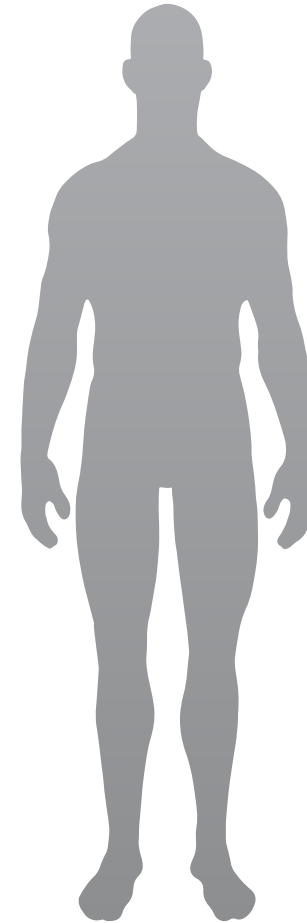
To gather information about the male sexual partners of AGYW most at risk of HIV infection and those already living with HIV in Zambia in order to more effectively target and improve male HIV prevention programming and services.

Study Purpose

To generate information to guide HIV prevention programming for AGYW's male sexual partners in order to reduce the risk of sexual acquisition of HIV for AGYW.

Study Objective

To describe the socio-demographic characteristics of AGYW's male sexual partners, understand where AGYW meet their sexual partners, identify key features of their social and sexual networks, understand and define the health seeking behaviors of the male sexual partners, and highlight the opportunities and barriers for increasing their access to health services and their engagement in health and HIV prevention programs.



Identifying and characterizing male sexual partners of AGYW is a critical step to inform the design of appropriate and impactful targeted HIV programs and services for males and reduce HIV transmission among AGYW.

STUDY DESIGN

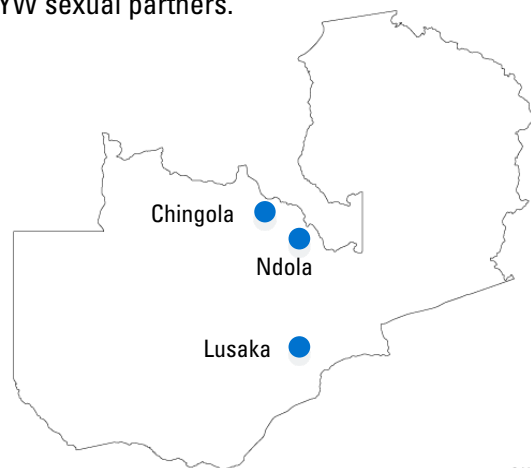
HOW DID THE STUDY WORK?

Data were collected in two sequential phases:

(1) Quantitative assessment of AGYW to provide a profile of their male sexual partners;

and then

(2) Qualitative assessment of men who met the profile for AGYW sexual partners.



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Phase I: Quantitative Surveys



Who? Adolescent Girls and Young Women, 15-24 years

- AGYW participating in DREAMS programs
- AGYW living with HIV

What questions did they answer?

- Who are their male sexual partners?
- How and where do they meet their sexual partners?

Phase II: Qualitative Interviews & Focus Groups



Who? Young Men, 20-34 years, who met the profile from Phase 1

- Potential male partners of AGYW from the general population
- Potential male partners living with HIV

What questions did they answer?

- What factors influence their access to health services?
- To what extent are the current HIV/AIDS prevention programs packaged and targeted to address their needs?

Important terms used during qualitative phase analysis

User: a respondent who reported having received one or more of the following services: HIV counselling and testing (HTS); voluntary medical male circumcision (VMMC); and/or HIV treatment (ART)

Non-user: a respondent who reported not having received any of the following services: HTS, VMMC, and/or ART

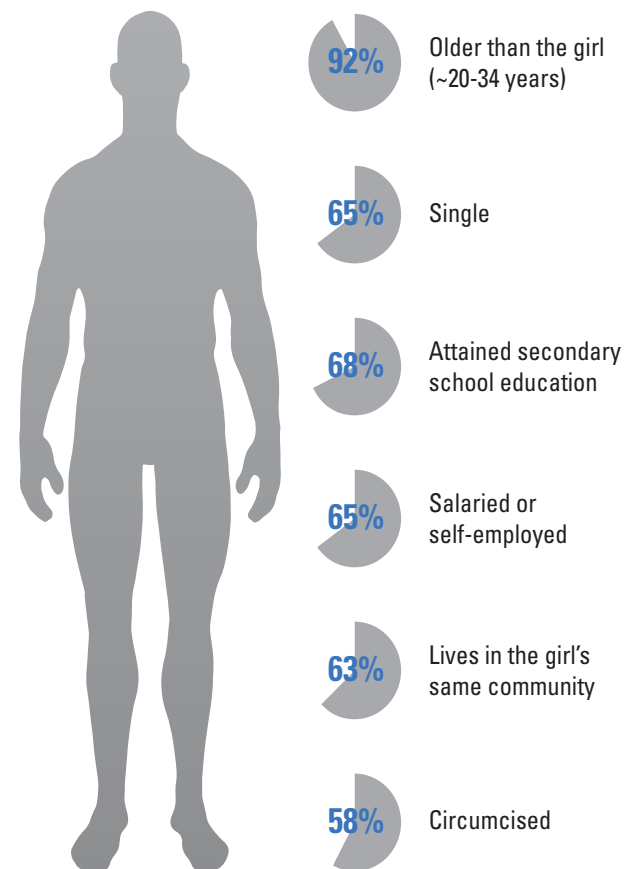
PLHIV: person living with HIV or people living with HIV

RESULTS

WHAT DID AGYW TELL US?



Figure 1: Profile of male partner



For full results, please see: [Annex 3](#) for Phase I Quantitative Results and [Annex 4](#) for Phase II Qualitative Results

RESULTS

WHAT DID MEN TELL US?



Fear of HIV diagnosis and living with HIV, and health system shut-out, fed and compounded limited access to credible health and HIV information, push these men to delay HIV care and treatment, until illness leaves them with no option, but to seek care.

Figure 2: Male partner factors affecting HIV service access

Facilitators

Client Factors and Support Networks

- ✓ Peer influence
- ✓ Persistent ill health and wanting to get better
- ✓ Family/partner support

Health System Enablers

- ✓ Positive attitude from health care staff

Barriers

Fear and Apprehension

- HIV diagnosis and living with HIV
- Failing to measure up to male societal norms
- HIV-related physical and psychological pain
- Undignified illness and death from HIV

Health System Shut-out

- Negative attitude from health care staff
- Perceived lack of privacy and confidentiality
- Long wait-times and high opportunity costs
- Health facilities/services tailored for women and children, not men

For full results, please see: [Annex 3](#) for Phase I Quantitative Results and [Annex 4](#) for Phase II Qualitative Results

DISCUSSION

WHAT DID WE FIND OUT?

The men who access and use services tap into a combination of individual factors, support networks, and health-system enablers to drive their behaviors and choices

This includes one or more of the following:

- positive peer support/influence, which is very important in decision-making about health and using HIV services;
- family/partner support, which men often only access when illness becomes obvious/serious, but which is important for both initial access and sustaining use;
- persistent ill-health, which when all else has failed, compels them to go to the clinic; and
- positive health staff attitude, which is critical for sustaining use.

This provides an opportunity to harness peer influence, family/partner support and positive staff attitude to promote and increase HIV/health service access and utilization.

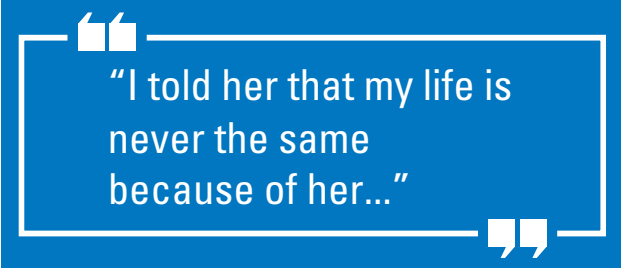
The men fear being diagnosed with HIV and feel shut-out of the health system

The men in this study fear a positive HIV test/living with HIV. Most of the men living with HIV they know were diagnosed late, with symptomatic HIV. The men therefore don't have many examples of men on ART who are strong, healthy and well. They view HIV as emasculating, isolating and a sign of weakness.

HIV diagnosis is seen as the start of an embarrassing/stigmatizing downward slope to early death. Many believe they have HIV from past/current high-risk behavior but are too afraid to test.

"The counselor I found, she was very encouraging; I came to the clinic because I was down with malaria, then she asked me if I had ever tested for HIV...she was so nice to me that I came back to her the day I started medication, ARVs – I told her that my life is never the same because of her."

- PLHIV, Ndola



"I told her that my life is never the same because of her..."

DISCUSSION

WHAT DID WE FIND OUT?

The men fear being diagnosed with HIV and feel shut-out of the health system

These men also feel shut-out of the health system. A number of factors act singly or in combination to make the health system inaccessible to them including:

- experienced, observed or peer-reported negative staff attitude, which emerged as the most significant health system barrier to HIV service access/use;
- perceptions that clinics are set-up for (and thus over-run by) women/children, which creates a strong cultural barrier for the men;
- strong preference for male HIV service providers, but clinics don't often offer choice; and
- issues related to confidentiality, long clinic queues/wait-times, and operating hours/service location that make service access and utilization difficult.

Given the limited contact with the health system, these men also have limited access to reliable health/HIV information to inform their health behaviors and choices. Peers, who are often equally ill-informed, are the primary source of HIV/health opinion that shapes individual health-seeking behavior. Most of these men are not aware of the benefits of early HIV diagnosis/ART. They self-medicate or use faith and traditional healers as their ports of first call for healthcare. When the problem persists/worsens or becomes obvious, as a last resort, they go to the clinic.

Fear of HIV diagnosis, lack of credible health/HIV information, and health system shut-out push these men to delay HIV care and treatment.

“...the people attending talk sarcastic...”

“The things we say about someone who is HIV positive, the way we treat those we know to be positive, the assumptions we make about promiscuous behavior. ... it is easier not to know than to be that person everyone points at and makes jokes about!”

- User, Lusaka

“You find that when you go to the clinic, the people that welcome you look at you as if you have committed a crime. Even when you are standing on the queue the people attending talk sarcastic.”

- PLHIV, Chingola

“...it is easier not to know than to be that person everyone points at and jokes about ...”

DISCUSSION

WHAT DO OUR FINDINGS MEAN?

These are 'well' and busy men: Most of the men in this study population, are 'well' 20-34 year-olds. Some may have HIV infection, but are not ill, and are therefore unaware of their positive HIV status and see no need and /or have no time to access HIV services.

Redesigning HIV services and programs is an imperative: These men will not access and utilize HIV services when they feel well, unless we redesign and tailor services to address barriers and meet some of their their needs. If we do nothing, they will continue to utilize clinics as a last resort and arrive already very sick, with symptomatic HIV.

Resonant messaging required: Many men in this study were not knowledgeable about HIV and health. Our redesign of HIV programs and services must therefore be

accompanied by HIV and health messaging that resonates with these men and encourages preventive health behaviours, service uptake and adherence to care.

Address fear and support health system fixes: Effective HIV service and program redesign requires interventions that address fear and fear fuels, especially perceptions about masculinity and support health system fixes to make the health system more accessible to these men

In for the long haul: While immediate male health-seeking behavior change would be ideal, it is important to recognize that change will most likely take place gradually and build in a supportive community (including peers), services, and SBCC processes for cementing incremental gains.

"I was not very surprised to be found HIV positive. In the first place, I had a problem, I had sores all over my head and I realized that I just had to come to the clinic...five days after I started ARVs I was surprised that all the sores all over my head disappeared!"

- PLHIV, Lusaka

"The men have to be sensitized, they have to be educated about the dangers of HIV, and they also have to be told the advantages of testing for HIV and starting medication if they are found to be positive. People should be told that being positive is not the end of the world; they should know that when you are positive you can still live as long as you take good care of yourself..."

- User, Lusaka

“...if you go to the clinic, you know you will find a big queue and you will be on that queue with women and children...”

RECOMMENDATIONS

HOW TO ADDRESS FEAR AND APPREHENSION?

1. Increase male access to correct and consistent HIV information: Provide clear, correct, and consistent HIV education and information in order to dispel myths and misconceptions, which fuel fear and apprehension, and assist men to better understand their health issues and make informed health choices and decisions.

2. Harness influencers that men listen to: Men listen to peers, faith leaders and other influential opinion-leaders. These influencers need skills and the capacity to provide correct and consistent HIV messaging and information.

3. Address social-cultural 'fear fuels': Tackle social-cultural norms of what a 'real man' should be, particularly those that facilitate high risk behaviors and prevent timely uptake of HIV services.

This may require building effective partnerships and leveraging traditional, civil and other structures/ organizations that work with men, to address issues of masculinity in relation to HIV.

4. Improve psychological and physical pain management: Refer to or incorporate programs that help manage psychological issues and pain related to HIV or health services. Programs such as VMMC must ensure adequate pain control. Requiring clients to buy pain medication is not always appropriate, as some can't afford it and end up suffering significant pain.



“... the best way you guys can help us is the way you have done with DREAMS, you just make a group for [male] youth that meet and talk about HIV/AIDS issues. I am sure this can help men to test...”

- Non-user, Ndola

RECOMMENDATIONS

HOW TO MAKE THE HEALTH SYSTEM MORE ACCESSIBLE TO MEN?

1. Address provider knowledge and attitude:

Respectful, empathetic, knowledgeable and professional conduct from providers in HIV services is important not only for initiating use, but also for sustaining use and avoiding program retention failures.

2. Increase provider choice, increase male providers:

Offering men a choice to be seen by a provider (male) who they are comfortable with is important for effective healthcare delivery.

3. Offer evening and weekend clinics:

Facilitate access for men who work during normal working hours and are unable to leave work to access care. Often, when weekend clinics are established, women and children also come in numbers. It is important to establish male-friendly

services, and tailor them to the needs of men, e.g. labelling a part of the clinic or a time slot “Men’s Clinic” helps create a space for men in busy clinics.

4. Provide integrated male services:

Men’s clinics should preferably provide integrated male services, in order to avoid stigmatizing HIV services. Specific ART pick-up points and days should be avoided.

5. Address privacy and confidentiality:

Facilities must do all they can to ensure they safeguard client confidentiality and privacy through (1) Provider re-orientation to respect client confidentiality and (2) Space reconfiguration to improve privacy.

“So, we need a clinic specifically for men...if it is possible even just create rooms where men can go and lock themselves away from others...”

- User, Lusaka



CONCLUSION

"I am a businessman; business is about how you receive the customers... for the customers to come back next time, you must have received them well the first time they came to your shop. That is the same with the nurses at the clinic; if the people have to continue coming to seek their medical treatment, nurses must show them a good hospitality."

- Non-user, Chingola



As Zambia edges towards HIV epidemic control, there is a key gap that needs to be addressed: finding the missing AGYW and men and providing them with a range of HIV services to them, including ART. The Male Characterization Study provides some insights about the barriers men face in accessing and using HIV services and provides helpful recommendations for improving programs and services in order to meet the needs of men.

Fear and apprehension emerged as nuanced but strong and pervasive barriers to HIV service uptake, as men delay service access until the problem is so serious, and medical attention is unavoidable. Real and perceived health system barriers, especially negative provider attitudes and a perceived priority towards women and children, make men feel shut-out of accessing HIV

and other health care services. Positive peer influence, strong family and other social support systems, and positive provider attitudes emerged as significant facilitators to service access and uptake.

Proposed interventions to address men's fears, including peer-led interventions, aim to improve their health seeking behaviors. Proposed health system interventions support tailoring service delivery to meet men's circumstances and needs and include providing differentiated service delivery and addressing negative staff attitudes.

Improved HIV knowledge, together with a more welcoming and accommodating health system, would greatly increase the effectiveness of HIV programs in reaching and effectively engaging both young men and AGYW towards HIV epidemic control in Zambia.

A photograph of a group of men in a room. In the foreground, a man wearing a white jacket, a blue shirt, and a grey cap sits on the floor, looking upwards and to the right. Behind him, several other men are seated on a bench or chairs, looking in various directions. The room has yellow walls and a wooden bench. A blue semi-transparent banner is overlaid on the left side of the image, containing the text 'ANNEXES: DETAILED STUDY INFORMATION' in white capital letters.

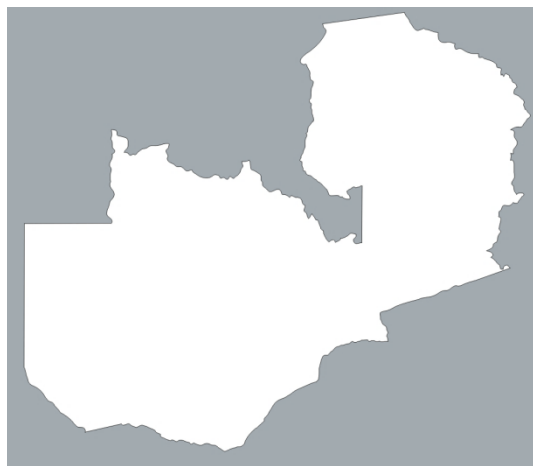
ANNEXES: DETAILED STUDY INFORMATION



ANNEX 1: BACKGROUND

INTRODUCTION

The HIV prevalence among the adult population in Zambia is 11.1%: ZDHS 2018



At study design, findings from the 2016 ZAMPHIA study showed that the adult HIV prevalence rate in Zambia was 11.6%, with the prevalence in women higher at 14.5% compared to men at 8.6%. HIV incidence among adolescent girls and young women (AGYW) 15-24, stood at 1.06%, 14 times higher than the incidence in males (0.07%) of the same age group.

The higher infection rates among AGYW were thought to be a result of a cycle of transmission in which older men (25-34) who have high HIV rates transmit HIV to AGYW. In turn, as these girls and young women age up, they begin to infect their longer-term partners (men 25-34) who are HIV negative.

A key aspect to this transmission cycle is that both men 25-34 and AGYW had poor viral load suppression rates (under 40%) and were thus able to transmit HIV to their sexual partners.

To break the transmission cycle, there was need to engage both AGYW and their sexual partners in HIV prevention.

However, lack of information and research

regarding the characteristics of men who are the sexual partners of AGYW, and the barriers and facilitators they face in accessing and utilizing HIV services, hindered implementation of informed and effective HIV prevention interventions.

Therefore, identifying and characterizing these men is a critical step to help design appropriate and impactful targeted services.

The [Characterizing the Male Sexual Partners of Adolescent Girls and Young Women in DREAMS Project Districts in Zambia Study](#) (herein referred to as the [Male Characterization Study](#) or MCS) characterized the male sexual partners of AGYW at risk of HIV, in order to improve targeting of HIV programs for males, and in order to reduce HIV transmission among AGYW.

The following detailed report highlights the key findings from the mixed methods study implemented in 3 DREAMS districts in Zambia.

The report also highlights recommendations to inform future programming and service delivery.

USAID DISCOVER- HEALTH PROJECT BACKGROUND



High quality health services and
products where they are needed most

The USAID DISCOVER-Health Project is a six-year United States Agency for International Development (USAID)-funded project that supports the Government of Zambia (GRZ) through the Ministry of Health (MOH), in the efficient and effective control of the HIV epidemic, childhood illnesses, and unplanned pregnancies in order to reduce associated morbidity and mortality. The Project aims to improve the lives of Zambians by ensuring equitable access to and use of high-quality HIV, maternal, neonatal and child health (MNCH), and family planning and reproductive health (FP/RH) services and products at district and community level.

Implemented by JSI Research & Training Institute Inc. (JSI), USAID DISCOVER-Health is designed and intended to take quality health services to underserved communities and populations, in order to address critical gaps in both access and equity, towards achieving defined public health goals and outcomes, including achieving HIV epidemic control in Zambia. These services, therefore, are designed to reach hard-to-reach pockets of the population that the mainstream health system is not reaching, including segments of people living with HIV (PLHIV) who had challenges accessing HIV treatment and

other services. Therefore, program rollout ensured that the services provided expanded access and equity, with strict attention paid to avoiding duplication. Further, the Project utilizes and sustains a health model that maximizes the relative strengths of the public and private sectors to deliver health products and services that reach all beneficiaries and consumer markets.

USAID DISCOVER-Health contributes to GRZ's efforts to achieve HIV epidemic control in Zambia, by 2020. Through direct service delivery and a predominantly outreach-based service delivery model, the Project provides greater access to HIV testing services (HTS), antiretroviral therapy (ART), prevention of mother to child transmission (PMTCT), voluntary medical male circumcision (VMMC), pre-exposure prophylaxis (PrEP), and other services to selected priority and key populations.

Under the DREAMS Initiative in Zambia, USAID DISCOVER-Health is funded to reach males aged 15 years and older (potential sexual partners of AGYW) with appropriate services, including VMMC, ART, and FP/RH services, that not only benefit these men personally, but also benefit their sexual partners through prevention of HIV transmission and other health benefits.

MALE CHARACTERIZATION STUDY

RESEARCH AIM, QUESTIONS, AND OBJECTIVES

Research Aim: To gather information about the male sexual partners of AGYW most at risk of HIV infection and those already living with HIV in Zambia in order to more effectively target and improve male HIV prevention programming and services

Primary Research Questions


1. Who are the male sexual partners of AGYW? What are their socio-demographic characteristics?
2. How and where do the AGYW meet their sexual partners?
3. What factors influence men who are the sexual partners of AGYW to access health services? What motivates male sexual partners to seek services? What barriers do the male sexual partners encounter as they seek health services?
4. To what extent are the current HIV/AIDS prevention programs adequately packaged and appropriately targeted to meaningfully address the needs of male sexual partners of AGYW?

The **specific objective** of this study was to describe the socio-demographic characteristics of AGYW's male sexual partners; understand where they meet; identify key features of their social and sexual networks; understand and define their health seeking behaviors; and highlight the opportunities & barriers for increasing

their access and use of health and HIV services.

The **sub-objectives** of the MCS were to:

1. Describe AGYW (including DREAMS participants, PLHIV AGYW, and vulnerable non-DREAMS AGYW) in terms of their socio-demographic characteristics, male sexual partners, and the circumstances of their sexual relationships in order to obtain insights into their male sexual partners.
2. Identify the current HIV prevention services accessed and utilized by AGYW potential male sexual partners, and to distinguish and describe opportunities and gaps in service provision and targeting to inform programming.
3. Identify AGYW potential male sexual partners' motivators and barriers to accessing and utilizing HIV-prevention services and sustaining care.



ANNEX 2: METHODOLOGY

STUDY DESIGN

OVERALL PROCESS



STUDY LOCATION

The study was implemented in 3 DREAMS districts in Zambia – Chingola, Ndola, and Lusaka – with higher overall HIV prevalence than the national average.

OVERALL STUDY DESIGN

MCS utilized a **mixed methods approach** with a sequential strategy. Data were collected in two phases: first a quantitative assessment of AGYW provided a profile of their male sexual partners. This was followed by a qualitative assessment of men who met the profile for AGYW sexual partners. Prior to the launch of the study, letters of consent for participation were obtained from key partners, including MOH, USAID, CDC, and others.

Phase I: Quantitative Surveys

Who? Adolescent Girls and Young Women, 15-24 years

- AGYW participating in DREAMS programs
- AGYW living with HIV

What questions did they answer?

- Who are their male sexual partners?
- How & where do they meet their sexual partners?



Phase II: Qualitative Interviews & Focus Groups

Who? Young Men, 20-34 years, who met profile from Phase 1

- Potential male partners of AGYW from the general population
- Potential male partners living with HIV

What questions did they answer?

- What factors influence their access to health services?
- To what extent are the current HIV/AIDS prevention programs packaged & targeted to address their needs?



PHASE I

QUANTITATIVE STUDY DESIGN

109 question survey covering socio-demographic data, sexual networks & behaviors, service utilization, and attitudes & beliefs

ELIGIBILITY CRITERIA

For **DREAMS AGYW**, participants had to: be female; be aged 15 – 24 years; report ever having had sex; reside in the recruitment districts; and participating in a DREAMS program.

For **PLHIV AGYW**, participants had to: be female; be aged 15 – 24 years; report ever having had sex; and know they were HIV positive and be in HIV care and treatment. Many were members of the Network of Zambian People Living with HIV/AIDS (NZP+).

Women in either group who were too physically or psychologically unwell, determined by the study and site providers, were not included.

RECRUITMENT and CONSENT

In December 2017, the study team met with DREAMS site managers and NZP+ coordinators to provide orientation to the study, get their approval, and obtain a list of their participants/members. The study team selected a systematic sample from each list, contacted those selected to inform them about the study and ask if they were interested in participating. If those selected were not found or did not agree to participate, the next person on the list was contacted until each site reached the pre-determined enrollment.

All adult participants (18+ years) were required to provide written consent. For those under 18 years

old, informed assent and parental/ guardian written consent were required.

All participants received 50 Zambian Kwacha (USD 5), mainly to cover transport costs.

SAMPLE SIZE

The sample was designed to enable comparisons between the 15-19 and 20-24 age groups, based on their relative HIV prevalence (4.8% and 11.2% respectively) with 90% power, and aimed to enroll 804 AGYW.

SURVEY TOOL

A structured survey was administered to create a profile of AGYW's male sexual partners. The survey collected information in the following domains:

- Socio-demographic data of respondents (AGYW) and their male sexual partners
- Key features of AGYW's sexual networks and behaviors
- Attitudes & beliefs about gender norms that may influence sexual behavior
- Use of HIV-related health services, including if AGYW discuss health services with their sexual partners and/or encourage them to use services such as HTS, VMMC, and ART

PHASE II

QUALITATIVE STUDY DESIGN

Recruitment locations for general population



Location: Markets
Occupations: Traders, welders, carpenters, plumbers, bricklayers



Location: Companies
Occupations: Casual workers & permanent employees in construction, mining, & other projects



Location: Bus stations
Occupations: Drivers, conductors, supervisors

Recruitment location for PLHIV



Location: ART Clinics
Target population: Male PLHIV on ART

ELIGIBILITY CRITERIA

For **potential male partners with unknown HIV status**, participants had to: be male; be aged 20 – 34 years; be in a sexual relationship; educated (at least secondary school); and have a formal or informal job.

For **PLHIV potential male partners**, participants had to meet all the criteria above, and to know they were HIV positive.

Men in either group who were too physically or psychologically unwell, determined by the study and site providers, were not included.

RECRUITMENT and CONSENT

In May-July 2018, the study team met with gatekeepers (employers, coordinators, civic leaders etc.) familiar with recruitment locations to provide orientation to the study, to get their approval, and to help identify potential participants. Recruiters (who were part of the research team) administered a standard screening tool to determine eligibility.

When recruiting from non-clinic locations, the study team categorized potential participants as users of HIV services if they currently or in the past had accessed services such as HTS, VMMC, or ART. Enrolled participants were invited to appointment times and assigned to user or non-user focus group discussions (FGD).

When recruiting from ART clinics for PLHIV male participants, the study team arranged a convenient time and location with potential participants to conduct an in-depth interview (IDI).

All participants were required to provide written consent. All participants who completed FGDs or IDIs received transport reimbursement of 50 Zambian Kwacha (USD 5) mainly to cover transport costs.

SAMPLE SIZE

The study enrolled 9 PLHIV men for IDIs, and 6-12 men per FGD for 6 FGDs with users and 9 FGDs with non-users.

GUIDING QUESTIONS

FGDs, lasting approximately 1 hour, and IDIs, lasting up to 90 minutes, were conducted using guiding questions in the following domains:

- Why do some men in Zambia access HIV services?
- Why do some men in Zambia not access HIV services?
- How can we design HIV services so that men in Zambia are more likely to access and use them?
- Why do some men force their female partners to have sex unwillingly?

DATA COLLECTION AND ANALYSIS

DATA COLLECTION

For quantitative data from **Phase I**: Data collection was supported using SurveyCTO software on tablets using English and the two main local languages (Bemba and Nyanja) used in the study locations. Daily spot-checks were conducted to ensure completeness and quality of data.

For qualitative data from **Phase II**: Trained research assistants recruited participants from the study locations based on the set profile criteria using a checklist.

FGDs of six to twelve participants each and IDIs were led by experienced, trained research assistants (social scientists) and were conducted in English, Bemba, or Nyanja. Each research assistant used an interview guide to follow during discussions.

Conversations were recorded using a digital audio recorder and the audio files were stored on a secure server. All the data from digital audio files were later translated and transcribed in English.

ANALYSIS

For quantitative data from **Phase I**: Microsoft Excel and Stata IC were used to generate frequencies and cross-tabulations to describe the social, demographic, economic characteristics, and sexual behaviour of the participants which characterised their sexual partners.

For qualitative data from **Phase II**: Data analysis used modified coding thematic framework to code the transcripts, group the codes, identify emerging themes, and describe and explain the findings.

LIMITATIONS

STUDY LIMITATIONS & ETHICAL CONSIDERATIONS



LIMITATIONS

Phase I only targeted DREAMS AGYW who were sexually active. The response rate might have been influenced by fear of being known that they were sexually active in a DREAMS context, which promotes abstinence, in addition to family planning and HIV prevention services.

Phase II was planned to use participants who met the profile of sexual partners of AGYWs and the AGYWs were encouraged to ask their partners to participate in FGDs. Very few of the actual sexual partners of AGYWs who were invited or introduced showed up, and most participants were finally recruited on the basis of the profile described in Phase I.

Participants in Phase II were predominantly drawn from urban DREAMS areas and thus the findings might not completely reflect the perceptions of access to and use of health services among all men who are sexual partners of AGYW in other settings in Zambia.

ETHICAL CONSIDERATIONS

The MCS was conducted with the utmost respect for the ethics of human subjects research. USAID DISCOVER-Health took necessary precautions to ensure risks to respondents were minimized and information was kept confidential.

The study protocol was reviewed and accepted by JSI Institutional Review Board and Eres Converge IRB in Lusaka, Zambia.

All participants provided written informed consent and participants under the age of 18 were required to provide written parental/ guardian consent to participate. The research assistants were thoroughly trained in ethics and though qualified social scientists, were re-oriented in interviewing skills, including how to ask potentially sensitive questions about knowledge, attitudes, and practices related to sexual behavior, partner relationships, and risk of HIV infection.

No names or other potentially identifiable information was collected.



ANNEX 3: PHASE I QUANTITATIVE RESULTS

QUANTITATIVE RESULTS

RESPONDENTS' PARTICIPATION AND CHARACTERISTICS

810 AGYW reported information on 1,743 male sexual partners

PARTICIPATION

1,610 AGYW were screened for eligibility, of which 810 (50%) were found to be eligible respondents. Of these 810, 556 (69%) AGYW were recruited from DREAMS programs, while 254 (31%) were PLHIV recruited primarily through NZP+, of whom 37 AGYW PLHIV also participated in DREAMS.

While all 810 respondents answered socio-demographic and behavioral questions, and contributed to the profile of their male partners, those who reported being sexually active in the 12 months before the survey (568) were asked more specific questions about their recent sexual relationship. Therefore, in selected cases the denominator used is not 810 (all respondents), but 568 (respondents who were sexually active in the prior 12 months).

CHARACTERISTICS

Among all participants, there were 259 (32%) girls aged 15-19, and 551 (68%) young women aged 20-24 years (Table 1). Almost two-thirds (65%) of participants

lived in Lusaka, with 22% from Ndola and 13% from Chingola.

Of the 810 respondents, 48% had some degree of secondary education (grade 8-12), 24% were married (most from the 20-24 years old group), and 70% were living with their parents or relatives. Among those 20-24 years old, 32% lived with their husband.

Just 16% of them had a job, formal or informal, and only 5% were the main household income providers, with their parents, other relatives or husband being the bread-winner in the rest of cases.

More than half (58%) of respondents reported having taken alcohol at some point, with 71% of those getting drunk at least once. However, the frequency of drinking was at least once a week in only 13% of the AGYW. Alcohol consumption appeared to take place mostly at home with friends and relatives, as just 18% of them reporting going to a public drinking place (bar, disco or night club) to drink within the prior week. The use of drugs was extremely uncommon (2%).

Table 1. Socio-demographic and behavioral variables (total contains row %, all others contain column %)		15 – 19 years		20 – 24 years		All	
		n	%	n	%	n	%
Total participants (% of all participants)		259	32%	551	68%	810	100%
District	Chingola	33	13%	70	13%	103	13%
	Lusaka	171	66%	357	65%	528	65%
	Ndola	55	21%	124	23%	179	22%
Education	None	2	1%	17	3%	19	2%
	Primary	147	57%	240	44%	387	48%
	Secondary	105	41%	277	50%	382	47%
	University / College	1	0%	4	1%	5	1%
	Question not answered	4	2%	13	2%	17	2%
Relationships	Married	12	5%	181	33%	193	24%
	In a relationship but not married	0	0%	0	0%	0	0%
	Single	243	94%	327	59%	570	70%
	Other (divorced, separated)	4	2%	43	8%	47	6%
Accommodation	Living with parents or relatives	231	89%	334	61%	565	70%
	Living with husband	10	4%	177	32%	187	23%
	Alone	0	0%	15	3%	15	2%
	Other (friends, boyfriend)	1	0%	2	0%	3	0%
	Question not answered	17	7%	23	4%	40	5%
Employment	Formal job	1	0%	22	4%	23	3%
	Informal job	13	5%	104	19%	117	14%
	None	237	92%	416	75%	653	81%
	Question not answered	8	3%	9	2%	17	2%
Main income provider for household	Parents or relatives	243	94%	346	63%	589	73%
	Husband	9	3%	172	31%	181	22%
	AGYW participant	7	3%	33	6%	40	5%
Alcohol and drug use	Ever had alcohol	152	59%	320	58%	472	58%
	...If ever had alcohol, ever been drunk	103	68%	232	73%	335	71%
	...If ever had alcohol, drinks at least once a week	16	11%	47	15%	63	13%
	Went to public drinking place within past 7 days	40	15%	108	20%	148	18%
	Ever used other drugs	9	3%	10	2%	19	2%

QUANTITATIVE RESULTS

SEXUALLY-RELATED PRACTICES

568 AGYW reported being sexually active in the 12 months before the survey

SEXUAL PRACTICES AND BEHAVIOR

More than 9 out of 10 (91%) respondents who had a sexual partner in the last 12 months were aware of their own HIV status, of whom 81% had disclosed the information to their current male partner (Table 2). Of those who ever tested for HIV, 65% had done it in the 3 months before the survey took place.

Within the same group, 69% reported using a family planning method, of which condoms represented 48%, injectable contraceptives 25% and oral contraceptives 7%.

Of the 160 (31%) sexually active AGYW on oral and injectable contraceptives, only 6% also use condoms, signifying a need to layer improved messaging about using condoms (and now PrEP) whilst on other contraceptive methods, to prevent HIV.

40% of respondents reported using a condom during the last sexual encounter. This was more common among 15-19 year olds than the older group of respondents, which includes more married AGYW.

In 81% of cases, the male partner is the one procuring the condom, either from a health facility or purchasing it from a pharmacy.

Over three quarters of respondents felt comfortable and free to ask their partners to use a condom.

TRANSACTIONAL AND FORCED SEX

13% of female respondents reported having engaged in transactional sex with their male partners in the past 12 months. In most cases, sex had been exchanged for cash, while in fewer cases it was exchanged with gifts, like a phone. Out of those who had some form of transactional sex, 25% used a condom.

About 26% of female respondents had experienced forced sex from their partner in the past 12 months, while 21% felt pressured by them to engage in sexual activity. Overall, the proportion of those who were either forced or pressured is 31%, with no difference across the age groups.

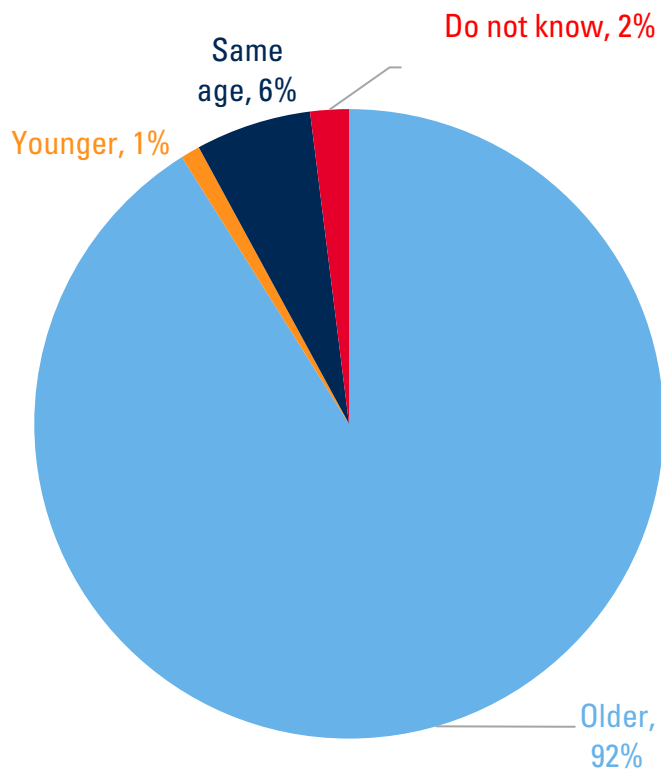
These findings prompted the addition of two questions on transactional sex and forced sex to the qualitative phase of the study.

Table 2. Sexual Practices and Behaviors (total contains row %, all others contain column %)		15 – 19 years		20 – 24 years		All	
		n	%	n	%	n	%
Had sex in last 12 months (% of all participants)		166	64%	402	73%	568	70%
Family planning	No FP method used or unknown	64	39%	111	28%	175	31%
	Any FP method used	102	61%	291	72%	393	69%
	...If any FP used, condoms	71	70%	118	41%	189	48%
	...If any FP used, injectable contraceptives	20	20%	120	41%	140	36%
	...If any FP used, oral contraceptives	5	5%	37	13%	42	11%
HIV	Aware of own HIV status	142	86%	377	94%	519	91%
	...If aware of HIV status, tested within last 3 months	44	31%	112	30%	156	30%
	Disclosed HIV status to current partner	101	61%	322	80%	423	74%
Condom use	Freedom to ask partner for condom	119	72%	318	79%	437	77%
	Condom use in last intercourse	99	60%	127	32%	226	40%
	...If yes, partner brought the condom	92	93%	91	72%	183	81%
Transactional sex	Engaged in transactional sex	24	14%	53	13%	77	14%
	...If yes, condom used in transactional sex	8	33%	11	21%	19	25%
Forced or pressured sex	Forced sex	41	25%	107	27%	148	26%
	Pressured for sex	38	23%	80	20%	118	21%
	Either forced or pressured	53	32%	124	31%	177	31%

QUANTITATIVE RESULTS

MALE PARTNERS AND AGE

Figure 3. Relative age of male partners



NUMBER OF MALE PARTNERS

The 15-19 year old female respondents reported an average of 2 lifetime sexual partners and the 20-24 year old respondents reported an average of 2.5 partners.

The average age for sexual debut was 17 years old for respondents in both 15-19 and 20-24 age groups.

MALE PARTNER AGE

Out of all male partners the respondents reported, 92% were older than the respondents, 6% of same age and only 1% were younger (Figure 2). The age difference was less than 5 years in over half of the cases, while a 10 year age difference was less common (10%).

Based on the respondents' answers and on their current age, we established that 92% of their male partners were aged 20-34 years old; and that 33% were 15-24 years old.

Table 3. Male partner age difference	n	%
1-2 years older	314	23%
3-4 years older	400	29%
5-9 years older	498	37%
10+ years older	137	10%
Older but unsure how much	11	1%

QUANTITATIVE RESULTS

MALE PARTNER PROFILE

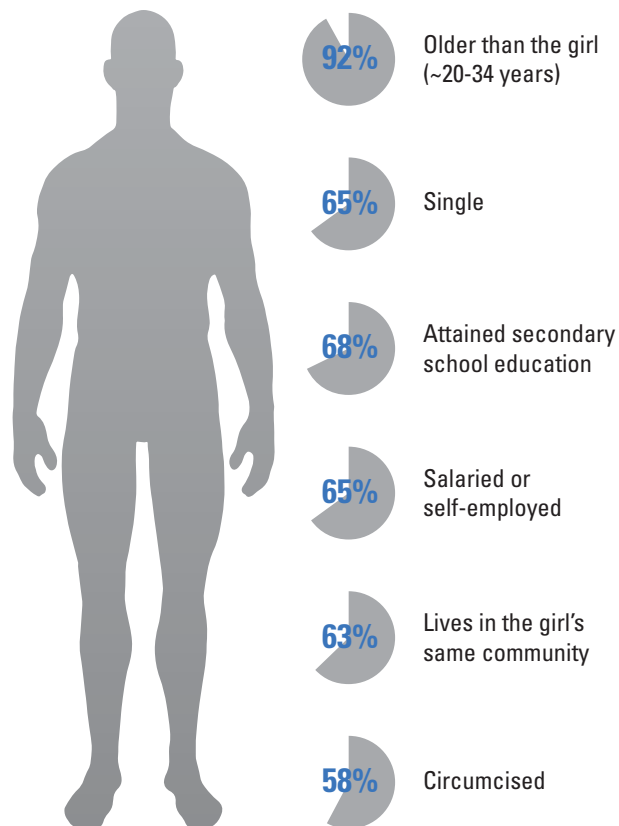


Figure 4: Male Partner Profile

MALE PARTNER PROFILE

In 63% of cases, male partners lived in the same neighborhood or community where the respondents lived.

Respondents reported that 65% of their male partners identified as single, 19% were married to the respondent, while 11% were married to someone else. A large majority of male partners were reported to be educated: 68% attained some degree of secondary education and 13% attained tertiary education.

About two thirds of the male partners (65%) were employed, whether that was formal, informal or a part-time casual job.

The place of their first meeting with the male partner was the street in almost 4 out of 10 cases (37%). Their own or a friend's house represented 23% of cases, followed by school (15%) and church (8%). Bars or dancing halls accounted for 5% of the responses.

72% of the respondents who had a sexual partner in the last 12 months knew the HIV status of their male partners, of which 48% knew it as a result of having tested together. Overall, 14% of respondents knew or thought their partner was HIV-positive.

Among the same group of respondents 58% indicated that their male partners were circumcised; and almost 9 out of 10 (87%) said they preferred a circumcised partner, citing HIV protection and better hygiene as the main reasons.

When asked about the partner's sexual relationships, 38% of the female respondents said they knew or believed their partner was promiscuous. They also stated that their male partners control the relationship in 75% of cases.

MALE CHARACTERIZATION STUDY

ADDITIONAL RESEARCH QUESTIONS

Research Questions Added after Phase 1 of the Study

Given the high rates of forced sexual intercourse (26%) and forced or pressured sexual intercourse (31%), reported by the AGYW (with no difference across the age groups), we included the following questions during the qualitative phase of the study in our discussions with the men.

1. Why do some men engage in transactional sex with adolescent girls and young women?
2. Why do some men engage in forced sex with women?

These questions were asked at the end, after rapport was fully established, and all primary research questions answered.



ANNEX 4: PHASE II QUALITATIVE RESULTS

QUALITATIVE RESULTS:

MALE RESPONDENTS' CHARACTERISTICS AND EMERGING THEMES



CHARACTERISTICS

A total of 123 males aged 20-34, with an average age of 30, were enrolled as they met the male partner profile characteristics identified in Phase 1 of the study.

FGD respondents were categorized as 'users' or 'non-users', with a user defined as a respondent who reported receiving one or both of the following services in the last 12 months

- 1) HIV testing services (HTS) and/or
- 2) HIV treatment (ART), or
- 3) ever accessed voluntary medical male circumcision (VMMC).

Those who did not report having received any of the three services listed above were defined as non-users. PLHIV men recruited from HIV clinics were categorized as PLHIV and were interviewed separately through IDIs.

A total of 15 FGDs, 6 with users and 9 with non-users, and 9 IDIs were facilitated.

EMERGING THEMES

The emerging themes that were identified through the FGDs and IDIs with male participants are listed below.

Facilitators of HIV service use

Facilitator Domain I: [Client Factors & Support Networks](#)

- i. Peer influence
- ii. Family support and responsibilities
- iii. Persistent ill health & wanting to get better

Facilitator Domain II: [Health System Enablers](#)

- i. Positive attitude of health care staff

Barriers to HIV service use

Barrier Domain I: [Fear & Apprehension](#)

Barrier Domain II: [Health System Shut-out](#)

Reasons for coerced and forced sex

Forced Sex Domain I: [Individual factors and group dynamics](#).

- i. Exposure to pornography
- ii. Widespread use of sexual boosters

Forced Sex Domain II: [Societal Factors](#)

- i. Break-down of traditional boy-child mentorship structures
- ii. Increasingly provocative dressing by women

FACILITATORS

DOMAIN I: CLIENT FACTORS & SUPPORT NETWORKS

“It also depends the way you play with your friends, but if you have friends who have been circumcised, they will encourage you with their experience”

- Non-User, Chingola

“I am motivated to take ART because I want to strengthen my blood cells. My wife also encourages me to take ART. She reminds me to take ART and she wakes me up to take medication when I am asleep.”

- PLHIV, Chingola

PEER INFLUENCE

The males in this study population talk to other males, who they view as peers, about their health and health services, more than they talk to any other group.

Both men who are users and those who are non-users of HIV services mentioned peer influence as very important in decision-making about health, including using HIV services. Peers emerged as the primary source of health information and opinion that shapes individual health seeking behavior. Peer influence was singled out as an especially important facilitator for HTS and VMMC services, with access and utilization almost always influenced by peer support and/or favorable reports.

PARTNER/FAMILY SUPPORT

Across all groups, men indicated that having supportive family members/partners is important for service access and use. Respondents told us that there are not many men who find it easy to discuss health and HIV with family members and sexual partners, and therefore this facilitating factor is generally underutilized by men. Family members/partners are often only brought into the picture when illness

becomes serious and/or obvious. Among the users, virtually all those who reported family/partner support said it is important for facilitating access to services, but even more important for sustaining use – because there is no need to hide the illness or medication.

PERSISTENT ILL HEALTH & WANTING TO GET BETTER

The men said that they sought health services, especially HTS and ART, when they had persistent ill health and were left with no option but to seek clinic services.

Among users and PLHIV, more than three quarters of the men indicated that they are/were, worried about HIV infection because of personal high-risk behaviors, but delay/delayed seeking HIV testing services for fear of a positive test and living with known HIV positive status. The men all know/knew that persistent ill health could be an indication of HIV disease, and most said that is the point to seek testing. It will be important to change this narrative and encourage service access and utilization before ill-health to ensure good health outcomes for these men.

FACILITATORS

DOMAIN II: HEALTH SYSTEM ENABLERS



POSITIVE ATTITUDE OF HEALTH CARE STAFF

Men reported that they find it easier to seek health services including HTS, VMMC, condoms and ART if the health care staff are respectful, friendly, non-judgmental, caring, professional, and welcoming.

Across users, non-users and PLHIV, men strongly expressed that they require to be treated with respect and dignity by healthcare workers and are sometimes not. The men indicated that if they feel respected and are engaged in a professional manner by providers, they will go back to that health facility and sustain care, and they will tell other men to access their healthcare from the facility.

Positive staff attitude emerged as a very important determinant for facilitating access and use of HIV services by men, and importantly, for sustaining utilization.

“I think they should put people [in the clinics] that are patient, caring and brave. The moment you speak to them and they are patient and caring, you will feel better. Us people don't hide diseases if people are caring and patient. . .so if they are polite and patient we will be going there.”

- User, Lusaka

BARRIERS

DOMAIN I: FEAR & APPREHENSION

“...The difficulty which is there among men is the fear if they find us with the HIV virus. So we decide to go to the pharmacy whenever we experience pain in our body because the pharmacist will give us the drugs when we explain how we are feeling and also our condition, since the pharmacist is business minded. So the difficulty is when we are sick we go to the pharmacy instead of the clinic because of fear...”

- Non-user, Chingola

BARRIERS

DOMAIN II: HEALTH SYSTEM SHUT-OUT

“...The way I have observed...the way it is concerning accessing HIV services ... men are not considered. We are not focused on, where HIV is concerned. You find that women are taking 90% of the ARVs and men are not taking ...men are left out. You find men are busy focusing on alcohol ...HIV medication they are not focusing on it. That is why women are living longer than us men. So there is much emphasis on women and children, not men...”

- User, Lusaka

BARRIERS

DOMAIN I: FEAR & APPREHENSION

“... our sexual behavior is very bad because of the groups we are found in, when we associate with certain group the group members will encourage you have sexual partners for example when you do not have a sexual partner other group will see you to be weak. Again when you are found HIV positive for example at the age of 25 years there is just a deep thought over how many more years you would keep taking medication...”

- Non-user, Ndola

“... it might be low self-esteem [why men are so afraid of a positive HIV test]. Like you look down on yourself [when you test positive].”

- PLHIV, Lusaka

“... three quarters of us are scared that when you take a test and I am found HIV positive, I will become a laughing stock in the community... And again, as the result of this fear us youths stay with an HIV virus in our bodies until our CD4 count drops before we know our HIV status...”

- Non-user, Ndola

MEN FEAR AND ARE APPREHENSIVE ABOUT:

A POSITIVE HIV DIAGNOSIS, AND LIVING WITH HIV

Fear of HIV diagnosis is very prevalent among the men in this study population. The men generally view HIV diagnosis as a sign of weakness. They consider living with HIV as emasculating and isolating and avoid HIV testing because they would rather not know. This is partly because most of the men they know who are on ART were diagnosed late (perhaps because they too feared HIV testing), when they are obviously sick – this is their measure of men living with HIV. These men therefore do not have many examples of men who are on ART who are strong, healthy and well, and equate HIV infection to sickness.

FAILING TO MEET THE GRADE

The men indicated that society expects them to be strong or to ‘man-up’ about sex and health. They fear being perceived as ‘less than’ what they and society view as a ‘real man’ and so they conform to societal expectations by having multiple sexual partners, which puts them at high risk of HIV, and try to deny and hide any health problems

when they arise, as that is seen as a sign of weakness and failing to be man.

HIV-RELATED STIGMA AND DISCRIMINATION

The men revealed that HIV-related stigma and discrimination are still very prevalent both in the health facilities and in their community. They told us that obvious HIV disease is looked down upon by them and their communities, often not in an overtly cruel way, but in a joking manner. PLHIV men indicated that due to what they believe are societal expectations about what it means to be a strong real man, internalized HIV-related stigma is also very prevalent.

HIV infection is often equated with weakness and failing to be a man, and clinic care arrangements that force them to line up with women and children just reinforce this.

BARRIERS

DOMAIN I: FEAR & APPREHENSION

“...At times it is what us as men do that prevent us from going to the clinics, here is a person who sleeps around with prostitutes and we tend not to want to go to the clinics because we already think we are sick, we think we already have HIV because of our behavior...” - User, Ndola

MEN FEAR AND ARE APPREHENSIVE ABOUT:

BEING DISRESPECTED

Men were very clear that there is a level of respect that they expect, including when they access health services. This is intrinsically tied to societal norms and expectations that a real and strong man commands respect, and the generally held view that a man who is ill because of HIV is a weak man and therefore ‘less than a real man’ and perhaps not quite deserving of respect. The need to be respected is a very strongly held expectation by most men in this group. Men who feel disrespected when they access health service do not return and tell peers, who then also stay away.

PAIN

Suffering physical pain from procedures such as VMMC or both physical and psychological pain from HIV disease is a barrier. Many of these men have a history of high HIV-risk behaviors, and had underlying anxiety, confusion and even psychological pain about their health, that clearly also needs to be addressed! Some told us that an HIV diagnosis would lead them to contemplate suicide and would prefer not to know that they are HIV positive.

UNDIGNIFIED DEATH

Men tie HIV diagnosis to imminent death from AIDS – many still believe that a positive HIV diagnosis is a death sentence. They also believe that the road to death from AIDS often appears undignified and is embarrassing (one becomes a laughing stock in the community).

To a large degree, men’s apprehension about and fear of HIV is not only about their own health status but is driven by lack of access to correct information (including information about the efficacy of HIV treatment) and about not knowing enough to make the right health seeking choices. The perceived problems in accessing healthcare add to the anxiety. Peers have emerged to fill the information gaps, but if this information is incorrect, it fuels myths and misconceptions...and more apprehension.

According to the 2018 ZDHS, only 46% of males 15-49 had comprehensive knowledge of HIV. Inadequate information and misinformation can create unnecessary anxiety and prevent timely access to HIV testing, prevention and treatment services.

BARRIERS

DOMAIN II: HEALTH SYSTEM SHUT-OUT

“What I saw there was so disappointing and I can never go back there, people were entering the testing room without even knocking.”

- Non-user, Ndola

“I think just access to treatment is already discrimination...there are days that they have put specifically for ART and people will see you whether you like it or not...”

- PLHIV, Lusaka

“You find that women are standing on the same line with us men. It’s better us men are given a different place and our own counsellors. You find that if you go to the clinic you know that you will find a big queue and also you will be standing on the same queue with women and children...”

- User, Ndola

NEGATIVE ATTITUDE OF HEALTH CARE STAFF

Negative staff attitude emerged as the most important barrier to both seeking services and to sustaining care for users and as a key barrier to seeking services for non-users.

Negative attitudes from healthcare staff may not have been personally experienced but if their peers report experiencing poor staff attitudes, it is a strong deterrent.

The exception is PLHIV men on ART who told us that they sometimes have no choice, but to endure disrespectful treatment from healthcare providers. They view ART as a lifesaving service – they indicated that they will access and use ART, even endure poor health staff attitude or anything else for that matter, in order to live, for themselves and for their families. A caution however, is that about one quarter of the PLHIV men indicated that negative staff attitude is a spur for switching facilities without telling the clinic staff.

PRIVACY AND CONFIDENTIALITY

Men strongly feel that matters related to their health, including and especially anything relating to sex, HIV, and other STIs, should be dealt with in private and remain confidential. Over three quarters of non-users cited

perceived and/or experienced lack of privacy and confidentiality as major barriers to HIV services in public sector health facilities. Privacy and confidentiality were seen as multi-faceted including the physical space not being set-up and/or adequate to assure the user that there is privacy/confidentiality and a lack of cultural competency by staff.

LACK OF CONSIDERATION/ BESPOKE SERVICES FOR MEN

Most of the men indicated that it is difficult for them to queue up with women and children to access services and will only do so if they are very sick and need clinic services. The men admitted that this is a cultural/social barrier but that it is a real barrier nonetheless. Many users and non-users indicated that if they had services tailored to them and their needs, they would utilize HIV services more.

Approximately two-thirds of the men we spoke to indicated that they would prefer male providers to female providers across the HIV service platforms, but especially for VMMC, where virtually all prefer a male provider. This is another social/cultural barrier, but for most men it is a very significant barrier. It is however, worth noting that, with the exception of VMMC, a third of the men do not mind female providers.

BARRIERS

DOMAIN II: HEALTH SYSTEM SHUT-OUT

“When you go to the public hospitals, you find that there are long queues and you find that us men we don’t like queues, we like fast things...”
- Non-User, Lusaka

“I was tested for HIV by a female personnel and she is the one that put me on ART. When I look at my friends, I would love them to be tested by fellow men so that they do not shy...as they are not as open as I am.”
- PLHIV, Ndola

FACILITY INCONVENIENCES

Over three quarters of non-users cited long wait-times at public sector facilities as a major barrier to HIV service access and use. Many non-users linked long wait-times to their decision to self-medicate or buy drugs from chemists without a clinical diagnosis. Many users cited long wait-times as one of the reasons why they go to private clinics, drugstores, faith healers, and traditional healers.

The men also reported that the location of services can be too expensive in terms of time and transport to access. Actual lack of transport money and fear of losing income from taking time off

from informal jobs are both barriers. Some men indicated that they had benefitted from well-publicized outreach services that bring services closer to where they live or work.

In addition, virtually all the users and non-users cited unavailability of out-patient services, outside normal working hours, at some public sector facilities as a major barrier to HIV service access and use. They indicated that the long queues at the facilities make it impossible for them to leave work to go and line up for services and that they would lose wages if they did. Both users and non-users indicated that they would use services more if the clinics were open outside normal working hours.

“...they close literally on time, if it is 15:30hrs they close...and you will find that most guys are working and knock off at 17:00hrs so they have nowhere to go because the clinic is already closed...and given the lines that are there already, they cannot leave what they are doing to go and line up at the clinic...”

- User, Ndola

INSIGHTS FROM THE FGD: DISCUSSIONS WITH MEN ABOUT COERCED OR FORCED SEX AND TRANSACTIONAL SEX

“If you think like that, then all the sex I have had is transactional!”

FORCED SEX AND TRANSACTIONAL SEX

After completing the main section about HIV services in the focus group discussions with men, a question was asked about the reasons why sometimes men force their female partners to have sex unwillingly. The main reasons mentioned by the participants are discussed below.

The men were very clear that these are their opinions of why men who engage in such behaviors do this, not their personal experience.

PERCEPTIONS ABOUT FORCED SEX

In discussing forced sex, what emerged is that most of the men did not believe that there is anything wrong with a man forcing a woman he is married to or who he is in a regular relationship with to have sex with him, especially if he is supporting her or giving her gifts and money. They relate forced sex to forcing sex with only girls/women one is not in a relationship with or married to.

Clearly this explains why AGYW report such high rates of forced/coerced sex. They and the men are coming from two different perspectives in their understanding forced/coerced sex.

PERCEPTION ABOUT TRANSACTIONAL SEX

Most of the men do not view giving gifts or money to a regular girlfriend in exchange for sex as transactional sex – it is expected that a man will give money and gifts to a girlfriend. Quote “if you think like that, then all the sex I have had is transactional!”

According to the men, if one does not give gifts and money, one is unlikely to maintain a relationship with a girl, and the girl will refuse to have sex with him, and in their view, rightly so. The men indicated that it is clearly understood in their communities that girlfriends expect to be given gifts and money.

In their view only sex with a sex worker is considered transactional sex.

INSIGHTS FROM THE FGD: DISCUSSIONS WITH MEN ABOUT COERCED OR FORCED SEX AND TRANSACTIONAL SEX

“After taking a booster, a man has to find a way of relieving himself.”

FORCED AND COERCED SEX

INDIVIDUAL FACTORS AND GROUP DYNAMICS

Pornography: High availability of pornography dens within communities where groups of men gather to drink, smoke and watch pornographic content together, and quote “come out supercharged for sex and it is easy to make a mistake of forcing.”

The men reported that pornography is also widely available to individual men on any simple mobile phone, and sometimes the content watched is about forcing women, which gives some men ideas about forcing. The men believe the strict laws related to forced sex especially with under-age girls is a deterrent, but only to some degree, as not all girls report.

Widespread use of sexual boosters: The men reported that both conventional sexual boosters like Viagra and traditional sexual boosters are freely available for one to buy and use, on the street. If a man cannot afford to pay a sex-worker to have sex with him, then he will force a girl to have sex with him.

SOCIETAL AND EXTERNAL FACTORS

Break-down of traditional boy-child mentorship structures: The men said breakdown of traditional and community parenting and teaching systems for the boy-child, especially in urban settings, where some boys have limited or no access to social education and mentoring from older men in their family about appropriate behaviors towards women is the main reason why forcing girls and women to have sex is increasing. However, the men also said the breakdown of parenting and teaching systems for girls on how to dress and behave also contributes significantly.

Increasing provocative dressing by women: The men said that the way some women dress and behave leads to them being raped. The men indicated that some women dress provocatively, and the way they behave in front of men gives the signal that they are available for sex, and men take their cue from this. If the girl resists, it could end up in forced sex.



ANNEX 5: REFERENCES

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