Author’s response to reviews

Title: Echoes of old HIV paradigms: Reassessing the problem of engaging men in HIV testing and care through women’s perspectives

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Author’s response to reviews:

Dear Editor,

We are happy and thankful for the thoughtful and comprehensive comments provided by the reviewers. We believe these comments have strengthened the manuscript. Please find below our responses to the comments in red. We are in agreement with the majority of the comments and we have made changes accordingly.

I have also attached a tracked changes and ‘clean’ version of the manuscript.

Sincerely,

Leila Katirayi
Reviewer #1:

Introduction

It would be helpful to say more about barriers to long-term adherence to ART in the introduction, and not primarily cite evidence of people defaulting. Thank you for the suggestion. We have intentionally selected data that focuses on ART adherence under new the regimen of ‘Option B+’ or lifelong ART. Therefore, there was not a lot of data on long-term adherence under these guidelines. Since this paper is using data that is focused on ‘Option B+’ we would prefer to keep the background focused on this topic as well.

Can you provide further clarity of Option B + in the introduction, and also what you mean by 'seemingly healthy' individuals? We have now changed the wording to ‘asymptomatic.’

It would be helpful to provide more exiting evidence around men's reluctance to test for HIV or adhere to ART treatment due to norms of masculinity, poor access in the introduction. For instance you may want to refer to the articles. We have now included additional statements to introduce both the challenge of masculinity norms and the health facility being viewed as a ‘female space’ from both of the articles mentioned below. We have kept the coverage of these topics in the introduction short to avoid repetition with the discussion, where both topics are well covered and cited.


Sexual and reproductive health perceptions and practices as revealed in the sexual history narratives of South African men living in a time of HIV/AIDS. Stern, Rau, Cooper 2014. in SAHARA.

Can you explain more why Zimbabwe and Malawi were chosen for comparison and how these two study sites came about? Additional text has been added to answer this question in the beginning of the study design section.

I think it is very interesting to explore norms of masculinity from women's perspective; this is certainly a gap in the literature and I think makes the methodology a novel contribution.

Methods

This is a good description but some further details would be helpful. How long did interviews and focus groups last? Details added in data collection section.
Who conducted the IDIs and FGDS? All data were collected by trained research assistants (information provided in the data collection section).

How was confidentiality in focus groups discussed/clarified? Additional text added in the data collection section.

Can you say more about process of translation and how accuracy was ensured/checked? Information provided in the last sentence of data collection section.

Can you also clarify overall research question and how men's influence on women's adherence to ART came to be a focus from analysis? The research question for this paper is ‘how do women understand and interpret men’s attitudes towards HIV and ART and how does it shapes the woman’s experience with ART?’ Please see the middle of the study design section.

Was this a grounded focus out of a larger study? Yes, additional text has been added to clarify how men’s influence on women’s adherence came out of the initial study. Please see study design section.

Can you more about anonymous findings in the ethics section? Are you referring to ‘availability of data and materials’ section? Study reports were disseminated at the local level to stakeholders and the MoH. The study reports list the exact sites from which the data were collected. Therefore, the study team decided to not share the original data out of concern for participants’ confidentiality.

Did the women have to be heterosexual to be eligible? There was no eligibility requirement for sexual orientation of study participants. No data was gathered on sexual orientation.

Findings

With the part of HIV testing, what about women's own attitudes and fear towards testing? This was discussed in a previous paper: Katirayi, L., Namadingo, H., Phiri, M., Bobrow, E.A., Ahimbisibwe, A., Berhan, A.Y. et al. HIV-positive pregnant and postpartum women’s perspectives about Option B+ in Malawi: a qualitative study. Journal of the International AIDS Society. 2016; 19:20919

When you say that some men would only disclose their status after women test, does this mean men encouraged their female partners to test for HIV? There was no data about men encouraging their female partners to test.
Interesting low rates of disclosure. It would be great to tie this in discussion to evidence that poor disclosure hinders long term ART adherence. Additional text has been added to the discussion section.

Also interesting point about men knowing they are HIV infected but wanting wives to test; could this be linked to men wanting to blame female partners for acquiring HIV? There is literature from South Africa that suggests this and would be good to tie to this potential in the discussion. My understanding from the data is that it’s not necessarily that the men ‘want’ their wives to test. But they do not want to disclose their own HIV status to their female partners for the reasons mentioned. From the data it seems that the men are not so much looking for somebody to ‘blame,’ rather they are just trying to avoid the topic of HIV (testing, treatment, etc.) at all costs.

The discussion is very strong, but would also benefit from drawing more strongly on a theoretical framework. For instance, drawing on Connell's notion of hegemonic masculinities seems highly appropriate. While I think the findings about men's poor knowledge, access to ART CARE, and the lingering attitudes to HIV important, I think it's important to also emphasize men and women's agency of adhering to ART and how this can shift over time, and the broader contextual barriers to adhering to ART, even if this was not found in your own findings, but to acknowledge these factors have also been found to affect men's adherence to ART in the discussion. You could refer to for example:

We have added additional text about contextual barriers to the discussion using the article suggested below and about Connell’s hegemonic masculinities and the role of agency in creating one’s own definition of masculinity.

Conceptions of agency and constraint for HIV-positive patients and healthcare workers to support long-term engagement with antiretroviral therapy care in Khayelitsha, South Africa in African Journal of AIDS Research

There is also some literature around how sometimes men being diagnosed with HIV can cause a shift in their identity as men and lead to healthier lives, adherence practices. It is important to understand what makes this possible. Please refer to for example: Living with HIV as a man: Implications for masculinity by Sakhumzi Mfecane 2008. Thank you for the reference; this article was insightful and encouraged us to look at additional literature on changing masculinity norms. We have included ideas regarding men’s reconstructing their interpretation of masculinity in the discussion from the following article:

Please include a brief point on reflexivity, and how authors were aware of this in the study design, conduct and interpretation of the findings. Additional text on reflexivity was added to the data collection section.

I hope and trust that with these revisions, the paper will make a strong contribution to the literature on men's HIV testing, including from the perspectives of women, which I highly appreciate for capturing those relational dynamics.

Reviewer #2:

This reads as a very useful and interesting article. The research responds to the gap or 'blind spot' in knowledge on heterosexual men's attitudes to HIV and ART.

I agree with the potential usefulness of recognizing the similarity of findings across the two country samples. I suggest a sentence or two on what kind of contexts it would potentially apply to. Additional text has been added to the transferability of results section.

Other studies have found links between disclosure of status and risks for women of intimate partner violence. It's not clear if this study screened for IPV or asked questions about IPV. I recommend it to be included or at least mentioned as a question to ask in future studies. This study did not screen nor ask participants about IPV. While we agree that IPV is a critical topic in the area of disclosure, this was not an area we explored at all in this study. Therefore, we are hesitant to make recommendations based on topics not included in the study.

415: I suggest nuancing or qualifying 'religion has been identified as a barrier' to be specific about the way it is a barrier here. Some organisations like INERELA have used religious spaces as enablers for treatment. Perhaps 'religion that is disconnected from health education' or such a description could be more specific. Point taken. Additional text has been added to acknowledge that religion can be both a barrier and facilitator. The text specifies that it is a barrier in this case because prayer is supposed to replace ART.

425: Any comments about men's support for exclusive breastfeeding? Would be useful to know since it adds information to how men can support PMTCT. Unfortunately, there was no data on this topic.

443: What were HCW's attitudes to men accessing health services for their own health and testing / treatment / adherence? The HCWs did not discuss men accessing health service for their own health. The initial focus of this study was on acceptability of lifelong ART among pregnant and postpartum women, so HCWs discussed women wanting to discuss with their husbands first, women telling the HCW to go and tell their husband the information, and the need for couples HIV testing and counseling. HCWs did confirm that the ‘man is the head of the
house’ and needs to be educated and involved in order for ART to initiation and adherence to be successful. HCWs extensively discussed the need for male involvement.

571: I recommend using the terms 'gender responsive' or 'gender sensitive' instead of male friendly. While more women engage in health services they may not agree that health services are necessarily ‘female friendly’. The paper (32) provides some background to this recommendation.

The term ‘male friendly’ was used by our study participants, so we would prefer to keep this wording in order for my interpretation to reflect the participants’ perspectives as closely as possible.

605: This paragraph highlights another limitation or omission in the article. The article has not sufficiently addressed the community level reinforcement of gender norms. Fear of HIV due to lack of information is indeed one aspect, but that fear occurs within a context of community norms that reinforce that men should stick to the patriarchal stereotype. Shifting gendered behavior is not only an individual choice, but requires community level change to be sustainable, again building on (32). Therefore providing information more effectively to individual men will be an important aspect, but this information needs to be contained in community wide efforts to shift norms, through community mobilization and community level media, as addressed in 633 to 647. What's still missing though is to note that this communication directly address gendered power imbalances, and that the communications should be combined with interventions that also attempt to equalize these power imbalances between men and women. Point taken. We have added additional text about the OMC and Stepping Stones program and how it challenges typical hegemonic masculinity norms to encourage support of their female partners.

Reviewer #3: This article is well-written and timely. For the literature review, there is a great deal of literature on traditional gender norms/roles and HIV testing/ access to ART and tendency to access healthcare in general. It is important to acknowledge/note this body of research in the context of men's uptake of HIV testing/ART. I suggest including this in the background. The following are some references that might be helpful:


Point taken. These are great articles and provide a lot of insight into the challenges with men and HIV. They are both cited in the paper. Instead of providing this in the background section I’ve included most of this information in the discussion section. We felt that the information was better placed in the discussion when introducing the main two theories explaining men’s lack of
engagement at the health facility. Initially, we had some of this information in the background section and it became repetitious.

It would also be helpful to have more insight on traditional gender roles in Malawi and Zimbabwe to contextualize the findings. There is a wealth of literature on this. We added more on this in the ‘Malawi & Zimbabwe’ setting section (first paragraph).

Finally there is a growing body of literature of intervention focused on addressing harmful gender norms that affect men's access to healthcare, including HIV treatment and ART. It would be helpful to mention this in the conclusion in relation to this study. Excellent point. Text added on this topic in the discussion section (near the end).