

Health worker experiences of and perspectives on engaging men in HIV care: A qualitative study in Cape Town, South Africa

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Health Worker Experiences of and Perspectives on Engaging Men in HIV Care: A Qualitative Study in Cape Town, South Africa

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Abstract

Men generally fare worse than women across the HIV cascade. While we know much about how men perceive the health services, we know little about how health workers (HWs) themselves have experienced engaging with men and what strategies they have used to improve this engagement. We interviewed 12 HWs in public health care services in Cape Town to better understand their experiences and perspectives. Health workers felt there were significant gaps in men's engagement with HIV care and identified masculine gender norms, the persistent impact of HIV stigma, and the competing priorities of employment as key barriers. They also highlighted a number of health service-related challenges, including a poor perception of the patient-provider relationship, frustration at low service quality, and unrealistic expectations of the health services. Health workers also described several strategies for more effectively engaging men and for making the health services both more male friendly and more people friendly.

Keywords

qualitative research, healthcare workers, men, HIV/AIDS, gender

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Introduction

HIV continues to be major global health problem, with South Africa having the largest number of individuals living with HIV in the world.¹ Age and gender have a marked effect on HIV epidemiology across the life course with women and men having different risk factors and different pathways and exposure to diagnoses and treatment.² There have been a number of critical gender-specific responses to the HIV epidemic among women, including preventing mother-to-child transmission, supporting pregnant and postpartum women, addressing the ongoing rising incidence among adolescent girls and young women, and in general empowering women and girls socially and economically in order to reduce the high burden of HIV among women.^{3,4}

There are strong indications, however, that men, across a range of social and country contexts, have poorer engagement with HIV care and higher mortality than women.⁵ Men tend to access HIV prevention and treatment services less than women,

and their health outcomes are worse across the HIV cascade.⁶ They tend to delay HIV testing longer and access HIV testing

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What Do We Already Know about This Topic?

Men's outcomes across the HIV prevention and treatment cascade are lower than they should be, in part because of discomfort accessing and making use of HIV-related health services.

How Does Your Research Contribute to the Field?

Most of what we know about men's discomfort in their encounters with health workers (HWs) comes from men—this study adds to our knowledge about how HWs themselves experience their engagements with male patients and what strategies they use to improve those engagements.

What Are Your Research's Implications toward Theory, Practice, or Policy?

There are numerous ways that the encounter between HWs and male patients can be improved and be made more male friendly, including services that are more responsive to men's needs, and better education and support for both men and the HWs serving them.

less often than women.⁷ When diagnosed HIV positive, their linkage to HIV care and antiretroviral therapy (ART) is usually less than for women.⁸ They also tend to fall out of the HIV care cascade at higher rates than women in terms of ART interruption and discontinuation, and their health outcomes may be worse in terms of achieving a low viral load and reduced mortality.^{9,10}

Research on the factors driving these poor outcomes among men has identified a wide range of factors. Much of this research has focused on patriarchal and hegemonic gender norms and practices related to masculinity as the dominant factors shaping men's health-seeking practices (often for the worse).^{11,12} However, the design and quality of health services, including in particular health worker (HW) attitudes and practices, also contribute to men's poor engagement with HIV care. Men often report experiencing health facilities and HWs as unwelcoming to them as men and as less responsive to male health care needs.^{13,14} Men have also identified the long waiting times and the location and opening hours of health facilities as barriers to access for men who may work far from their home and may have to lose a day's wages to attend a clinic.¹⁵ We also know from research in Malawi and elsewhere that while most women will have regular opportunities during late adolescence and adulthood for engagement with health services related to family planning, pregnancy, and childbirth, men generally lack such a routine "universal access point" for engaging with the health services.^{16,17}

Although most interventions to improve men's engagement with HIV services have to date focused on increasing men's awareness and motivation through demand creation strategies, there have been some efforts to address the supply side of the equation. Most supply-side strategies have focused on creating more male-friendly services through, for example, hiring more male staff, providing gender sensitization training to staff, extending clinic hours, opening male-friendly or male-only clinics, and integrating HIV services with other services likely to engage men (such as tuberculosis [TB], substance use, or voluntary male circumcision programs).¹⁸ There is little evidence available on the costs or effects of these interventions or on the most effective balance between demand-side and supply-side approaches. There is growing consensus, however, that improving the responsiveness, acceptability, and effectiveness of health services for men is an important barrier to overcome in addressing the HIV epidemic.¹⁹

Nearly all of the studies of men's experiences of health services, however, come from men themselves. This literature has been critical in diagnosing the key barriers to access from men's perspectives. If we are to know how to improve health services for men, however, it is equally important to understand the experiences and perspectives of the HWs who engage with men in HIV care. Since HWs and their relationships with male patients will be a critical factor in any strategy to increase supply, access, and quality of health services, a better understanding of their experiences and perceptions of men in HIV care will be crucial in developing more responsive and effective services for men.

Methods

Study Design

This article reports on a qualitative study with HWs in Cape Town's public sector health services who work regularly with men living with HIV. The study employed a cross-sectional study design using in-depth, semi-structured interviews. The study was part of a larger research project—"Using Information to Align Services and Link and Retain Men in the HIV Cascade" (or iALARM)—whose aim is to develop and deliver health information interventions to more effectively coordinate the work of health system and community service providers and, ultimately, better link and retain men in HIV services.²⁰

Setting

The study was conducted in the Cape Town community of Gugulethu, within the Klipfontein health subdistrict. The people living in Gugulethu are primarily black, Xhosa-speaking South Africans. Black South Africans living in peri-urban settings like Gugulethu have among the highest HIV prevalence rates in South Africa.²¹ Gugulethu is densely populated, with a significant number of residents living in informal housing. It is

one of the oldest but fastest-growing township communities in Cape Town.²²

Data Collection

To be eligible for inclusion, HWs had to be certified clinical practitioners providing HIV services for at least 3 years at facilities run by either city or provincial authorities or in the nongovernmental organization (NGO) sector in Gugulethu. Participants were initially recruited through facility managers in Gugulethu who identified eligible staff members and referred them to study staff. We used purposive sampling to generate a sample of HWs for an initial round of interviews. Our sampling criteria were designed to produce a sample that was diverse with respect to gender, length, and type of clinical experience and sector (public or NGO). Informed consent from HWs was documented in writing before interviews were conducted. We conducted our first round of interviews before stopping due to initial saturation of the data. We later conducted 3 follow-up interviews with participants to clarify and further refine findings from analysis of the initial interviews. No HWs declined to participate or dropped out during the study.

Data were collected through semi-structured interviews using an interview guide with key framing questions that allowed for a free-flowing conversation with the interviewee.²³ This allowed HWs not only to provide their perspectives but also to expand on them by, for example, telling stories that may lead the researcher to new, relevant questions. Interviews were conducted in a quiet and private space (either by N.M. or R.M., both postgraduate students who did not know the participants before the study), usually in the HW's office. No one else was present at the interviews, which lasted 30 to 45 minutes and were recorded with the participant's permission. Field notes were also made during the interview.

Data Analysis

Data were analyzed using inductive thematic analysis. Thematic analysis is a method of analyzing and describing the patterns and themes found in the data.²³ Data analysis entailed transcribing all audio recordings, reading all transcripts, and then using thematic coding to develop and apply an initial coding framework to identify passages of texts or words from transcriptions that were linked by a common theme or idea.²⁴ This allowed the researchers to index the text into categories and establish an initial framework for thematic analysis. Then, through an iterative process, codes were further refined and reduced to thematic categories, such as *difficulty disclosing* or the *impact of alcohol*. Once the transcripts had been coded using this initial framework (by N.M. and R.T.), further thematic analysis and interpretation were conducted with 2 additional coauthors (N.L. and C.C.) in several rounds of analysis meetings. R.T. and N.M. then drafted the initial written findings, and these were again further refined through a series of analysis meetings with the full author team.

Data Quality and Study Rigor

The researchers undertook a number of efforts to improve the trustworthiness of the study findings.²⁵ We used the same core interview schedule with each participant, developed full transcripts, and held several rounds of iterative analysis meetings with the broader study team. Participants were recruited through line managers and all were aware of the broader iALARM project and expressed comfort with the study objectives. Issues of researcher positionality were also addressed. N.M. is a black South African woman and R.T. is a black Zimbabwean woman, and we discussed the potential impact of their experiences and positionality during both the design phase and during the analysis meetings. We had worked to enable transferability of findings, as appropriate, by providing further context on the study site in both "Methods" and "Findings" sections. We included a range of different types of clinicians and lengths of experience. And we have presented initial findings for discussion at a large community meeting in Gugulethu as well as at a City Health "Research Day" event hosted by the City of Cape Town Health Department. Ethical approval was provided by the University of Cape Town Faculty of Health Sciences Human Research Ethics Committee (#802/2014 and 655/2016).

Findings

Characteristics of Participants

A total of 12 HWs (5 men and 7 women) working at health care facilities in the Klipfontein subdistrict of Cape Town were interviewed between 2016 and 2019. Health workers in the study had worked within the health system between 5 and 24 years and included 2 facility managers, 4 nurses, 1 doctor, 2 counselors, 1 program coordinator, and 2 health service managers. Five of our HWs were male nurses, offering an important glimpse into the experiences and perceptions of this underrepresented health service cadre.

In "Findings" section, we start with a general description of HWs' views on gendered patterns of engagement in HIV and health care, followed by a synthesis of their perceptions of the factors shaping men's engagement in HIV care. These factors include the impact of masculine gender norms, community stigma around HIV, economic barriers, and the often-difficult relationship between male patients and the health services. We conclude with a section on the strategies HWs used to engage men in HIV care and their views on how health care service delivery might better engage men in HIV care.

Health Worker Views on the Gendered Patterns in Engaging HIV Care

Health workers generally agreed that there were gender-related gaps in men's engagement with HIV care. They felt these gaps extended across all stages of HIV care, from not sufficiently engaging with prevention and accessing HIV testing, delaying, or not linking to HIV care once diagnosed HIV positive, to

struggling to remain engaged in care and successfully virally suppressed. Getting tested and staying in treatment once diagnosed and initiated on ART were identified as the 2 main challenges among men for HIV care.

Although several participants acknowledge the gendered complexities of HIV specifically, they felt that this was not a problem unique to HIV care. A mid-level clinical manager explained that they faced 2 main challenges engaging men in health care more generally: firstly, the challenge of attracting men, and secondly, the challenge of retaining men in care:

... the first stage itself to attract men into the health system is challenging ... if you go look at the numbers, you'd see that obviously, very few men come to visit our clinics. I don't know if they're going to private. I don't know the figures there but obviously there's some research that indicates that men generally do not feel like visiting health facilities until they are to the point where they are acutely sick and they can't take it anymore. Yes, so that first to get them in the system, and once they are in the system, it appears that they struggle to adhere for whatever reason. I mean I don't have reasons why they are not as compliant as women are. So those are the two things I think men struggle with, entering the system and when they are in the system it's hard to maintain them ...

Men were said to struggle more than women with seeking health care when they felt ill, and when they did visit the clinic, they were less comfortable with the experience. Health workers gave examples of men delaying seeking care to the point where they could no longer tolerate the discomfort associated with an illness, and of men who once diagnosed, went into denial about being HIV positive. Participants also pointed to a mismatch between the health care needs and expectations of men and what the health services offered or focused on. There are many services and campaigns focused, for example, on maternal and child health issues, but less focused attention at the primary care level, around men's sexual and reproductive health needs (especially sexual dysfunction) or other health needs.

Although HWs acknowledge gendered differences in the way men and women engaged with the health services, some felt that differences in individual patient's history, personality, and their prior experiences with the health services were as, and sometimes more, influential. Denial of one's diagnosis, for example, was described as a powerful barrier to care for both men and women. One HW said that after a patient accepts an HIV-positive result, she ceased to see any gendered differences between her patients. Another said she refused to generalize, and she was adamant that regardless of gender, if someone did not want to take their medication, they would not.

Despite their generally bleak assessment of men's engagement in care, though, there was a sense among some HWs that there has also been positive change over the past decade. Examples of positive change included the fact that more HIV-positive men were bringing their partners to test for HIV and increasingly, men who would usually only visit a traditional healer would now also visit the clinic. Male health care workers, in particular, reported that their male patients who participated in

"adherence clubs" were doing well and showing above average interest in their health. Adherence clubs are groups attached to a clinic and facilitated by a community HW, where patients who are stable and adherent on ART can come and collect their medication without a formal clinic visit.²⁶

Health Worker Perceptions of Factors Shaping Men's Engagement in HIV Care

Health workers provided a range of reasons for why they thought there were gaps in men's engagement with HIV care. These factors included masculine gender norms and HIV stigma that made it difficult for men to seek care, economic pressures, especially among those men precariously employed, and persistent institutional challenges related to men's experiences and perceptions of the health services

Masculine gender norms. Health workers reported that gendered beliefs about masculinity that put pressure on men to show strength and not reveal any illnesses or other signs of weakness were critical barriers to care. They noted that many men had difficulty in accepting an HIV-positive test result and could not reconcile the prevailing gender norms around being a successful man with the idea of living with HIV. They described how men's initial reactions, along with denial, often included anger and threats of suicide. Men's frequent denial of their HIV-positive status was identified by HWs as a primary reason for their delay in being linked to care for ART eligibility assessment and ART initiation. A HW explained,

Those who are in denial ... they will actually get angry, 'why you trying to actually ruin my life? Why you telling me this and that?' I will actually know that this patient needs more and more counseling, I will try and be patient and try by all means ... to actually show that particular person that this is not the end of the world.

An additional barrier, again rooted in local gender norms, was that men often expressed reluctance to openly discuss health problems of a sexual nature with female HWs. This was especially pronounced among men who originally came from rural areas of the country and did not feel comfortable being examined at all by female staff.

Community stigma against HIV. Health workers reported that the stigma of being HIV positive was a significant factor among their male patients, causing men not only to drop out of services but also to default once initiated on ART. Men feared that members of their communities would see them in health care facilities and assume (or discover) that they were HIV positive. They did not want to be seen in clinics since many members of their communities (such as friends and neighbors) were unaware of their HIV status and could see them seeking HIV and/or TB services.

The neighbours are coming here, too many people are seeing each other here, friends, the people who are related to them, so they are thinking of all that.

The way patient care is organized in the health facility does sometimes put patients at risk of disclosing their HIV status. It can leave little confidentiality as the allocated waiting areas and consultation rooms can often be a clear indication of a patient's condition. Patients did not want to be seen waiting outside or entering dedicated HIV and TB clinic rooms for fear of stigma, and this discouraged them from being consistent in their engagement with the health facility. A female nurse explained how stigma was associated with fear of disclosure within the health facility:

Stigma is still a lot for some people, it's stigma – it's isolation. Because even the health system isolates HIV-positive patients. For instance, people know the line to nurse Mangana's [pseudonym] room is for patients coming for ART. They are scared that if the sister passes or a community member, 'They will know I am HIV positive', and that fear is why they will not come back again. The structure of the clinic should change. Every [HW] should be trained to work with all patients.

One HW spoke to a teacher in that community who was uncomfortable collecting his ARV out of fear that he might be seen by the parents of the children whom he taught. Some men were said to prefer accessing HIV testing and ARV services in a different health care clinic from the one in their community, to increase privacy and confidentiality. Health workers reported that sometimes men would initiate care or drop out of care at one clinic, only to reinitiate care at another clinic, as if they were a new patient who did not know their HIV status:

Women are more open than men, and with some men, when they test positive in this clinic . . . he'll prefer to run away and go to another clinic. Some of them run away from other clinics and they come to this clinic. When you initiate them or take the baseline bloods . . . you discover this person has been on ARVs in X clinic or in Y clinic. But they're coming to you like it's the first time they [have] ever initiated ARVs.

These examples point to the persisting power of HIV stigma, a social barrier that affects both men and women, but one that is often intensified by masculine gender norms to not show weakness.

Economic considerations. Health workers reported that staying in HIV care became difficult when a male patient was employed because they needed to balance going to the clinic with the need to not miss a day of work, especially for families already in poverty. For those with unsympathetic employers, there was the greater fear of losing their job, with men facing the difficult task of how to balance the competing interest of their health needs against their economic needs. One HW explained,

In some families it is only the man working most of the time. So, if the man normally expected to be at work, then that means that self-care is not a priority and is not going to improve because that guy needs to be at work. So, you find that especially when ARVs came out and they were every two weeks, people complained about their bosses at work. Some men were retrenched if HIV positive because they had to go to the clinic (to get their pills) . . . Those who are working would love to ensure care, but sometimes it's impossible.

Men who were unemployed were regarded as having more opportunity to attend the health care facility and to adhere to treatment. On the other hand, HWs point out that men who were unemployed were more at risk from other factors exacerbated by unemployment, including problems such as substance abuse, which may negatively affect ART adherence.

Expectations and responsiveness of the health services. Health care workers also identified several issues related to the health care services that they thought hurt men's engagement with care. The main issue identified here related to men's perception of the patient-provider relationship as poor; in particular, HWs reported that some of their patients felt that health care workers had a poor attitude and that they were not responsive to the patient's health needs.

Health workers were aware that they had a reputation among patients of seeming "unkind" (in how they treated patients) and "rough" (in how they examined patients). Female HWs said they were aware that men had negative stereotypes of them and that, as a result, some men preferred to be seen by a male HW.

Yes, there is a lot, there is a lot about the nurses' attitude. You listen to radio, people will tell that they don't get good care from us. I was recently in Khayelitsha in a youth development meeting. They were complaining about us not giving good care, having bad attitude.

Health workers acknowledged that this was a common perception of nurses and noted that, in their own defense, nurses sometimes became frustrated at the lack of cooperation on the part of male patients, such as defaulting from treatment.

Health workers also pointed to poor interactions between patients and clinic reception staff and acknowledged that such frustrations could only be addressed at a higher level of health system management. Health workers described how a negative experience at the start of a clinic visit often resulted in men forming a negative opinion of all subsequent interactions with HWs, including nurses.

I don't know whether I'm trying to defend my colleagues and myself, [but] what I've noticed is that the community does not differentiate between clerks and nurses. Everybody that is in clinic is [seen as] a nurse.

Health workers felt that some of the frustration of male patients may also be due to their unrealistic expectations. Health workers argued that some patients did not have a full understanding of the health system, HW roles, and how health

services were delivered. Another health systems barrier frequently identified was the long waiting times that men said made them hesitant to visit health facilities. Participants offered a range of reasons for men's frustrations with waiting times, including that men were more impatient than women, that they were less familiar with or accepting of the persistent fact of long waiting times in the public services, and that they did not understand the organization's patient flow system or appreciate the heavy workload of clinic staff.

Some HWs were of the view that men also did not always understand the clinical process either, such as the need for a thorough physical examination before prescribing medicine. Others felt that men were irresponsible in relation to their own health, that some had attitudes of entitlement related to their status as men (entitling them to more respect and privilege), and that men were impatient and simply did not like to wait.

Health Worker Strategies and Recommendations for Enhancing Men's Engagement

Health care workers described several strategies they employed to improve the direct engagement between patients–providers as well as recommendations for how the health services more broadly could better engage men by promoting male-friendly service delivery approaches.

Improving the engagement between patients and providers. Health care workers (both female and male) shared numerous examples of their own efforts to improve patient–provider interactions with male patients. Most efforts were geared toward tailoring their clinical communication to establish more of a rapport with the patient and to allow the patient to “open up” about what the real problem is. The use of icebreakers, and joking with the patient, assisted in getting male patients to engage in conversations that they would otherwise deem “uncomfortable” or “embarrassing.” A female nurse noted that she engaged male patients in some open-ended interactive conversation, which made it more comfortable for her male patients to undergo their physical examination.

One element of this strategy was to try and be more “relatable” to their male patients to encourage them to open up about their health. Speaking in the language men understood and related to—often by using simpler and more colloquial forms of language—was one way of connecting with their patients. A male HW noted that in addition to being of the same gender as his patients, coming from the same culture and sometimes even from the same local community was a major advantage in engaging men and allowing them to share deeply personal health concerns. This was especially true of health problems related to sexually transmitted illness, but also problems of sexual dysfunction that men were said to find more difficult to raise with female HWs.

[The issue ranges from] some men wanting to be treated by a male nurse, which has become a scarce commodity itself, to somehow the men seeking services that somehow we are not competent to

provide. Like, [the] majority of them, I'm told, they do come there for erectile dysfunction issues. So issues that are beyond the normal scope of practice of our professional nurses . . .

Simply being attentive to their male patient's needs and questions was thus one of the key strategies for engaging men. One health care worker, though, described a contrasting approach. She would take on a more serious demeanor with male patients whom she felt may not be respecting her professional competency as a way of affirming her professional role. She would sometimes give them an ultimatum and inform her patient of the value of her time and tell him to leave if he did not want to be seen by her.

Sometimes a man will come because he has problems with his genital parts and there's no other doctor . . . he will tell you. 'I've got this problem' but he'll refuse to be undressed in front of you. And . . . [I say], 'OK, if I can't undress you, you don't need help, you go out. Oh, so you really want to see me? . . . I don't have time . . .' All the time, for certain people, you have to affirm your status as a professional.

She said this approach was effective because it encouraged men to see her as a professional first, rather than as a woman first, and that it also worked against the disrespect and entitlement that male patients could sometimes show female HWs.

Some HWs also pointed to the importance of encouraging men to advocate for change. One HW suggested that part of the reason men may be complaining about poor health care services is that patients are now more informed of their right to proper health care. Along the same lines, some HWs said they even encouraged patients to use their personal power and agency to demand better treatment when visiting health care facilities. They told men about the various channels for lodging complaints about mistreatment of patients in health care facilities. Another HW said that in the past, he has had to intervene and instruct reception staff on ways to improve their patient record folder retrieval so as to improve the patient flow. All of these efforts focused on engaging men not only by addressing their own medical concerns but also showing them how their active engagement could improve the local health system, a system that feels to many of them as both low quality and hard to hold accountable.

Recommendations for male-friendly health services. There was a recognition that more could certainly be done to improve patient satisfaction with primary care services, for both men and women. A major area for improvement that HWs identified was fixing administrative problems related to the reception services, such as opening patient record folders for new patients and retrieving patient record folders for enrolled patients. This could reduce long waiting times. They added, though, that frontline staff also needed to have a more patient-friendly approach to engaging with patients in general, and especially with men who are feeling uncomfortable about

attending the clinic and/or aggrieved by their previous treatment in the health services.

Health workers also pointed out current initiatives for dedicated male services in the Cape Town area and argued that this represented an important recognition that the health authorities were aware of and trying to respond to gaps in health care for men. These initiatives included special clinic days for men's health, a male wellness center for health screening (part of an NGO–government partnership), and a satellite clinic for men's health care that has an all-male staff. These initiatives have had varying level of success and the sense was that some of these services, though effective and acceptable, were not sustainable in the long run. One health manager noted that there were also a range of other male-friendly initiatives that could be tried, including extended, after hours services and Saturday services.

One middle manager reflected on the multiple challenges of offering dedicated male health services, arguing that male nurses are few in number, there is insufficient administrative staff capacity and technical resources to enable appropriate and integrated information and monitoring systems, and such stand-alone and male-specific services are inevitably more costly. This manager argued that more comprehensive planning was needed to assess the feasibility and sustainability of services to enhance male engagement in care. She did argue, though, that the general health services could be much more proactive and responsive at trying to engage men in health services. This would require a shift in mindset among staff and managers, to see men as a group that requires special attention. She explained,

In general, I'd say probably it has been accepted as a norm that men don't come, which should change. Basically, we should have a mindset shift to say that they are a special group like we are looking at . . . But I think it's inadequate, . . . more [of] that needs to be done to make sure . . . [that] every single health worker understands that men should be treated as a special group in order for us to be able to attract them into the health system, make them partners in managing whatever conditions we have, as well as being able to retain them within the system, as soon as they enter, at least we should not lose those that we have attracted.

She explained that ultimately men should feel free to be use the general health services and that male-friendly services were really just patient-friendly services. In the interim, however, she argued that there may be a need for dedicated male health services:

So I think there is still a need for a special space for them (men) until we get to a point where we say now we have saturated the space, they are part of the health system and they feel free in any health facility despite it not being called men's clinic at the point where they are ready to be treated by any other health personnel . . . whether they are female or male. So I think just giving them that space for me works well for them and it shows that we do care and want them to be part of the system.

She, like several other HWs, felt that getting men better engaged in care would require proactive work and focus on the part of the health services, but that this focus need not be permanent and that a service that was more friendly to all of its patients would inevitably be more welcoming to men.

Discussion

This study examined the experiences and perceptions of HWs who provide HIV services in public-sector primary care settings in a subdistrict of Cape Town, South Africa. It explored their views on the factors that may be driving men's poorer engagement across the stages of the HIV care cascade and sought to identify strategies that HWs used to better engage men in HIV care.

The literature describing the psychological, social, and gender-related barriers to men's engagement in care is sizeable and HWs in this study described many of the same barriers described in this literature, including men being in denial about their HIV status, men fearing HIV stigma, men not seeking care, remaining in care or fully engaging with HWs because of gendered cultural norms, and fears of being seen within the clinical space by friends and neighbors.^{7,18,27-32}

Some of the most important findings from HWs in this study, however, relate to a relatively underexplored set of issues in the literature—the interactions between male patients and the health services themselves.¹⁶ Health workers in this study recognized, for example, that men often had strongly negative stereotypes of HWs caused by unpleasant experiences, such as encountering “rude” reception staff and long waiting times in health facilities. Health staff expressed a desire to provide friendly and efficient health care services to their male patients, but acknowledged this did not always happen. The patient–provider relationship is often characterized as one of mistreatment by providers who are described as overworked and underpaid.³³ In this study, HWs did not deny these problems, but they also expressed regret for poor treatment of patients and aspirations for improved provider–patient relationships. They acknowledged that poor patient–provider relationships may contribute to patients avoiding certain care facilities²⁸ and that more patient-centered care would be more holistic, improve patient–provider relationships, and promote good health in patients.³⁴

Our study also found that HWs employed a range of techniques to enable them to relate to male patients and to allow male patients to feel more comfortable discussing their health conditions. Health workers used icebreakers such as jokes, spoke in familiar versions of the local language, or put on a more “tough” and professional attitude to improve how they related to their patients. This finding is similar to other studies that have described HW strategies to improve interpersonal interactions with their male patients. Male community care workers (CCWs) in one South African study used methods such as a friendly attitude, being clear about the purpose of their visits, and indirect conversation to avoid threatening the masculine gender norms of their male patients.³⁵ As in this

study, the aim of such strategies was to allow men to open up to health care staff and actively engage with health care.

Health workers in this study also used language as a way to improve their engagement with men and, in some cases, demand more respect from men. In another South African study, CCWs enacted similar performances to gain compliance from their patients. The “performance” a nurse selected depended on the patient and could range from coercive to supportive approaches.³⁶ Health workers used their knowledge of what was socially acceptable in order to decide which performance would work with a particular patient. The shared social context between the HWs in that study, and their patients, helped them to know how to select appropriate performances.³⁶ An accurate and accepting understanding of their patients’ cultural values can lead to important, positive clinical outcomes.³⁷

With respect to the implications of these findings for research and practice, our study demonstrates the complex and multidimensional nature of men’s and HWs’ engagement with each other in the health services. This engagement cannot be reduced to simply an issue of restrictive gender norms (as important as these may be).¹⁷ This means that the avenues for improving this engagement must also be multidimensional. It is also clear that many HWs, despite their somewhat negative assessments of men’s health-seeking practices, also really want to better engage men. Future research should explore in more detail what kinds of strategies might improve this relationship, and future interventions should build off of the good will and good intentions of HWs, male and female, and not assume that all HWs are merely stigmatizing of male patients.

A strength of this study is the range of health care workers included and their extensive experience of the health services, which allowed for sharing deep insights. Participants included health service managers, clinical staff, and lay counselors. A male HW had extensive experience in working in various male-focused health care services, in the public sector, and community-based settings and was, therefore, able to offer a unique perspective. In retrospect, given the important role ascribed to frontline reception services in this study, one limitation is the absence of reception staff in the sample. The qualitative methodology may limit transferability of the findings to other settings.

It is likely that no one strategy will be sufficient to improve men’s engagement in HIV services and that more thinking is needed around what would constitute an a comprehensive, feasible, and sustainable set of strategies to improve men’s engagement in care, not only in HIV, but in all areas of health care where men’s engagement is poor. While there may be need for research, policy, and interventions focused on male-specific services, we also at the same time need to look at how we can transform the existing, predominantly female-staffed health care services into a service that effectively and sustainably increase the supply, access, and quality of health care services for men. Along with the HWs in our study, we ask what would a primary care service look like that is both patient-friendly and male-friendly, in ways that would motivate and

incentivize males to engage with health care services in general and in ways that address their HIV care needs?

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References

1. Joint United Nations Programme on HIV and AIDS. *Global HIV & AIDS Statistics — 2019 Fact Sheet*. UNAIDS; 2019.
2. Boesten J, Poku N. *Gender and HIV/AIDS: Critical Perspectives from the Developing World*. Ashgate; 2009.
3. Harrison A, Colvin CJ, Kuo C, Swartz A, Lurie M. Sustained high HIV incidence in young women in southern Africa: social, behavioral, and structural factors and emerging intervention approaches. *Curr HIV/AIDS Rep*. 2015;12(2):207–215.
4. Joint United Nations Programme on HIV and AIDS. *HIV Prevention Among Adolescent: Fast-Tracking HIV Prevention Among Adolescent Girls and Young Women*. UNAIDS; 2016.
5. Joint United Nations Programme on HIV and AIDS. *Blind Spot: Reaching Out to Men and Boys*. UNAIDS; 2017.
6. Cornell M, Cox V, Wilkinson L. Public health blindness towards men in HIV programmes in Africa. *Trop Med Int Health*. 2015; 20(12):1634–1635.
7. Fleming PJ, DiClemente RJ, Barrington C. masculinity and HIV: dimensions of masculine norms that contribute to men’s HIV-related sexual behaviors. *AIDS Behav*. 2016;20(4):788–798.
8. Sharma M, Ying R, Tarr G, Barnabas R. Systematic review and meta-analysis of community and facility-based HIV testing to address linkage to care gaps in sub-Saharan Africa. *Nature*. 2015;528(7580):S77–S85.
9. Cornell M, Johnson LF, Wood R, et al. Twelve-year mortality in adults initiating antiretroviral therapy in South Africa. *J Int AIDS Soc*. 2017;20(1):21902.

10. Tsai AC, Siedner MJ. The missing men: HIV treatment scale-up and life expectancy in sub-Saharan Africa. *PLoS Med.* 2015; 12(11):e1001906.
11. Jewkes R, Morrell R. Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention. *J Int AIDS Soc.* 2010;13:6.
12. Jewkes R, Morrell R, Hearn J, et al. Hegemonic masculinity: combining theory and practice in gender interventions. *Cult Health Sex.* 2015;17(suppl 2):S112–S127.
13. Skovdal M, Campbell C, Madanhire C, et al. Masculinity as a barrier to men's use of HIV services in Zimbabwe. *Global Health.* 2011;7.
14. Katirayi L, Chadambuka A, Muchedzi A, et al. Echoes of old HIV paradigms: reassessing the problem of engaging men in HIV testing and treatment through women's perspectives. *Reprod Health.* 2017;14(1):124.
15. van Rooyen H, McGrath N, Chirowodza A, et al. Mobile VCT: reaching men and young people in urban and rural South African pilot studies (NIMH project accept, HPTN 043). *AIDS Behav.* 2013;17(9):2946–2953.
16. Dovel K. *Shifting Focus From Individuals to Institutions: The Role of Gendered Health Institutions on Men's Use of HIV Services Denver: Health and Behavioral Sciences*, University of Colorado; 2016.
17. Dovel K, Yeatman S, Watkins S, Poulin M. Men's heightened risk of AIDS-related death: the legacy of gendered HIV testing and treatment strategies. *AIDS.* 2015;29(10):1123–1125.
18. Colvin CJ. Strategies for engaging men in HIV services. *Lancet HIV.* 2019;6(3):e191–e200.
19. Dovel K, Shaba F, Offorjebe OA, et al. Effect of facility-based HIV self-testing on uptake of testing among outpatients in Malawi: a cluster-randomised trial. *Lancet Glob Health.* 2020; 8(2):e276–e287.
20. Colvin CJ, Pinxteren MV, Schmidt BM, et al. Health Information as a catalyst for community health system engagement. *South Afr Health Rev.* 2018;2018:135–139.
21. Shisana O, Rehle T, Simbayi L, et al. *South African National HIV Prevalence, Incidence and Behaviour Survey, 2012*. Human Sciences Research Council; 2014.
22. Brown DC, Belue R, Airhihenbuwa CO. HIV and AIDS-related stigma in the context of family support and race in South Africa. *Ethn Health.* 2010;15(5):441–458.
23. Green J, Thorogood N. *Qualitative Methods for Health Research*. 4th ed. SAGE; 2018.
24. Matthews B, Ross L. *Research Methods: A Practical Guide for the Social Sciences*. 1st ed. Pearson Longman; 2010.
25. Lincoln YS, Guba EG. *Naturalistic Inquiry*. Sage Publications; 1985.
26. Kehoe K, Boulle A, Tsondai PR, et al. Long-term virologic responses to antiretroviral therapy among HIV-positive patients entering adherence clubs in Khayelitsha, Cape Town, South Africa: a longitudinal analysis. *J Int AIDS Soc.* 2020;23(5): e25476.
27. Dahab M, Charalambous S, Hamilton R, et al. "That is why I stopped the ART": patients' & providers' perspectives on barriers to and enablers of HIV treatment adherence in a South African workplace programme. *BMC Public Health.* 2008;8:63.
28. Horter S, Thabede Z, Dlamini V, et al. "Life is so easy on ART, once you accept it": acceptance, denial and linkage to HIV care in Shiselweni, Swaziland. *Soc Sci Med.* 2017;176:52–59.
29. Chikovre J, Gillespie N, McGrath N, Orne-Gliemann J, Zuma T; Group ATS. Men, masculinity, and engagement with treatment as prevention in KwaZulu-Natal, South Africa. *AIDS Care.* 2016; 28(suppl 3):74–82.
30. Mooney AC, Gottert A, Khoza N, et al. Men's perceptions of treatment as prevention in south Africa: implications for engagement in HIV care and treatment. *AIDS Educ Prev.* 2017;29(3): 274–287.
31. Moshabela M, Zuma T, Orne-Gliemann J, et al. "It is better to die": experiences of traditional health practitioners within the HIV treatment as prevention trial communities in rural South Africa (ANRS 12249 TasP trial). *AIDS Care.* 2016;28(suppl 3): 24–32.
32. Leichter JS, Paz-Bailey G, Friedman AL, et al. 'Clinics aren't meant for men': sexual health care access and seeking behaviours among men in Gauteng province, South Africa. *SAHARA-J.* 2011; 8(2):82–88.
33. Govender V, Penn-Kekana L. Gender biases and discrimination: a review of health care interpersonal interactions. *Glob Public Health.* 2008;3(suppl 1):90–103.
34. Little P, Everitt H, Williamson I, et al. Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations. *BMJ.* 2001;323(7318):908–911.
35. Gittings L. 'When you visit a man you should prepare yourself': male community care worker approaches to working with men living with HIV in Cape Town, South Africa. *Cult Health Sex.* 2016;18(8):936–950.
36. Vale E. I know this person. *Why Must I go to Him? Techniques of Authority Among Community Health Workers in Cape Town*. Centre for Social Science Research; 2014.
37. Flores G. Culture and the patient–physician relationship: achieving cultural competency in health care. *J Pediatr.* 2000;136(1): 14–23.