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Viewpoint Men and antiretroviral therapy in Africa: our blindspot

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As antiretroviral therapy (ART) becomes more widely available, issues of access and equity within and between populations are becoming increasingly important. In the early years of ART, there were understandable concerns that due to gender inequalities, men might have better access to treatment than women (Wood et al. 2003). However there is mounting evidence that men are at a distinct disadvantage in the roll-out of ART in Sub-Saharan Africa. Disproportionately fewer men than women are accessing ART across Africa (Muula et al. 2007). Men are starting ART with more advanced HIV disease (Cornell et al. 2009, Stringer et al. 2006), men are more likely than women to die on ART (Cornell et al. 2010, Taylor-Smith et al. 2010) to interrupt treatment (Kranzer K et al. 2010) and to be lost to follow-up on ART (Ochieng-Ooko et al. 2010).

Despite this evidence of gender inequity in access to ART, most international and national ART-related policies and programmes in Africa are still blind to men. For example, nowhere in the UNAIDS epidemic updates or country progress reports is men's access to ART identified as a gap and prioritized for urgent action. The recent 2010 Global Report on the epidemic (UNAIDS 2010) highlights the need to ensure equitable access for children, pregnant women and key populations at risk; men's inequitable access to ART is mentioned only in passing. This lack of attention to men permeates the international funding arena. The United States, the largest bilateral donor, has provided funding for treatment for nearly 2.5 million individuals through its PEPFAR programme. Although 62% of these are female, PEPFAR does not identify men's access to ART as an issue requiring action. The Global Fund for HIV/AIDS, TB & Malaria (GFATM), the largest multilateral HIV/AIDS funding agency, identifies equitable access to services as fundamental to its mission. Despite this, the Fund's comprehensive strategy document on gender equality and HIV/AIDS fails to identify gender inequity in access to ART (Global Fund to Fight TB 2008).

Many southern African countries have made remarkable progress in expanding access to ART, but patients have been disproportionately female. In South Africa, about 55% of those living with HIV are women but more than two-thirds of patients receiving public sector ART are female (Cornell et al. 2010). Similarly in Zambia, 54% of those living with HIV are women yet 63% of adults starting ART in Lusaka were female (Stringer et al. 2006). Both countries have detailed national strategic plans yet neither identifies male access as a gap or includes plans to address it (National Department of Health, National HIV and AIDS Council 2006).

Why are we blind to this glaring inequity in access to treatment? One possible explanation is that public sector health services in many parts of Africa historically have focused on maternal and child health issues, and in turn most health care services are often oriented to engaging women. Another possibility is that advocacy for women's rights in the HIV

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epidemic has been highly successful and has overshadowed the needs of men. In sexual and reproductive health circles, men's health issues are often seen as secondary to those of women and men have been described as the 'forgotten fifty per cent' in sub-Saharan Africa (Varga 2001). A similar phenomenon may exist with access to and uptake of ART.

Ensuring equitable access to ART for men should not prejudice any other vulnerable group, or threaten the gains made in HIV prevention and treatment for women. However, global and national plans and programmes need to recognize this as an issue requiring urgent attention. Such immediate orientation will signal a true commitment to equitable access to ART in Africa.

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