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The importance of masculinity and gender norms for understanding institutional responses to HIV testing and treatment strategies

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We applaud Dovel et al. [1] for bringing attention to the gender disparity in HIV mortality in Africa. Their article is a thoughtful and insightful examination of evidence from across the region and they have adeptly pinpointed the institutional policies of health service settings as a key area to target to reduce disparities in HIV mortality.

While Dovel and colleagues provide an important perspective, we challenge their minimization of the importance of gender norms – and specifically norms of masculinity – as a primary cause of this disparity. Dovel et al. partly discount masculinity as an explanation because men initiate HIV testing and treatment "at similar rates as women" and because they claim that naming masculinity as a driver of this disparity "blames men" (p. 1123). Several recent studies have highlighted that norms of masculinity such as self-reliance and strength present important barriers to men engaging in each of these behaviors [2–5] and that men initiate HIV testing, care and treatment less than women in many African settings [6–9]. The conceptualization of masculinity as *blaming* men offered by Dovel et al. is exceedingly narrow. Scholarship shows that masculinity is not an individual construct but a structural factor that shapes individual behavior [10, 11]. Norms of masculinity are embedded within societal level gender norms and enforced by social institutions (e.g. schools, military, and government) and social networks (e.g. family members, peers) [10]. Thus, research showing that masculinity is contributing to HIV mortality disparities is highlighting a social structure that needs to be modified, not problems with individual men's behaviors.

The authors' narrow conceptualization of masculinity ignores the fact that that the institutional policies – which Dovel et al. correctly point out are crucial drivers of this disparity – exist because these institutions operate within a system of gender norms that emphasizes women's vulnerability and men's lack of vulnerability [12, 13]. For example,

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Dovel et al. highlight how policies encouraging men to attend antenatal visits are marketed as important for the mother's health and completely ignores the father's health (p. 1124) [1]. This implicit message that women need health services and men do not is in fact driven by underlying gender norms that men are strong and independent and women are vulnerable and need to be taken care of.

Importantly, Dovel et al. acknowledge that policies are shaped by donors' and institutions' conceptualization of the problem: "Women are frequently depicted as the face of AIDS in sub-Saharan Africa (SAA)…Donor dollars, policies and HIV programmes have followed suit, resulting in a near-exclusive focus on women." (p. 1123). This did not occur by accident, but rather as a response to women's invisibility in the early days of the epidemic [12, 14, 15]. Pregnant women and housewives were a palatable focus for donors and policy-makers, whereas gay men and drug users were not [12, 16]. Female sex workers were initially problematized as blameworthy disease vectors, but funding increased when they began to be viewed as victims of gender inequalities [12]. Gender norms played an important part in the transition to the women's vulnerability paradigm: institutions focused limited resources on *vulnerable* women and pressed men to take responsibility for themselves and be *self-sufficient* [12, 14]. This vulnerability vs. self-sufficiency dichotomy is at the heart of societal gender norms and at the heart of institutional policies in place today that dictate how, when, and where HIV testing, care, and treatment occurs. Ignoring these roots makes it more challenging to make policy changes that will have this much needed gender-specificity.

We certainly agree with Dovel et al. that institutional policies are impeding men's HIV testing, care and treatment; however, we also contend that masculinity – and societal gender norms more broadly – are primary contributing factors. Reducing the disparity in HIV outcomes will require changes at both the policy/institutional level and changes in gender norms. To address this disparity, we urge the development of interventions that operate at both the (1) community-level to change men and women's conceptualization of gender/masculinity, and (2) institutional-level to transform how policy makers and service-providers think about the epidemic and priorities. Gender-transformative interventions – those that aim to shift masculine gender norms towards gender equality as a strategy to achieve health goals – are one potential avenue [17, 18]. However, these evidence-based interventions have yet to be applied to the HIV treatment cascade. This type of multi-level intervention targeting both community-level conceptualizations of gender and institutional level gender-related policies is likely to be effective at rapidly reducing this critical gender disparity in HIV mortality in sub-Saharan Africa.

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