initial reaction was mixed, but all agreed with the main message: clinical experts who write guidelines are often influenced by (usually) declared financial conflicts and by equally important undeclared intellectual conflicts of interest. These conflicts of interest should be managed by placing the final responsibility for recommendations in the hands of unconflicted methodologists. The result will be improved integrity of future guidelines.

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Expanding HIV care in Africa: making men matter

By contrast with many public health programmes, the drive to scale up combination antiretroviral therapy (cART) in the developing world has been constantly appraised for equity. Strong advocacy efforts have brought to the attention of policy makers groups who are often overlooked in service provision, such as men who have sex with men, sex workers, prisoners, and migrants.

Efforts to improve access for women have received particularly important attention in the rollout of cART. There have been calls to establish a UN agency for women as key to combating the AIDS epidemic,[1] and international advocacy groups have called on donors to provide more funding for women's issues[2] and to prioritise women's rights in the fight against HIV.[3] Clinical research is also a gender issue, with major granting agencies specifically mandating that women be included in proposals.[4] But with all this focus on girls and women, where do we stand with providing care to men?

Emerging evidence suggests that we are far more successful at providing cART to women than to men. One of the largest studies of cART coverage from the ART-LINC evaluations across 23 cohorts in Africa (n=28 259) found that men represent a significantly smaller proportion of cART recipients than women (32%, 95% CI 28–36%), although men made up about 41% of infected patients.[5] Similarly, a systematic review of 21 cART programmes in southern Africa found a pooled proportion of 40% (95% CI 0·37–43·0%) men receiving cART, significantly less than the proportion who were HIV positive by sex (46% male).[6] Almost consistently, men appear to enter cART programmes at a more advanced clinical stage and, as a consequence, mortality rates are higher in men.[5,7] Whilst published data on retention in care is mixed, with some studies reporting more men defaulting[8] and others reporting the contrary,[9] data from Médecins Sans Frontières's programmes in 109 763 patients in 18 countries show that loss to follow-up at 2 years is higher in men (15·8%) than in women (12·7%), even though most patients (62%) were women (Pujades M, Epicentre, Médecins Sans Frontières, Bern, Switzerland; personal communication).

Differing health-seeking behaviours between sexes are often dismissed by the notion that men view ill health as a sign of weakness and vulnerability.[10] However, behavioural differences are only part of the explanation: in many countries antenatal care services provide an important entry point to HIV/AIDS testing and treating, which creates a particular opportunity for women to access care. Similar access points do not exist for men,

although circumcision programmes, if expanded, would provide such an opportunity in the future.

The focus on women has been well documented for important reasons. Yet, most attention on men has addressed their increased risk profiles because men are more likely to transmit HIV for reasons that include less condom use, more sexually transmitted infections, more partners including polygamous marriages in some cultures, more alcohol misuse, and more transactional sex.[10] Men are also more likely to have careers that keep them far from their families for long periods (eg, in the military or in migrant labour such as mining), which might predispose them to high-risk situations. At the same time, men are less likely to get tested than are women, and so less likely to know their status.[11] Men's movements in search of work might make access to services and adherence difficult. Efforts to understand men's health-seeking behaviour are poorly understood in the AIDS epidemic, and encouraging men to get tested and into treatment is a major challenge, but one that is poorly recognised.

As well as supporting a group that is currently underserved, such a focus would probably have broader public health and economic benefits. Male HIV-positive patients' groups are an important social contributor that can be harnessed to reach out to high-risk male counterparts to reduce risky behaviour, support health and adherence among themselves, and develop small business initiatives for other HIV-positive patients. Moreover, in many settings, men are major providers of household income and enrolling them into treatment would increase economic opportunity for the whole family.

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While there has been an expectation of gender inequality that favours men, the evidence indicates that we are doing a disproportionately poor job of providing them with the medical assistance they need. There is much we can learn from efforts to increase female participation in cART programmes, but far from being seen as a challenging group requiring specific interventions, reflections on men and HIV/AIDS are usually limited to their culpability as drivers of the epidemic. Addressing these issues effectively means moving beyond laying blame, and starting to develop interventions to encourage uptake of prevention, testing, and treatment for men—for everyone's sake.

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