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**Refining HIV prevention efforts for
AGYW through the engagement of their
male sexual partners**

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Abstract

Despite significant progress in HIV prevention and treatment services in African countries, adolescent girls and young women (AGYW) aged 15-24 years continue to experience disproportionately high HIV incidence rates compared to their male peers. Focusing HIV prevention efforts on male sexual partners of AGYW may reduce HIV transmission, as many new cases occur within these peer sexual relationships. Our analysis draws on targeted literature reviews and data from existing national and sub-national datasets on the male sexual partners of AGYW from five countries – Cameroon, Eswatini, Kenya, Lesotho, and Mozambique. This paper examines factors influencing HIV acquisition among male sexual partners of AGYW and their engagement with HIV-related services, and provides recommendations for interventions.

Male sexual partners of AGYW face significant HIV acquisition risks and persistently low HIV testing rates across Cameroon, Eswatini, Kenya, Lesotho, and Mozambique. Early sexual debut, age-disparate relationships, and multiple sexual partnerships are reported key drivers of HIV acquisition. Sexual partnerships are frequently characterised by power imbalances stemming from age and resource (economic and material) disparities, with many AGYW reporting that their first sexual partners were substantially older. Multiple concurrent partnerships are common among male sexual partners, which further complicates relationship dynamics. Critical gaps persist in men's engagement with HIV testing, prevention, and voluntary medical male circumcision services, with many men unaware of their HIV status. Key barriers to accessing HIV services include financial constraints, work commitments, and concerns about the loss of social status. Services become more appealing when they are convenient and address confidentiality concerns, particularly regarding HIV-related stigma.

Recommended interventions are to ensure HIV services are affordable and accessible, and to combine widespread information dissemination with targeted approaches, including U=U (Undetectable = Untransmittable) messaging to educate and motivate men, and addressing power imbalances through educational programmes. Integration of HIV services into existing healthcare and other systems, coupled with innovative delivery methods through healthcare providers, traditional healers, and social media platforms, could improve male engagement. While evidence suggests that targeted interventions can be cost-effective, continued research is essential to better understand effective engagement strategies for men in HIV prevention and care services, including the assessment of their needs, barriers, and motivators that are unique to them per se and not only as male sexual partners of AGYW.

Introduction

In sub-Saharan Africa,¹ adolescent girls and young women (AGYW) aged 15-24 years have a higher rate of HIV incidence than their male counterparts (UNAIDS, 2022). While there have been substantial reductions in overall HIV prevalence among AGYW in Eastern and Southern Africa since the mid-1990s, due to their increased access to HIV prevention and treatment services, new cases continue to be reported at a high rate (Murewanhema et al., 2022). In 2024, 45% of all new HIV cases occurred among AGYW (UNAIDS, 2025), with many of these cases happening in the context of sexual relationships between AGYW and their male sexual partners (Ayton et al., 2023). Leaving AGYW vulnerable and unable to maintain positive health behaviours, these relationships are often characterised by power and gender imbalances emanating from age disparate and transactional sexual relationships, poor partner communication, violence, challenging negotiation dynamics, and varying levels of relationship stability (Atkins et al., 2021; Ayton et al., 2023). For example, in some situations, male sexual partners decide if and when HIV prevention methods such as condoms are used during sexual intercourse (Hoffman et al., 2020; Mushamiri et al., 2019). Additionally, many male sexual partners of AGYW who are living with HIV do not know their HIV status, nor do AGYW know their male partner's status (Hoffman et al., 2020). Thus, any HIV prevention efforts for AGYW should also include their male sexual partners as they are key to reducing the risk of HIV transmission – both for themselves and AGYW.

In this paper, we examine factors that increase HIV acquisition risk among male sexual partners of AGYW, analyse their engagement with HIV-related services,

¹ We acknowledge the contested nature of the term 'sub-Saharan Africa,' which has been criticised for homogenising diverse African contexts and perpetuating colonial frameworks. Where possible, we use specific country names or subregional designations (Eastern Africa, Southern Africa, Western Africa). We recognise that all geographic terminology carries historical and political implications.

and provide recommendations for interventions, policies and programming to improve male engagement in HIV healthcare. Our analysis draws on targeted literature reviews on the male sexual partners of AGYW from five countries – Cameroon, Eswatini, Kenya, Lesotho, and Mozambique. These five countries were focus countries in one component of a Strategic Initiative of the Global Fund, which had the goals of optimising HIV prevention and reducing HIV incidence among AGYW in these countries. The countries represent diverse contexts in Africa, as they vary in HIV prevalence rates, cultural contexts, and healthcare system structures. Kenya and Cameroon represent larger, more diverse populations with varying regional HIV burdens (Jin, Restar & Beyrer, 2021), while Lesotho and Eswatini have among the highest HIV prevalence rates globally (Teasdale et al., 2025). Mozambique faces significant challenges related to healthcare access and infrastructure (Sousa et al., 2024).

The literature synthesis was complemented by secondary data analysis of existing national and sub-national datasets. However, complete datasets were not available for all countries across all indicators examined. For instance, quantitative data on early sexual debut among men was available only for Cameroon, Kenya, and Lesotho, which limited regional comparisons. Where country-specific data were unavailable, we relied on regional studies or inferences from available Demographic and Health Survey data. We primarily utilised country-specific data from the UNAIDS NAOMI Spectrum database, and focused on HIV-related indicators for young men aged 15-24 and 25-34 years (UNAIDS, n.d.). Data specifically focusing on male sexual partners of AGYW were rarely available in these datasets. As a proxy, we used data on men in these age groups, based on evidence from Reynolds et al. (2018), which suggests that these age ranges may represent typical male partner demographics for AGYW in some sub-Saharan African contexts.

Findings

While data specific to the male sexual partners of AGYW were not available for all five countries, the combination of existing literature complemented by data on adolescent boys and young men provided sufficient information for several important insights on key factors that influence the risk of exposure to HIV amongst AGYW and their male sexual partners.

Risk of exposure to HIV

Sexual partnerships involving AGYW are often characterised by power imbalances that stem from age and resource disparities, as well as by multiple partnerships. These dynamics manifest in several ways across different contexts. In Mozambique, more than 1 in 2 women aged 19-24 years reported that their

first sexual partner or partner in the past 12 months was 5 or more years older than they were (Instituto Nacional de Estatística, Ministério da Saúde & Instituto Nacional de Saúde, 2022). Age patterns vary – in Eswatini, for instance, most male respondents (71%) reported current or recent partners between 0-4 years younger than themselves. Furthermore, power differentials persist through varied mechanisms (Reynolds et al., 2018). For example, 78% of male sexual partners indicated a preference for younger women, citing perceptions of them being more agreeable and less likely to engage in conflict (Reynolds et al., 2018; Pulerwitz et al., 2022). These power imbalances are further complicated by patterns of multiple sexual partnerships. In Maroua, Cameroon, studies in a university setting showed significantly higher numbers of lifetime sexual partners among males ($p < 0.0001$), with 63.6% of males reporting three or more partners compared to 46.7% of females (Noubiap et al., 2015). In some districts of Mozambique, 45.5% of men who reported having sex with AGYW had three or more sexual partners in the past 12 months, while 35% of pregnant women reported that their partners had engaged in extramarital affairs (Chapman, do Nascimento & Mandal, 2019).

The intersection of these dynamics – whether through age disparities, resource imbalances, or concurrent partnerships – creates significant barriers for AGYW in negotiating safer sexual practices (Chapman, do Nascimento & Mandal, 2019). Male sexual partners often dominate decision-making regarding condom use, and their perception of AGYW as having lower HIV risk than older women can lead to reduced protective behaviours (Reynolds et al., 2018). This risk is compounded by men's reluctance to discuss their HIV status with their younger partners (Reynolds et al., 2018). AGYW may find themselves unable to assert preferences for safer sex practices, particularly when faced with fears of relationship loss or economic consequences (Chapman, do Nascimento & Mandal, 2019).

According to both data analysis and findings from literature, the incidence of early sexual debut (having sexual intercourse for the first time before 18 years of age) among male sexual partners was high (Reynolds et al., 2018; Demographic and Health Survey Kenya [DHS], 2022; Noubiap et al., 2015). In Lesotho, young men tend to start sexual activity at an early age, with more than 40% initiating sex before the age of 17 (Reynolds et al., 2018). Similarly, in Kenya, 21% of 20-34-year-old men reported that they had an early sexual debut, with variations showing rates as high as 35.8% in certain areas. Also in Kenya, 19% of adolescent boys and young men reported having had sex before the age of 15 (UNAIDS, n.d.). In a study of university students in Maroua, Cameroon, 80.8% were sexually active, with a mean age at sexual debut of 18.1 years (Noubiap et al., 2015). Male students were more than twice as likely as female students to report sexual debut before age 18, as were students of urban origin (Noubiap et al., 2015). The 2018 Violence Against Children Surveys from Lesotho found that an early sexual debut (below 18 years old in this case) increases the risk of HIV

transmission (Mchenga et al., 2025). Similar quantitative evidence is not currently available from Mozambique, Kenya, and Eswatini.

The risk of HIV acquisition among men aged 15-49 shows consistent age-related patterns across countries, with higher rates among older age groups, although the magnitude varies significantly by location. In Cameroon, HIV prevalence among men aged 25-34 (2.4%) is nearly triple that of men aged 15-24 (0.9%), with an even wider gap in the East Region (4.3% among men aged 25-34 vs 1.6% among those aged 15-24). Similar age-related patterns are observed in Eswatini, where HIV incidence rates are substantially (over four times) higher among men aged 25-34 (1.46%) compared to those aged 15-24 (0.31%). In Kenya, while overall incidence rates are lower, the pattern persists, with higher rates among older men (0.09% for ages 25-34) than younger men (0.05% for ages 15-24). Geographic variations are also notable within countries. For instance, in Kenya, Nyanza Province reports significantly higher new infections across both age groups compared to other regions, while North Eastern Province reports minimal new infections (UNAIDS, n.d.).

Young men's engagement with HIV-related services

Critical gaps persist in young men's engagement with HIV testing and prevention, and voluntary medical male circumcision (VMMC) services. Low rates of HIV testing amongst young men is another factor increasing the risk of transmission both for themselves and their AGYW partners. In Kenya, among men living with HIV, 38.7% aged 25-34 are unaware of their HIV status (DHS, 2022). This lack of awareness can be attributed, at least in part, to the relatively low rates of past-year testing among men: only 25% of men aged 15-24 and 55.6% aged 25-29 had undergone HIV testing in the past year and received results (DHS, 2022). Low rates of annual HIV testing among men were associated with an increased risk of HIV acquisition among both them and their partners, as neither was aware of their HIV status (Doyle et al., 2018). For instance, a study conducted in Gem (Siaya) in Kenya revealed that 30.9% of AGYW with spousal partners, 38% with regular partners, and 63.6% with casual partners were unaware of their male partner's HIV status (Doyle et al., 2018).

Issues arising from the lack of HIV-testing uptake are further compounded by low rates of pre-exposure prophylaxis and condom use among male sexual partners of AGYW (Drake et al., 2015; Cabral et al., 2018). In Lesotho, men had lower rates of HIV testing and pre-exposure prophylaxis than women did, while VMMC and condom use were lower for older men (25-34) than younger men (15-24) (Lesotho Population-based HIV Impact Assessment, 2020). In Mozambique, the reasons for not undergoing VMMC included the fear of complications, circumcision not being part of one's culture, and not having

enough time to attend circumcision-related services (Hines et al., 2021). Despite this, 85% of the Mozambiquan men knew that VMMC was partially protective against HIV acquisition. Additionally, 96% of women believed men should be circumcised; however, only 29% of women had ever spoken to their male sexual partners about it (Hines et al., 2021).

Among men, key obstacles to the use of HIV services include financial constraints, work commitments, and concerns about losing social status (UNAIDS, 2022), although these barriers manifest differently across countries and age groups. In Lesotho, HIV-related stigma remains one of the biggest barriers to HIV testing, with men expressing concerns about being seen at health facilities and their HIV-positive test results becoming known in their communities. One study found that HIV-testing services become more appealing to men when services are convenient, when the men feel that their concerns about stigma and confidentiality are attended to, and when their perceptions that health facilities are spaces for women are minimised (Michalow et al., 2019). This masculinity-related stigma intersects with HIV-related stigma, because men face social pressure to appear strong and invulnerable, which makes healthcare-seeking behaviour culturally challenging (Leichter et al., 2011). In Cameroon, age-specific barriers were clear: younger men (21-30 years) displayed higher acceptance of HIV testing, often due to its normalisation and free availability, while middle-aged men (31-40 years) were concerned about how testing would affect their work commitments. These concerns point to a need for flexible hours and workplace-based services (Katirayi et al., 2023). Following this age-related trend, older men (41 years and above) exhibited the lowest inclination for testing; they expressed fears about social repercussions and concerns about maintaining their status within family and community structures (Katirayi et al., 2023).

However, all age groups in Cameroon were motivated to begin treatment post-HIV diagnosis, which indicates that post-test support and treatment readiness represent important intervention opportunities (Katirayi et al., 2023). Additional barriers identified across countries include transportation costs to reach health facilities, particularly in rural areas of Mozambique and Lesotho; economic hardship for men supporting families when they take time away from income-generating activities; fear of partner abandonment or relationship dissolution upon HIV diagnosis; and cultural beliefs about masculinity that discourage help-seeking behaviours (Leichter et al., 2011; Michalow et al., 2019). Healthcare facility environments that are perceived as female-oriented spaces exacerbate these barriers, as do concerns about confidentiality breaches by healthcare workers who may be well known within small communities (Michalow et al., 2019). There was little comparative data related to HIV testing and VMMC from Eswatini.

Recommendations

These insights indicate that there are three areas to strengthen HIV prevention efforts. First, the development of interventions is required to specifically address power imbalances within relationships, by focusing on empowering both AGYW and their male sexual partners. This could involve educational programmes aimed at promoting good communication, gender equality, and mutual respect. Communication enhancement programmes, focused on improving dialogue between male sexual partners and AGYW by offering tools and skills for effective communication on topics related to sexual health, including HIV prevention, could be offered and tailored to each country's cultural context.

In Cameroon, where university students showed high levels of sexual activity and risky sexual behaviour (Noubiap et al., 2015), campus-based peer education programmes could be implemented through existing student organisations. In Lesotho and Eswatini, where traditional leadership structures remain strong (Leichliter et al., 2011; Reynolds et al., 2018), interventions should engage traditional authorities and healers as implementers. Mobile testing units may be particularly effective in Mozambique, where healthcare infrastructure challenges limit facility-based services, and in Lesotho, where geography hinders access to services in mountainous areas. Workplace-based testing programmes could address work-related barriers identified in Cameroon, and address risk in and around large infrastructure or high-mobility areas in Lesotho and Eswatini. Kenya's national HIV prevention plan recommends integration of interventions across sectors, including the primary healthcare sector (Katirayi et al., 2023).

Early and age-appropriate programming is also key, as children and adolescents learn and internalise gender norms and stereotypes at a young age, with these patterns of behaviour typically solidifying by around age 15 (United Nations Children's Fund, 2020). A correlation between lower education levels, insufficient knowledge about HIV, and higher HIV prevalence indicates the importance of in-school interventions (Njuguna & John-Stewart, 2023; Makusha et al., 2023). These programmes could also offer an educational component to raise awareness about HIV prevention and transmission, and the importance of shared responsibility within relationships (Peltzer et al., 2012).

Second, despite efforts to tackle the accessibility and acceptance of HIV services among men, and emphasising the importance of promoting a more gender-equitable form of masculinity, greater efforts to understand men's unique needs are required in order to make HIV testing services more available, accessible, and affordable for male users (Njuguna & John-Stewart, 2023). This may involve providing free or low-cost testing services, expanding testing locations, and extending testing hours to accommodate diverse work and life schedules. In Kenya, where work commitments were identified as barriers, extended clinic

hours and weekend services could be integrated into the existing primary healthcare infrastructure.

Secondary distribution of HIV self-testing kits, in which women pass kits on to their male partners, may empower both male sexual partners and their AGYW counterparts to take control of their health, thereby promoting regular testing and early detection (Agot et al., 2020). HIV testing services should be integrated into routine sexual and reproductive health care, with the aim of normalising regular HIV testing as a standard part of health practices. Several African countries are currently integrating HIV testing into family planning services by training family planning providers to offer HIV testing, incorporating HIV counselling into contraceptive consultations, and establishing systems of referral between HIV and reproductive health services (Narasimhan et al., 2019). For example, some programmes now routinely test male sexual partners who accompany women to antenatal care visits (Drake et al., 2015), while others have integrated HIV testing into sexually transmitted infection treatment services that men are more likely to access (Leichliter et al., 2011). With their smaller populations and higher HIV prevalence, Eswatini and Lesotho could benefit from community-based distribution of HIV self-testing kits through female partners and peer networks, which would build on existing community health worker programmes (Agot et al., 2020).

Index testing, in which the sexual partners of people diagnosed with HIV are offered testing, is another route to reaching male partners of AGYW. However, partner notification can expose young women to intimate partner violence and other harms, so it requires violence-risk screening, voluntary participation, and safe referral pathways (Stangl et al., 2020).

Mozambique's healthcare-access challenges could mean that other forms of service-delivery, such as mobile testing units that can reach remote areas, are needed (Leichliter et al., 2011; Michalow et al., 2019). In Cameroon, pharmacy-based distribution might be effective given men's comfort with private healthcare providers; in Lesotho, distribution through traditional healers could address both accessibility and cultural acceptability concerns.

Third, targeted interventions should be prioritised as they could address the unique needs and challenges faced by men in different age groups (Makusha & Gittings, 2024). Targeted approaches may have a positive influence on the impact and cost-effectiveness of interventions. For instance, an evaluation of the impact and cost of the HIV/AIDS National Strategic Plan for Mozambique 2015-2019, using projections from the Spectrum Goals Model, found that, compared to maintaining 2015 coverage levels, scaling-up to meet the National Strategic Plan's targets would avert 110,000 cases over 2015-2019, and the accelerated scale-up scenario would avert 145,000 cases, across all ages. This corresponds to

a discounted cost of all cases averted of US\$ 16,612 (current targets) or US\$ 13,380 (accelerated scale-up; Korenromp et al., 2015).

The cost-effectiveness evidence from Mozambique suggests that targeted approaches could be scaled across countries, but implementation would need to account for health system capacity. For instance, Kenya and Cameroon could support more complex targeted interventions, while Lesotho and Eswatini might focus on simpler, high-impact approaches. Thus, geographic and age-based targeting should be complemented by awareness campaigns using various channels. U=U (Undetectable = Untransmittable) messaging should be incorporated, and adapted to local contexts, to educate and motivate men to maintain an undetectable viral load.

Evidence suggests that male sexual partners of AGYW are responsive to HIV-related information from healthcare providers, traditional healers, pharmacists, as well as social media, radio and television (Leichliter et al., 2011; Reynolds et al., 2018). In rural areas of Mozambique and Lesotho, radio and traditional media could be emphasised, while social media platforms could be used more effectively in urban areas of Kenya and Cameroon. Widespread information dissemination could facilitate the development of multi-level behavioural interventions that are taken up more effectively by targeted communities (Coates, Richter & Caceres, 2008).

Conclusions

While AGYW have a higher rate of HIV incidence than their same-age male peers in sub-Saharan Africa, an increased focus should be placed on this male population, particularly in high-burden countries, as many new cases occur in the context of sexual relationships between AGYW and their male sexual partners. Possible drivers of HIV transmission from male sexual partners to AGYW include early sexual debut, age-disparate and multiple relationships, and low rates of HIV-testing among male partners of AGYW. Further quantitative analysis, specific to countries, their sub-national geographic distribution, and trends over time, is required to confirm these drivers.

Interventions, such as addressing power imbalances within sexual relationships through educational programmes, ensuring HIV services are affordable, accessible and widely available, and using a widespread information dissemination approach alongside targeted interventions, are avenues to reach male sexual partners of AGYW.

Without inadvertently causing harm or neglecting other important aspects of care delivery, the focus on male sexual partners within AGYW HIV-prevention efforts requires careful planning and continuous evaluation. Moreover, continuous

research is necessary to better understand how to effectively engage male sexual partners in HIV-prevention efforts for AGYW, and how national HIV prevention programming is reaching men of all ages. This research includes assessment of male sexual partners' perceptions, needs, barriers, and motivators regarding HIV prevention and treatment. Such research could highlight the most effective strategies for reaching and engaging this demographic, thereby prompting the refinement and optimisation of interventions over time.

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The **Sustainable Societies Unit** (SSU) explores the social and institutional dimensions of economic development and the interaction between human society and the natural world. Its current foci include agricultural practices, human-wildlife conflict, winners and losers in South Africa's growth path, and the impact of the climate crisis. The SSU collaborates with the University of Cape Town's *Khusela Ikamva* Sustainable Campus Project, assisting with research on recycling and integrated pest management. The **Adolescent Accelerators Research Hub** generates evidence on which development accelerators – alone and in synergy with each other – can support adolescents in Africa to reach multiple Sustainable Development Goals. The Accelerate Hub is a partnership between governments, international agencies, NGOs, donors, adolescents and academics in Africa, Europe and North America. The **Safety and Violence Initiative** (SaVI) contributes to understanding and responding to violence and promoting safety. Its current focus is on the roles of parents in promoting the safety of children and adolescents.

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