# HIV And AIDS
# Prevention, Treatment
# Care and Support


Gender inequality remains one of the major drivers of HIV around the world. Among young people in sub-Saharan Africa, for example, HIV prevalence is considerably higher among females. In Asia, a significant proportion of new infections are occurring in women—many of whom have been infected by husbands or regular partners (UNAIDS, 2008). **Addressing the rigid gender norms and unequal power dynamics that make women (as well as men) vulnerable to HIV is therefore essential if the epidemic is to be halted.** There is a particular need to scale-up efforts that also engage men and boys (UNAIDS, 2008).

Most HIV infections are transmitted through heterosexual intercourse. Women are more likely to acquire the disease owing to a combination of biological and social factors (UNAIDS, 2008). The risk of women contracting the HIV virus during unprotected vaginal intercourse is two to four times greater than for men and this physiological vulnerability is further heightened by inequitable social norms that appear to condone forced or coerced intercourse.

Sexual coercion and violence are associated with decreased condom use and in the case of forced sex, the increased likelihood of HIV transmission due to possible injury to the genital tract and anus. Violence can also interfere with a woman's ability to access services—including testing and treatment—maintain adherence to antiretroviral (ARV) treatment, or carry out her infant feeding choices.

Many women suffer violence or are thrown out of the house when they reveal their HIV status to their husbands who often blame them for bringing HIV into the home. Sex workers are also highly vulnerable to HIV. This is because their low social status makes them unable to negotiate condom use and or access to information and services. Cross-generational sex and other norms also contribute to the relative vulnerability of women and girls and highlight to what degree power inequality underpins the epidemic.

**For men and boys, sexual experience is often associated with initiation into a socially recognized manhood, or as proof that they are "real men". Having multiple sexual partners is also perceived as a sign of virility:** In many countries men report having significantly more sexual partners than women (Wiederman, 1997).

Coupled with the fact that HIV is more easily transmitted sexually from man to woman than from woman to man, the fact that a man often has more sexual partners than a woman means that a man with HIV is likely to infect more persons than a woman with HIV. Just as gender norms influence motivations and decisions around sex—they also influence decisions and behaviours related to prevention. Although condom use has increased in much of the world, particularly among young people—there are still significant numbers of individuals who do not use a condom consistently (UNAIDS, 2008). This is mainly due to a lack of information and skills regarding the correct use of condoms; low risk perception; dislike of condoms; lack of communication between partners about matters related to sexuality and; rigid social norms which associate condom use with lack of manliness or trust between partners.

**In nearly all regions outside of sub-Saharan Africa, men who have sex with men (MSM) are among the groups most disproportionately affected by HIV, along with injecting drug users and sex workers (UNAIDS, 2008).** MSM remain seriously underserved, however, with respect to HIV prevention services. In some countries, only 40 per

cent of MSM report knowing where to go for an HIV test and having been given a condom in the previous year (UNAIDS, 2008). Moreover, due to widespread stigma and the fact that sex between men is criminalized in many countries, it is likely that the prevalence of HIV amongst MSM is significantly underreported and not accurately reflected in epidemiological data.

The vulnerability of MSM also leads to increased vulnerability in the wider population. Many MSM also have sex with women—acting as a "bridge" into the heterosexual population. Health programmes and services do not make the effort to reach out to MSM. Therefore, more research is needed to understand how to provide appropriate HIV prevention, treatment, care and support for MSM. Stigma, discrimination and fear of public exposure in many countries means that MSM are less likely to access appropriate services than other groups (UNAIDS, 2009).

Injecting drug use is on the rise worldwide and is also a major driver of the HIV epidemic in most countries outside of Africa and Latin America. This is owing to the behaviour itself but also to stigma and the lack of services. The greatest numbers of people who use injecting drugs are found in China, Russia and the United States and, with Russia and Ukraine seeing the greatest increase with a 1-5 per cent prevalence rate (UNAIDS, 2008). According to current estimates approximately 37 per cent of Russian injecting drug users are HIV positive (Mathers et al., 2008). Drug use is higher among men (though it is rising among women) and is highly associated with male attitudes toward risk-taking.

Finally, gender norms and inequities also affect those who receive and provide HIV care and support. Worldwide, women and girls shoulder a disproportionate share of caregiving. Girls are increasingly pulled out of school to take care of sick family members and to assume household responsibilities previously carried out by their mothers. Elderly women often take care of grandchildren orphaned by AIDS, finding themselves emotionally and physically taxed by tasks usually performed by much younger women (Peacock, 2003). Studies from the Dominican Republic and Mexico found that married women with HIV often return to their parents' home because they are unlikely to receive adequate care from their husbands (Rivers & Aggleton, 1998).

Research in Tanzania and South Africa has found that the fear of being ostracized and ridiculed by other men in the community is one of the major factors which inhibits men from being more actively involved in care and support activities (Aggleton and Warwick, 1998; Kruger, 2003). Another barrier is the fact that men often lack the necessary knowledge and skills about how to support and care for people living with HIV and AIDS. In general, however, there has been very little research about men's attitudes towards care and support and very few interventions have encouraged and empowered them to play a more active role in AIDS care and support (Peacock, 2003).

**BOX 1** **YOUTH AND HIV AND AIDS**

In 2007, an estimated 45 per cent of new HIV infections in adults occurred in young people under the age of 25 (UNAIDS, 2008). Underlying this specific vulnerability is a number of factors—including continued lack of knowledge and misconceptions about HIV transmission, the lack of consistent and correct condom use, higher STI rates and unequal gender relations. Moreover, the rights of youth are often not respected, particularly with regards to access to information and services related to sexual and reproductive health.

Gender norms can interact with age in different ways to compound the vulnerability of youth to HIV. In many settings, the role of intergenerational sex in HIV transmission, for example, has contributed to increasingly higher rates of infection among girls and young women. As a result of having had more sexual partners older men are more likely to be HIV-positive, and are therefore more likely to transmit the disease to younger partners.

In many of the highest prevalence countries married women are generally 5 to 10 years younger than their husbands and are among the most vulnerable to HIV and AIDS. This is because married couples are less likely to use condoms owing to the pressure to have children, familiarity but also to unequal decision-making power owing to age differences (Clark et al., 2006).

Young men, on the other hand, are often more likely to use alcohol and other drugs, including injection drugs (UNAIDS, 2008). Sharing used needles is the most efficient way to transmit HIV and is the major driver of the epidemic in Eastern European countries and a major contributor in some parts of Southeast Asia (UNAIDS, 2008). Alcohol and drug use is also linked to an increased likelihood to engage in unsafe sex and can increase risk among young people.

Compared to older MSM, many young MSM are also at increased risk owing to greater social exclusion from services and support networks that can help them to protect themselves from HIV.

**BOX 2** **MEN ON THE MOVE: MOBILE POPULATIONS AND HIV RISK**

Mobile populations, including migrants, refugees, truckers, migrant mine workers, and others help to drive the spread of HIV (and other STIs) in many settings. Male migrants often spend extended periods away from their wives and children. Distance from their families and a lack of traditional constraints on their behaviour may lead them to engage in commercial sex or extra-marital relationships.

Truck stops, mining towns, and other places, in which mobile men may pass through or live, often become hubs for commercial sex work as local residents (often living in impoverished circumstances) seek to earn money. Transient workers and illegal immigrants are also particularly vulnerable to HIV because they may not be able seek preventive care or treatment for fear of deportation or prosecution (Guttmacher, 2003).

## ENGAGING MEN AND BOYS IN HIV AND AIDS PREVENTION, TREATMENT, CARE AND SUPPORT

To date, programmes and services have had only a limited impact on male HIV-risk behaviours and—by extension—the overall vulnerability of everyone to HIV infection. One reason for this is that HIV programmes have focused mainly on providing information despite the fact that diverse studies show this alone is not sufficient to promote lasting and meaningful changes in sexual attitudes and behaviours (Boler & Aggleton, 2005).

Rather, it is only a first step towards real behavioural change. Other factors, such as communication and negotiation skills, access to services and SRH commodities, peer influence, gender attitudes, and desensitization to risk, generally guide if, when and how a man acts upon his knowledge.

Another reason why many existing programmes only have a limited impact is that they do not address the broader community/social norms that underlie male behaviour and other gender and HIV-related vulnerabilities and inequities.

### GROUP EDUCATION

HIV prevention education that is limited to simplistic, fact-based messages about modes of transmission and risk behaviours does not promote change. Men and boys need opportunities to discuss gender and sexuality and how norms and stereotypes influence their own attitudes and decision-making. Prevention options, including condom use, should be presented as part of a broader discussion in which men and boys critically weigh the costs and benefits of various behaviours and decide for themselves what is most realistic and appropriate in relation to their values and lifestyle. Additionally, men and boys need accurate SRH information and the necessary skills in order to apply this knowledge.

**Although it is not necessary to overwhelm men and boys with technical details, education programmes should provide a basic understanding of transmission, how to prevent HIV, testing, disease progression, living with HIV, and addressing stigma and discrimination.** Many men and boys lack practical information about HIV prevention and even basic sexual education. Common areas that need to addressed include the "window period" for HIV testing and the difference between HIV and AIDS.

Many men also express misconceptions and doubts about condoms, including their efficacy against HIV and the impact on sexual pleasure. Education programmes should provide information about correct and consistent condom use, how to negotiate with partners, and how and where to access condoms and health services. This information should be linked to skills-based lessons—for example, practicing putting condoms on a model of a penis, and speak with a partner about condom use.

**When discussing the relationship between condom use and negotiation and gender-equity, programmes might want to introduce the female condom.** The female condom, like its male counterpart, is a barrier device used to prevent unintended pregnancy, HIV and other STIs. The female condom is the only

female-initiated technology currently available that enables women to protect themselves, though it is still unfamiliar to many women and men. Nevertheless, it should be promoted as a prevention method, and can be used to explore male ideas about female sexuality, and the role of female-initiated methods. UNFPA advocates comprehensive condom programming, which includes the promotion of male and female condoms alongside communicating for behavioural change, market research, segmentation of messages to different target audiences and the optimized use of reproductive health and HIV/AIDS clinics. This last point is designed to promote prevention, advocacy and the coordinated management of supplies.[23]

**Information about the link between substance use and HIV vulnerability is also important for men to know.** Worldwide, men account for approximately four-fifths of people who use injecting drugs, and studies have shown that male users are also more likely to share needles and avoid using condoms (Lindblad, 2003). Males also use other substances at higher rates than females. For many men and boys, for example, using alcohol or another substance helps them prove their manhood or fit in with a male peer group. It is important that men and boys have the opportunity develop harm-reduction skills and to deconstruct the pressures which may lead them to use drugs and alcohol.

Finally, education programmes should also offer men an opportunity to reflect on their involvement in care giving. As mentioned before, men (and society in general) often believe that care giving is an exclusively female task. This means that it is women and girls who bear a disproportionate burden of taking care of ailing family members—especially with regards to HIV. **It is not enough that programmes emphasize the need for men to assist in caring and supporting family-members (especially when they are ill) but also to create opportunities for men to learn the skills necessary—from active listening and providing basic medical attention to cooking and cleaning.** The Faraja AIDS Orphans and Training Centre in Tanzania has been encouraging men to become involved in Home Based Care (HBC) since the late 1990s and have found that the involvement of community leaders is vital. Local leaders have an important role to play in identifying appropriate male volunteers and breaking down stigma around HIV/AIDS and home care work. The Centre has also found that mobilizing male volunteers has a positive impact on the community by spurring men to become involved in other AIDS related activities (CPHA, 2005/2006).


23 For more information on comprehensive condom programming visit UNFPA at http://www.unfpa.org/hiv/programming.htm

# CASE STUDY 1

## POSITIVE MEN'S UNION (POMU) / UGANDA

(PROGRAM TYPE: GENDER SENSITIVE)

Originally founded as a support group by eight HIV-positive men in 1993, the Positive Men's Union (POMU) encourages members to become involved in prevention efforts and provide care for themselves, their families and communities. Chapters throughout Uganda carry out a range of activities including support groups, awareness-building, income generation, support and long-term planning for affected families and collaborative meetings with women's organizations to discuss HIV/AIDS-related gender issues.

As in many other settings, most Ugandan men are still not open about their HIV status—and often do not even inform their spouses and children. This can be attributed in large part to a reluctance to be seen as weak or sick or needing support. POMU members recognize the importance of men talking to other men and, for this purpose, organize to raise awareness about testing and establish support groups for HIV positive men to share experiences. In these groups, men often want to discuss broader issues such as unemployment and poverty, but their participation has also led to an increase in health-seeking behaviour and improved communication with their partners. (Barker and Ricardo, 2005)

# CASE STUDY 2

## MEN AS CAREGIVERS IN ZIMBABWE

(PROGRAM TYPE: GENDER TRANSFORMATIVE)

Padare, an NGO in Zimbabwe, carries out community-based trainings to engage young and adult men on the need to share with women and girls the responsibility of caring for family members of others living with AIDS. The trainings are developed after consultations with the target groups of men and focus on empowering them to take on care-giving roles and responsibilities in their communities. Padare encourages men to challenge the myths and socio-cultural norms that reinforce the division of care-giving in the home and community settings. At the end of the training, the participants are provided with kits with gloves and other materials to enable them to be home-based caregivers. (Shumbu and Eghtessadi nd)

FOR MORE INFORMATION: www.padare.org.zw