

MEN, MASCULINITIES AND HIV/AIDS: *STRATEGIES FOR ACTION*

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INTRODUCTION

Starting the Discussion: Gender, Masculinities and HIV

Gender norms and the gender-based power differentials between men and women, amongst different groups of men, and amongst different groups of women, are key drivers of men's and women's vulnerability to HIV. While the concept of gender is often perceived to refer primarily to women and girls, gender norms shape socially acceptable notions of masculinity as well as femininity and help define what it means to be a man as well as a woman. Masculinity, as defined in this paper, refers to the complex and multiple ways that manhood is socially defined across historical and cultural contexts, and to the power differences between specific versions of manhood or groups of men.¹ Gender further encompasses alternate identities, such as transgender or intersex.

The use of a gender perspective in the context of HIV requires us to look at the relations and power hierarchies among all sexes and sexual identities, as well as the structural contexts that reinforce and create power relations between and among them. For example, in much of the world, men are expected to be sexually knowledgeable and active, and they face pressures to engage in sexual risk taking or even violence. Sexual behaviour studies globally indicate that men – whether married or single, heterosexual, homosexual or bisexual – have higher reported rates of partner change than women.² In addition, men are more likely to have

multiple partners simultaneously, more likely to have a sexual partner outside of their regular or long-term relationship, and more likely to buy sex. In many cultures, variety in sexual partners is seen as essential to the nature of men.³ In practice, this means that men will likely have more sex partners on average than women. Conversely, women are expected to be sexually passive, discouraged from acquiring knowledge about sex, suggesting condoms or contraceptive use, or accessing sexual and reproductive health services. Many of the world's women have little power to negotiate safer sex, including when, with whom, and how sex occurs.

Contemporary patterns of work and living conditions, which encourage migration or working in high-risk conditions, and situations of poverty and social exclusion, which commonly drive sexual exploitation, make both men and women vulnerable to HIV. Global studies affirm that high percentages of women, girls, transgender people and some men and boys, particularly in conflict settings, have experienced sexual violence. In areas with high HIV incidence, sexual violence increases vulnerability to HIV.⁴ An inability to discuss or question inequitable aspects of men's sexual practices has limited HIV prevention efforts.

Stigma and discrimination against men who have sex with men (MSM) and transgender individuals also exacerbates HIV vulnerability in a number of ways. Risk factors such as poverty and invisibility along

with negative social attitudes may lead to internal stigma (shame, low self-esteem), thus decreasing health-seeking behaviour and increasing sexual risk-taking. It is important to note, however, the complex nature of sexual and gender identity and its implications in the context of HIV. For example, not all MSM define themselves as homosexual or are labeled as such by society at large, which may complicate the ability of health programs to reach them. In some contexts, it is common for MSM also to have sex with women. Social stigma against sexual minorities has further precluded passage and implementation of laws and policies protecting them, as well as the development of HIV prevention campaigns and services explicitly directed toward sexual minorities. Furthermore, discriminatory and homophobic attitudes also may contribute to vulnerabilities for heterosexual women and men, as homophobia can be used to reinforce traditional, non-equitable views about manhood. All of these issues must be included in a gender perspective in addressing the HIV epidemic.

The international community, including the United Nations, has come to recognize the importance of a gender perspective and engaging men and boys in programming to address HIV. For example, the UNAIDS *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV (Agenda for Women and Girls)* acknowledges the need for male involvement in a gender-equitable response to the pandemic: “Men must work with women for gender equality, question harmful definitions of masculinity and end all forms of violence against women and girls. Men’s responsibility for children and the care

of their families is key to HIV prevention work, as is their involvement in mitigating the effects of the epidemic. Changes in the attitudes and behaviours of men and boys, and in unequal power between women and men, are essential to prevent HIV in women and girls.”

In order to effectively address the HIV epidemic, we must understand how social constructions of gender, including masculinities, put both women and men at risk. Most importantly, we must understand how these constructions can be transformed using rights-based approaches. This includes employing a gender transformative approach that seeks to change underlying gender norms, specifically those related to masculinities. Given what we know about how these norms and power structures drive the epidemic, we can improve the health and well-being of men and women of all sexual and gender identities. Gender transformative approaches, as referenced throughout this paper, go beyond addressing the needs, aspirations and capacities of females and males. They also challenge biased and discriminatory policies, practices, ideas and beliefs and attempt to change them.⁵ Such transformative approaches are inherently rights-based as they include attention to human dignity, the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all, free from discrimination on the basis of sex and gender roles.

ORGANIZATION OF THIS PAPER

The purpose of this paper is to provide practical guidance to policymakers and program managers on how to engage men and address harmful male norms in seven key areas of intervention in relation to HIV/AIDS:

- ❶ Social and Behaviour Change in Men
- ❷ Violence against women
- ❸ Men, Sex Work and Transactional Sex
- ❹ Men, Substance abuse and HIV/AIDS
- ❺ Male Circumcision
- ❻ Men, VCT and Treatment
- ❼ Male Norms and the Caregiving for People Living with and Affected by HIV/AIDS

The paper provides a brief overview of the issues related to masculinities in each of the above areas and then provides recommended “strategies for action” based on promising practices of engaging men and boys for gender equality and for men’s own gender-related vulnerabilities related to HIV in HIV prevention, care, treatment and support. Most of this paper focuses on policies and programs addressing masculinities in the context of heterosexual relations, but it also discusses important findings and recommendations in relation to MSM and transgender individuals where relevant and available. The paper closes with final cross-cutting strategies for action as well as recommendations for policy and programs on engaging men and boys in addressing the gender dimensions of HIV. An annex (APPENDIX 1) includes a list of related tools and resources that may be useful for policymakers and program managers.

1. SOCIAL AND BEHAVIOUR CHANGE IN MEN



Prevention programmes will not be optimally effective unless they are supported by effective initiatives to address the social factors that increase risk and vulnerability, including gender inequality, HIV stigma and discrimination, and the social marginalization of the populations most at risk of HIV exposure.

2008 UNAIDS Report on the Global Epidemic

Until recently, HIV rates for men have exceeded those for women in every region, but HIV prevalence in women has begun to match, and in sub-Saharan Africa to surpass, prevalence in men.⁶ Considering the vast majority of this transmission is sexual, the sexual behaviour of men and women and the social norms and power dynamics that influences the relations of men, women, girls and boys, including men who have sex with men and transgender people, must be understood for effective programming.

Many behaviour change prevention strategies, particularly those that focus on the “Abstinence, Be Faithful, Use a Condom (ABC)” approach,ⁱ as

i The ABC approach employs population-specific interventions that emphasize abstinence for youth and other unmarried persons, including delay of sexual debut; mutual faithfulness and partner reduction for sexually active adults; and correct and consistent use of condoms by those whose behavior places them at risk for transmitting or becoming infected with HIV. It is important to note that ABC is not a program; it is an approach to infuse throughout prevention programs (available at www.pepfar.gov)

well as information-only based approaches,ⁱⁱ have proven limited in reducing the risk of HIV.⁷ Unless equally aimed at changing men’s behaviour, such approaches are often irrelevant for women who do not have the choice to abstain, are already the faithful ones in the relationship, and whose partners refuse to use condoms.

THE ISSUES

Individual behaviour change strategies fail to address gender-related inequalities in sexual relationships.

Dominant and prevailing norms of what it means to be a man shape many of the attitudes and behaviours that fuel the HIV epidemic. These include: multiple and concurrent partnerships, low or non-use of condoms, viewing sexual and reproductive health as a woman’s issue, limited health-seeking behaviours, and homophobic attitudes. These behaviours and attitudes interact with structural factors such as poverty and social exclusion, increasing men’s vulnerability to HIV. For example, men who migrate for work or men in the military who spend long periods of time away from home may be particularly vulnerable to HIV.

ii Prevention of HIV requires a multi-pronged and multi-sectoral approach that combines not only information and basic education including health education, but also, among others, access to voluntary and confidential counseling and testing, provision of protective measures such as condoms, vigorous efforts to combat stigma and discrimination, the provision of antiretroviral drugs, addressing violence that can directly elicit HIV transmission, and addressing social and economic disempowerment.

Among these prevalent social norms is that to be socially recognized as men, men and boys must have sexual experiences at an early age and with numerous sexual partners.⁸ Global sexual behaviour studies indicate that heterosexual men, married and single, as well as homosexual and bisexual men, have higher reported rates of partner change than women.⁹

The same notions of masculinity that encourage multiple sexual partners also support the idea that male sexuality is “uncontrollable” and “spontaneous”;¹⁰ and that use of a condom in this context can curtail a man’s sexual pleasure. In many contexts, conceptions of men as strong and invincible translate into an unwillingness or reluctance to seek health services.¹¹ For instance, a study of VCT services in South Africa found that men accounted for only 21 percent of all clients receiving services. Yet, women and men who know their status are much more likely to use condoms.¹²

Thus, while condom use has increased in much of the world, this increase is inconsistent. In some countries, condom use has even declined among men.¹³ A review of Demographic and Health Surveys across 35 countries revealed that despite a high percentage of men reporting knowledge of condoms, actual use of condoms is quite low.¹⁴ Lack of information and resources, low risk perception, and dislike of condoms are important factors in low male condom use. Men also display lower self-care and health-seeking behaviour in general. Rigid views about sexual behaviour, in particular an assumption of heterosexuality, also reinforce homophobia. This inflexibility makes men who have sex with men particularly vulnerable and may reduce their access to necessary services and social support.

At the same time, men have a major influence on women’s access to health services. A study of low-income households in Pakistan found that families seek health care more often for boys than girls and are more likely to use higher-quality pro-

viders for boys.¹⁵ In some parts of the world, men are more likely to be in control of economic assets and resources and may limit women’s ability to pay for health services or use transportation, affecting women’s ability to access VCT and treatment.¹⁶ In some instances, women have reported that their male partners prevent them from using treatment, either because they use the drugs themselves or because they fear the impact of the treatment on pregnancy.

Prevention programs for men have tended to focus on the behaviour of key populations at higher risk.

Early male-focused responses to HIV, many of which are relevant and still used today, targeted men who have sex with men (MSM), one of the most vulnerable populations to HIV. The majority of MSM-focused programs use peer and group education to promote “safe sex”, through the correct use of condoms and water-based lubricants and alternatives to anal sex, many with relative success.¹⁷ For example, a trial study of a program in Senegal, which combined peer education and media sensitization on HIV prevention and counseling and testing, led to increased knowledge and use of HIV testing services.¹⁸ In a few countries, mostly in Latin America, mass media campaigns, such as those carried out by Brazil’s National AIDS Campaign have sought to reduce homophobic attitudes in the general public.¹⁹

Among men who define themselves as heterosexual or bisexual, HIV prevention programs have generally targeted so-called “high-risk” populations, such as migrants and other populations predominantly comprised of men, including truck drivers, mine-workers, the police, prison populations and the military. Many of these targeted approaches have proven successful in preventing HIV, at least in short-term impact evaluation studies. For example, a program in Brazil providing cross-border truckers with prevention counseling and HIV testing and screening for sexually transmitted infections led to

a significant increase in their condom use with non-regular partners.²⁰ In Uganda, a World Bank-funded project increased condom use among members of the Ugandan People's Defense Force. In Ghana, Family Health International's group and one-on-one HIV/AIDS education decreased HIV prevalence among the armed forces from 4.2 percent in 1989 to an estimated 2.0 percent in 2003.²¹

STRATEGIES FOR ACTION

Invest in male-friendly HIV prevention strategies.

While the aforementioned programming is critical, it does not target the male population as a whole. Effectively involving men in HIV prevention involves not only social programs focused on changing predominant gender norms, but also addressing the cultural traditions associated with male health-seeking behaviours. Strategies for male involvement in HIV prevention include: couple VCT in male-friendly and accessible settings, training and support for service providers and counselors to address male-specific sexual and reproductive health needs and providing a broad package of male SRH services including, information counseling, testing and treatment for HIV/AIDS and STIs. Peer education is also important, especially in reaching the most vulnerable groups of men and in developing acceptance and trust among such groups. Equally important is the creation of safe spaces for men and boys to discuss issues of male sexuality, sexual identity and gender equality.²²

Scale up comprehensive gender transformative behavioural prevention programs.

Thanks to rigorous program evaluations in recent years, gender transformative approaches are now broadly recognized as essential strategies to stem the HIV epidemic.²³ A handful of programs at the community level have demonstrated ability to improve men's attitudes toward gender equality and in turn reduce risk for HIV and other STIs. Perhaps most widely acclaimed is the Stepping Stones

program, which has been implemented in over 40 countries and has proven to reduce violence against women and promote condom use through group education and discussion about gender, sexuality, misogyny and homophobia.²⁴ The Men as Partners program implemented by EngenderHealth sensitized providers to the special sexual and reproductive health needs of men. On national and regional levels, Soul City, a soap opera that highlights a range of social issues in the context of HIV in South Africa has transformed gender attitudes while improving HIV/AIDS-related communication, changes affirmed in rigorous impact evaluation.²⁵

Invest in programming aimed at adolescents and young people, reaching boys and young men with messages that focus on changing inequitable gender norms.

Initiatives such as Program H in Brazil and Sexto Sentido in Central America focus on developing gender-equitable attitudes among younger men, which correlate with safer sex. For Program H, the combination of a comprehensive curriculum along with a lifestyle social marketing campaign for promoting changes in community or social norms related around masculinity is key. Developed by Instituto Promundo, the program has been empirically shown to influence safer sexual behaviours including increased condom use, reducing gender-based violence, as well as fewer unplanned pregnancies, improved partner negotiation skills, and increased utilization of health services in several Latin American and Caribbean countries.²⁶

Sexto Sentido, a social "social soap opera" encouraging viewers to break taboos and question stereotypes, has tackled such complex issues as sexual orientation, rape, abortion and domestic violence. Aimed at young people between ages 13-24, it has been shown to encourage increased use of HIV/AIDS services and communication about HIV prevention and sexual behaviour, as well as increased openness to having homosexual friends.²⁷

2. VIOLENCE AGAINST WOMEN

In the past two decades, women's rights practitioners, governments and United Nations entities have devoted significant attention to the role of men and boys in preventing and addressing violence against women and girls. According to the *United Nations Declaration on the Elimination of Violence against Women*, violence against women is defined as "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life." Whereas gender-based violence (GBV) is an overarching term referring to violence against women and men, girls and boys, the majority of programming in this area focuses on violence against women and girls, not only because they are the primary targets for GBV, but because of the exacerbated consequences they suffer from it compared to men and boys.²⁸

Within the movement to end violence against women, there is a growing consensus around the need to focus on primary prevention. This refers to stopping violence before it begins by changing violence-supporting norms and behaviours, primarily, though not always, perpetrated by men. Primary prevention is a rights-based approach necessary to avert a serious public health, security and justice problem.²⁹ In recent years, evaluations of programs have yielded evidence of well-designed and well-implemented primary prevention programming, with a strong focus on male

involvement. These include grassroots initiatives conducted through schools, community-based health programs, microfinance schemes, trainings in fatherhood and caregiving as well as mass media and community communication campaigns. Many of these combine group education, legal and social support for survivors of violence, and training of health workers, police, social service and justice sector staff in dealing with violence against women.

THE ISSUES

Violence against women and HIV are inextricably linked in many settings.

Gender-based violence is now widely recognized as an international public health and human rights concern. A complex combination of biological and social factors links violence against women with increased risk of HIV. Violence and threats of violence or coercion may limit women's ability to negotiate safe sexual behaviours, particularly use of condoms during sex.³⁰ Multi-country studies have found intimate partner violence to be significantly associated with women's risk for STIs, including HIV.³¹ One reason for this may be that abusive men are more likely to have other sexual partners, unknown to their wives.³² Furthermore, vaginal trauma and lacerations resulting from violent sex offer the perfect conduit for HIV transmission, while emerging research shows that violence against women may weaken their immune systems, putting them at

risk for HIV and other health problems.³³ Women who have been sexually abused in childhood may participate in more sexual risk-taking behaviour as adolescents or adults, thereby increasing their risk for HIV.³⁴

Women's HIV-positive status has also been recognized as a cause for violence. Literature from the United States and sub-Saharan Africa suggests that women refrain from disclosing their serostatus to partners due to the fear of violence and other adverse consequences.³⁵ According to one study, women living with HIV have been found to be 2.7 times more likely to have experienced a violent episode from a current partner than HIV-negative women, and this rate is even higher among younger women.³⁶

STRATEGIES FOR ACTION

Reach boys to promote gender-equitable norms from an early age.

Evidence suggests that promoting gender-equitable norms in youth, who are generally more open to change, is an effective way to shape attitudes and behaviour regarding violence against women.⁴⁰ School-based programs have been popular and widely documented in the United States and other high-income countries.⁴¹ A 2008 Center for Disease Control-commissioned review of programs to prevent first-time male perpetration of sexual violence documented effective strategies ranging from conflict resolution training, to encouraging male responsibility for ending violence against



A 2006 WHO multi-country study found that the percentage of women who reported physical or sexual violence by a partner ranged from 15 percent to 71 percent, with the majority of settings falling between 29 percent and 62 percent.³⁷

Prevention of violence against women requires changing dominant gender norms.

Research suggests that violence against women, particularly intimate partner physical and sexual violence are part of a constellation of beliefs and attitudes that drive high-risk behaviours such as sex without the use of condoms, multiple sex partners and poor health-seeking behaviours.³⁸ Likewise, inequitable gender norms often put the burden of responsibility on women, seemingly justifying sexual violence on the basis of a woman's dress or behaviour. For example, according to one Demographic and Health survey in Kenya, 55 percent of men approve of violence against wives who neglect the children, and 45 percent approve of violence against wives who argue with their husbands.³⁹

women, either through peer education or direct intervention around incidents of violence.⁴² The length of programs also varied from one hour to one year, the latter including programs such as the Fraternity Anti-Violence Education Project. Rigorous evaluation of Safe Dates, a ten-session curriculum pioneered in the United States, found that the program effectively prevented dating violence and perpetration as much as four years after student's participation. Effective sexual violence prevention strategies employed in this program change dating violence norms, decrease gender stereotyping, and increase awareness of community services.⁴³

Integrate prevention of violence against women in community-based HIV prevention strategies targeting young men and boys.

In lower-resource settings, where schools systems are weak or are accessed by few, school-based programs may not be best positioned to reach youth. Community-based outreach strategies, particularly those already addressing high-risk behaviours are an opportunity to link the harmful effects of both violence against women and HIV. For example, the Stepping Stones program uses group discussion and education in community settings to address gender norms, sexuality and associated risk behaviour associated with HIV. Implemented in 40 countries worldwide, Stepping Stones provides the most convincing evidence that addressing gender norms in the context of HIV programs can effectively reduce violence.⁴⁴ An evaluation of this program in South Africa found evidence of reduced male physical and sexual violence against partners two years after participating in the program.⁴⁵ In India, the Yari Dosti project, an adaptation of Program H in Brazil, took a similar approach and saw sexual harassment of women and girls decline from 80 percent prior to the intervention to 43 percent afterward.⁴⁶



Stepping Stones program uses group discussion and education in community settings to address gender norms, sexuality and associated risk behaviour associated with HIV.

Reach men in settings where they gather and where harmful gender norms are often reinforced.

Beyond schools and the general community setting, programs should reach out to men in strategic settings such as the workplace or uniformed services. UNFPA, for example, has implemented projects with the armed forces of Ecuador, Nicaragua, Paraguay and Peru, which sought to improve knowledge and behaviour related to sexual and reproductive health, including HIV/AIDS, intimate partner and sexual violence, and gender equity. Qualitative evaluation of the projects found increased knowledge in each of the areas, but also a need for increased focus on addressing the role of gender norms in condoning violence.⁴⁷

Support mass media that highlight links between violence against women and HIV.

Another effective method to improve attitudes and to some extent, behaviour related to violence and HIV is mass media “edutainment”—entertainment designed to educate as well as entertain. Edutainment campaigns provoke reflection about harmful, inequitable attitudes and behaviours related to masculinities. They personalize risk via identifiable characters and reinforce messages through ongoing storylines. Two examples, Puntos de Encuentro in Central America and Soul City in Southern Africa, use television dramas, radio programs and information packets to promote gender equality and reduce risk of violence and HIV. Evaluation of Puntos de Encuentro found increased support for gender equity, increased communication about HIV/AIDS, intimate partner and sex, greater sense of capacity to solve problems related to domestic violence and increased condom use in some groups.⁴⁸ An extensive impact evaluation of Soul City showed that it had reached 86 percent of the population, leading to a ten percent decrease of those who view intimate partner violence solely as a domestic issue and an increase in viewers’ likelihood to report abuse.⁴⁹

Engage men as partners in women's economic empowerment initiatives.

Women's economic empowerment is an important factor in their ability and confidence to avoid or leave violent relationships. Furthermore, evidence points to the women's economic contribution to the household as a protective factor against violence because husbands and partners value their household contribution. According to a study in Bangladesh, fewer incidences of violence against women have been found amongst female members of credit organizations than amongst the general public.⁵⁰ In some contexts, women's economic empowerment has conversely served as an impetus for violence, a threat to their partner's virility and household decision-making power.

These different scenarios underscore the need to engage men in changing gender norms and as partners in women-targeted microfinance programs.ⁱⁱⁱ In South Africa, for example, the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) study found that a microfinance program combined with a gender and HIV prevention curriculum was able to reduce intimate partner violence by 55 percent.⁵¹ In the rural African context where poverty and rigid gender norms fuel HIV, early evidence from the IMAGE intervention suggest shifting individual perceptions, communication and power dynamics, and the potential to influence community-level processes.

Qualitative assessment among IMAGE participants suggests changes in perceived social and economic well-being. Despite initial discomfort in discussing gender and sexuality, growing relevance of these issues is emerging, resulting in constructive engagement of men and youth.⁵² Based on those results, the IMAGE's strategy to engage men and boys in community participation efforts may have been essential to offsetting increased violence due to conflicts stemming from women's increased empowerment.

iii It is important to note the difference between microcredit, a small loan, and microfinance, a more inclusive, progressive term describing access to the full range of financial services. Microcredit, alone, is not enough to make significant changes as loan recipients, and in particularly women, face barriers to accessing the financing and financial services needed to scale up their business (e.g. access international markets). This is the reason that many microenterprises are bought by men who later access those financing services to expand their business. The IMAGE project does include more than mere microcredit and it also requires recipients to open savings accounts, which earn interest. Further details available at <http://www.accion.org/microcredit-vs-microfinance>.

3. MEN, SEX WORK AND TRANSACTIONAL SEX

The term “sex work” refers to female, male, and transgender adults and young people aged 18 or over whom receive money or goods in exchange for sexual services, either regularly or occasionally.⁵³ Thus, sex workers encompass a broad group of individuals working in settings such as brothels, bars, on the street, or in their own homes.⁵⁴ Many sex workers form part of an organized industry managed by controllers, or pimps, while others are self-employed. Still others occasionally exchange money, gifts or favors for sex as part of transactional sex. While some engage in sex work by choice, others are forced or coerced through violence, trafficking, debt-bondage or the influence of more powerful adults.⁵⁵

Sex work and “sexual exploitation” constitute important risk factors for HIV. Whereas the levels of risk faced by sex workers can be vastly different, depending on geography (country, urban/rural), workplace environment (brothel, night club, on the street, etc.), and whether or not they have condom access, they all tend to share certain characteristics which make them susceptible to HIV. These shared characteristics include multiple partners, inconsistent condom use and low social and economic status.

While women and girls represent the largest group involved in sex work, the numbers of boys and men in the field is steadily growing.⁵⁶ There are also smaller numbers of transgender individuals, including transvestites and transsexuals, involved in sex

work, as this may represent their only means of livelihood.⁵⁷ Because women and girls are most often the ones selling sex in exchange for money and are more vulnerable to sexual exploitation, the majority of interventions for HIV prevention focus on female sex workers and male clients of sex workers.⁵⁸ However, men who sell sex often suffer from multiple forms of discrimination that impede their access to prevention resources; and they commonly face aggression from other men, clients and law enforcers, which pushes them to work underground.

High levels of stigma and discrimination against sex workers underscore the importance of evidence-informed measures as integral to an effective and comprehensive response to HIV. Such a rights-based response supports the right of both men and women working in the sex industry to “make informed choices about their lives, in a supportive environment . . . free from coercion, violence and fear.”⁵⁹

Sex work and transactional sex, particularly among youth, are common worldwide.

Data from Demographic and Health Surveys in sub-Saharan Africa indicate that the proportion of all sexually active women engaging in transactional sex varies from 1.6 percent in Niger to 11.0 percent in Zambia.⁶⁰ Among 15-19 year old young women, an age group with one of the fastest growing rates of HIV in the region,⁶¹ the numbers increase to 2.0 and 26.6 percent, respectively.⁶² In specific populations, these numbers increase dramatically. In urban Mozambique, for example,

researchers found that 63 percent of working-class secondary school girls receive material help from their current sexual partners, compared to only 6 percent of middle-class secondary school girls.⁶³ Similarly, sample survey research with men has found high rates of demand for paid sex. Globally, studies suggest that approximately 9-10 percent of men pay for sex in any given year.⁶⁴ Preliminary results from the International Men and Gender Equality Survey^{iv} (IMAGES) in India, found that 27 percent of men ages 19-59 interviewed in two cities in a representative household sample had paid for sex, and 46 percent of those reported that they had paid for sex with a sex worker they believed was under the age of 18.⁶⁵

THE ISSUES

Sex workers are among those at greatest risk and vulnerability for HIV.

Data point to the fact that unprotected sex work and transactional sex play an important role in the spread of HIV. In countries with concentrated epidemics, the prevalence of HIV among sex workers reaches as high as 65 percent.⁶⁶ In countries with generalized epidemics, rates of HIV among sex workers are also extremely high, ranging from 30 percent in Yaoundé, Cameroon to 75 percent in Kisumu, Kenya.⁶⁷ HIV rates in male sex workers, including those who participate in the occasional exchange of sex for money, are not as well documented, but there is evidence they face increased risk of HIV, as they may be less able to negotiate protected sex. According to one study in Viet Nam, one in three (33 percent) male sex workers tests HIV-positive.⁶⁸

^{iv} The International Men and Gender Equality Survey (IMAGES) is a comprehensive household questionnaire on men's attitudes and practices – along with women's opinions and reports of men's practices – on a wide variety of topics related to gender equality. Topics include: gender-based violence; health and health-related practices; household division of labor; men's participation in caregiving and as fathers; men's and women's attitudes about gender and gender-related policies; transactional sex; men's reports of criminal behaviour; and quality of life. From 2009 to 2010, household surveys were administered to more than 8,000 men and 3,500 women ages 18-59 in Brazil, Chile, Croatia, India, Mexico and Rwanda.

Stigma, discrimination and violence against sex workers increase their vulnerability to HIV.

Stigma and discrimination and violence against sex workers, or the threat of such violence, inhibit HIV prevention, care and treatment from reaching sex workers.⁶⁹ Laws and policies that criminalize sex work frequently drive the practice underground, leaving sex workers vulnerable to harassment and abuse.⁷⁰ According to a survey of female, male and transgender sex workers in South Africa, Thailand, Turkey, the United States, and Zambia, 73 percent reported experiencing physical violence, and 62 percent were survivors of rape.⁷¹

Law enforcement officials are often the most common perpetrator of violence against sex workers. According to a survey of sex workers in India, 70 percent had been beaten by police and over 80 percent had been arrested without evidence.⁷² This abuse not only causes social stigma and isolation that prohibits sex workers from accessing services, but it can also contribute to HIV vulnerability more directly. In Cambodia, for example, research found that roughly one third of self-employed female and transgender sex workers and 57 percent of brothel-based/mobile sex workers had been raped by police in the past year.⁷³ In the same study, 34 percent of self-employed sex workers and 38 percent of brothel-based/mobile sex workers observed police harassing HIV/AIDS outreach workers.⁷⁴

Gender norms are at the root of the supply, demand and terms of sex work

Gender inequality is a factor in sex work. Women, girls, transgender people and men who have sex with men may face unequal access to education, employment, credit, and social networks, making sex work one of the few options for livelihood. Less common is examination of men's roles in sex work not only in terms of setting up and controlling the networks and institutions that recruit, promote and negotiate sex workers, but also in creating demand. Worldwide, men make up the majority of sex worker clients, in large part driven by gender-



...Sexual coercion is more socially accepted in situations where women receive money or gifts from the perpetrator. According to one South African interviewee, “If you can feed a horse, you can ride it.”

based cultural beliefs and social conditions.⁷⁵ For example, some traditions encourage young men to have their first sexual encounters with experienced women, usually sex workers.⁷⁶ Other popular myths encourage men to release their sexual tensions as soon as possible, thus encouraging reliance on sex workers.⁷⁷ In some cases, male demand for sex work is said to be characterized by a need for sexual dominance and sense of entitlement, which may manifest in sexual and economic exploitation and violence against sex workers.⁷⁸ Recent studies from sub-Saharan Africa and India seem to support these arguments. In India, Decker and colleagues found that traditional gender ideologies were linked to men’s solicitation of sex work.⁷⁹ Similarly, in South Africa, researchers found that men who reported more equitable gender attitudes were less likely to report engaging in transactional sex.⁸⁰

In some instances, young women articulate a sense of entitlement and empowerment that comes from transactional sex. In other instance, transactional sex may exacerbate men’s dominance over women, thus contributing to intimate partner violence.⁸¹ In South Africa, for example, women who engaged in transactional sex were more likely to have experienced forced sexual initiation.⁸² Additionally, sexual

coercion is more socially accepted in situations where women receive money or gifts from the perpetrator. According to one South African interviewee, “If you can feed a horse, you can ride it.”⁸³ In such contexts, negotiating safe sex may be unlikely. Numerous studies conclude that girls receiving money or gifts in exchange for sex face physical violence or rape for rejecting sexual advances, suggesting condom use, or attempting to discuss sexual matters.⁸⁴ Male sex work is also often characterized by gender-based stigma or homophobia. Whereas female sex workers are often stigmatized because they are women, male sex workers are stigmatized because they are homosexual or assumed to be by their attackers.⁸⁵ These issues, of course, vary tremendously by setting. Furthermore sex work and transactional sex are often quite different in their meanings and the vulnerabilities they create.

STRATEGIES FOR ACTION

As a first step, provide information on HIV prevention, care, treatment and support to sex workers and their clients.

The majority of HIV prevention strategies have focused specifically and solely on sex workers. Activities range from providing basic HIV/AIDS information, to promoting use of condoms and health services, to offering economic empowerment opportunities for sex workers who desire to seek alternative economic means.⁸⁶ While some of these strategies have been successful in curbing HIV, they also have their limitations. For example, Thailand’s “100 percent condom use program” has been widely hailed for reducing HIV incidence and increasing condom use among sex workers from 14 percent in 1989 to 90 percent in 1992.⁸⁷ Yet a UNAIDS evaluation of the program in 2000 indicated a need for complementary efforts with clients, as well as with non-commercial partners.⁸⁸ It should also be noted that there are reports that sex workers in Thailand consider the

100% condom use policy to be coercive. In India, the Avahan program focuses on providing coverage to high-risk groups: female sex workers, high-risk men who have sex with men, transgenders known as hijra, injecting drug users and also clients of sex workers, who are covered under men at risk interventions. While it is too early to assess Avahan's full impact, early signs are encouraging - data from some of Avahan's target areas suggest that sex workers have become more likely to use condoms with their clients, and rates of sexually transmitted diseases among the clients and those at risk have decreased.⁸⁹ Thus, programs must work with sex workers *and* also with the men seeking these services.

Ensure that HIV prevention programs with sex workers include skills-building in negotiating condom use.

As part of condom promotion among sex workers and their clients, sex workers must be given the skills to negotiate condom use. Undoubtedly, sex workers will encounter a range of clients who may or may not be sensitized for the need to use condoms to ensure protection from HIV and other STIs. As the HORIZONS program found, despite a strong and well-supervised peer education program among sex workers in a South Africa mining community, universal condom use could not be achieved without helping women negotiate condom use with male partners.⁹⁰

Invest in and evaluate programs that seek to reduce sexual exploitation and transactional sex.

Evidence shows that gender transformative approaches to HIV prevention aimed at men can reduce sexual exploitation by men.⁹¹ The government of Thailand, for example, has reported that broad efforts to alter social norms and behaviours have led to a significant reduction in the sexual initiation of men through paid sex and consequently, the rate of new HIV infections.⁹² In Calcutta, India,

the Sonagachi Project demonstrates an effective example of an association of over 60,000 sex workers who engage in self-policing to identify victims of trafficking, especially minors. Once identified, any victims of trafficking are taken to a halfway house or hostel to undergo job training and/or reunite with their families.⁹³ In the United States, the First Offender Prostitution Program educates men arrested for soliciting sex acts from sex workers. Former sex workers discuss the effects of sex work on women's lives, including the possibility of contracting HIV and other sexually transmitted diseases. Although evaluation data is not available, the program has received numerous awards for innovation and has been replicated throughout the country.⁹⁴ In the US paying for sex in most states is criminalized. By including this example, the authors are not advocating for criminalization of sex work. Further research should explore whether this approach would work in settings where the burden of criminality for sex work is placed on the sex worker, rather than the client.

There are few evaluated interventions targeting men specifically surrounding the issue of transactional sex. However, the Medical Research Council's evaluation of Stepping Stones in South Africa showed significant changes in men's attitudes and practices two years after the intervention, including higher condom use and less transactional sex.⁹⁵ Although not yet rigorously evaluated, the "Something for Something Love" and the "Be a Man" campaigns implemented by the Uganda AIDS Commission's Y.E.A.H (Young Empowerment and Healthy) Initiative are important examples to consider. "Something for Something Love", which targeted both males and females ages 15-24, promoted dialogue around cross-generational and transactional sex using radio drama, community outreach activities and media materials.⁹⁶ "Be a Man" addressed respect, care, love, faithfulness and non-violence in intimate relationships between men and women.⁹⁷

Sensitize controllers, police and law enforcement authorities to reduce harassment of sex workers.

Several HIV interventions empower sex workers regarding their rights, responsibilities and opportunities. However, fewer programs have worked with traditionally male-dominated sectors, like law enforcement, judiciary, and health services, to successfully reduce violence and abuse toward sex workers.⁹⁸ These interventions are necessary to increase sex workers' rights and access to HIV and STI services, and ultimately to prevent HIV. One notable intervention in Papua New Guinea effectively reduced police participation in gang rape of sex workers. Through a health and human rights-based strategy, the program included working with high-level police management, as well as training police as peer educators to raise men's awareness of how rapidly HIV can spread through group sex activities. In particular, policewomen became actively involved in protecting sex workers, and in several instances, sex workers were able to report and jail policemen who had raped them.⁹⁹ Further work is needed to sensitize controllers, police and other law enforcement authorities on the human rights of sex workers.

4. MEN, SUBSTANCE ABUSE AND HIV

The connection between substance use and HIV transmission is well-documented. Injecting drug use is estimated to be the cause of 10 percent of HIV infections worldwide,¹⁰⁰ and alcohol and other recreational drugs increase risky sexual behaviour. Studies show that men are more likely than women to use such substances, sometimes to fulfill societal expectations of what it means to be a man. In social situations and settings characterized by poverty and poor infrastructure, recreational alcohol use may be one of the few opportunities for social interaction and leisure. In many instances, men use drugs and alcohol as an escape from depression or other mental health issues resulting from social and economic pressures. HIV prevention programs that seek to decrease substance abuse should also address the underlying motivations for men's use of alcohol and drugs.

THE ISSUES

Men are more likely than women to abuse illicit substances, and alcohol.

An estimated four-fifths of the six to seven million injecting drug users around the world are men.¹⁰¹ Not only are these men at increased risk for acquiring HIV, they also are more likely to transmit HIV both through sexual intercourse and needle-sharing. According to a 13-city study based in Cairo, Egypt, the majority of injecting drug users reported never using condoms with regular sex partners.¹⁰² Another study addressed similar issues in St Peters-

burg, Russia, finding that men who injected drugs were more likely than female injectors to report having multiple sexual partners.¹⁰³

Men and boys also tend to abuse alcohol and other substances at higher rates than women and girls. For example, according to a 2003 national survey in the United States, males aged 12 or older were twice as likely as females to be dependent on or abuse alcohol or an illicit drug in the past year.¹⁰⁴ Likewise, in Latin America, community-based studies have found much higher proportions of men than women to be heavy drinkers.¹⁰⁵ Overall, disease burden due to alcohol consumption in the Americas and Europe is significantly higher for males than for females.¹⁰⁶

Substance abuse plays an undeniable role in the spread of HIV for men and women.

Injecting drug use by men results in high HIV risk for users and their female partners, and numerous studies have found drug users to be disproportionately likely to be involved in the sex industry or to engage in high-risk sexual activity.¹⁰⁷ Female injecting drug users are more likely than males to have sex partners who also inject,¹⁰⁸ with needle sharing and sexual risk taking co-occurring.¹⁰⁹

Indeed, important differences exist around behaviour involving injecting drug use for young men and women. According to a review of injecting drug user behaviour, as a rule, men "buy" sex, while women provide sexual services on a commercial basis, including for drugs.¹¹⁰ Women are also more

vulnerable to the development of addiction and to HIV infection.¹¹¹ Further research is therefore necessary to determine entry points for reaching young male and female injecting drug users with sexual and reproductive health and rights and HIV prevention messages.



Research has found that people who drink alcohol are more likely to engage in unprotected and commercial sex, as well as to have multiple partners compared to non-drinkers.

Alcohol use also has significant implications for HIV risk. A recent study in South Africa, for example, drew a direct correlation between alcohol consumption and the likelihood of men and women engaging in unprotected casual sex.¹¹² In rural eastern Zimbabwe, a population-based survey of nearly 10,000 women and men showed that visiting a beer hall in the last month was associated with both risky behaviour and with HIV infection itself.¹¹³ Similarly in Mumbai, India, intercourse with sex workers under the influence of alcohol was independently associated with having an STI or HIV.¹¹⁴

Substance abuse is seen as another way to achieve the ideal definition of masculinity.

In some contexts, overlapping risk behaviours of substance abuse, multiple and concurrent relationships, low condom use and violence characterize “what it means to be a man”. In Costa Rica, research has found that “macho” and homophobic attitudes are closely related to alcohol consumption and sexual risk-taking.¹¹⁵ In Micronesia, young men consume excessive amounts of alcohol to celebrate male courage and solidarity with other male youth.¹¹⁶ Young people in Brazil reported smoking marijuana or drinking before parties to give them the “courage to find a partner.”¹¹⁷ Finally, research in South Africa has shown that the capacity to drink heavily and engage in sex with multiple casual partners symbolized masculinity for men, whereas women viewed drinking as an opportunity to seek male companionship—particularly that of older men.¹¹⁸

STRATEGIES FOR ACTION

Invest in interventions that address underlying gender norms which fuel the full range of HIV risk behaviour, including substance abuse.

Despite the evidence that shows that gender norms are intertwined with substance abuse and risky sex, few programs take into account or address substance use and men’s specific motivations for drinking and taking drugs. While most harm reduction programs^v target men,¹¹⁹ they rarely address underlying gender norms and inequities. Experts agree that access to sterile needles for injecting drug users through syringe exchange programs is an effective way to connect hard-to-reach injecting drug users with health services.¹²⁰

^v Harm reduction programs typically seek to reduce the risks of sexual HIV transmission by linking injecting drug users to health and social services, including confidential HIV testing, counseling, and antiretroviral therapy.

However, a comprehensive approach to injecting drug use also seeks to reduce sexual risk behaviour both through education and condom availability, and by changing the underlying gender norms that drive both drug use and sexual risk.

The few programs that do address the intersection between alcohol and HIV have similar limitations in scope. Programmes focusing on alcohol use and HIV can offer opportunities to incorporate gender transformative messages and provide strategies to address the associations among substance use, physical strength, wealth or health. For example, programs in India and Zimbabwe have effectively used peer-educator approaches, recruiting and training bar patrons to provide risk-reduction messages and skill-building tools to other patrons.¹²¹ Although, both studies showed it was popular and entirely feasible to implement peer-educator approaches with men in drinking venues, neither intervention was more effective in reducing HIV risk behaviour than the control condition.¹²² Interventions such as these can, however, tailor messages to negate popular gender norms that contribute to risk reduction. On the other hand, Stepping Stones' comprehensive approach to HIV prevention, which includes discussion about the range of risk behaviour and gender norms, has demonstrated impact on both substance abuse and related HIV behav-

our. In a two-year follow-up evaluation, men who participated in the intervention reported fewer partners, higher condom use, less transactional sex, less substance abuse and less perpetration of intimate partner violence.¹²³ Other interventions focused on reducing HIV sexual risk behaviour among *shebeen* (informal neighborhood drinking venue) patrons in Cape Town and included HIV information/education, sexual communication skills building, and motivational interviewing to explore how alcohol can trigger lapses in safer sex. Following implementation, participants were more likely to practice all risk-reduction variables (increased condom use, consistent condom use, and acts completely protected by condom use; less drinking before sex, decreased likelihood of meeting a sex partner at a shebeen, etc.).¹²⁴

5. MALE CIRCUMCISION

Medical Male Circumcision (MMC) is now widely accepted as a key HIV prevention intervention, to be included as part of a comprehensive package comprising of HIV testing and counselling; STI treatment; education and promotion of safer sex practices, including the reduction of multiple concurrent partners; the provision of male and female condoms and education about correct and consistent use. The implementation of this comprehensive package is recommended in contexts of generalised HIV epidemics with low prevalence of male circumcision.

With two decades of observational studies and meta-analyses suggesting a link between male circumcision and increased protection against HIV transmission,^{125,126} and a number of studies indicating high levels of acceptability,^{127,128,129,130} three clinical trials on male circumcision were undertaken in Orange Farm, South Africa, Rakai, Uganda and Kisumu, Kenya.^{131,132} The results from all three trials provide conclusive evidence that male circumcision provides partial but significant protection against HIV infection: those men who were circumcised were between 55 and 76 per cent less likely to become HIV positive than the men who did not receive medical circumcision¹³³.

In March 2007, the WHO and UNAIDS jointly issued a set of recommendations on male circumcision stating that “the efficacy of male circumcision in reducing female to male transmission of HIV has been proven beyond reasonable doubt. This is an

important landmark in the history of HIV prevention... Male circumcision should now be recognized as an efficacious intervention for HIV prevention.” It included guidance on how best to integrate male circumcision into other HIV services. The relevant section reads:

Male circumcision should never replace other known methods of HIV prevention and should always be considered as part of a comprehensive HIV prevention package, which includes: promoting delay in the onset of sexual relations, abstinence from penetrative sex and reduction in the number of sexual partners; providing and promoting correct and consistent use of male and female condoms; providing HIV testing and counseling services; and providing services for the treatment of sexually transmitted infections.¹³⁴

A number of countries have now developed, or are in the process of developing national MMC guidelines, including Zambia, Kenya (where 85,000 men have been circumcised), Swaziland, Botswana, Rwanda, Zimbabwe, Namibia and South Africa.

THE ISSUES

Concerns about disinhibition and women’s vulnerabilities to HIV and violence.

MMC roll out has been slowed by concerns that it might lead to “disinhibition” or “risk compensation”, the idea that some men might conclude

that the partial protection offered by MMC allows them to engage in more risky sexual behaviour. Concerns have been raised that circumcised men might have more concurrent partners, or that they might resume sex before the circumcision wound had fully healed. Fears have been raised, especially by women's rights advocates that circumcised men might be less willing to use condoms and thus might pressure women into having unsafe and unwanted sex, and run the risk of unintended pregnancy. Additional concerns have been raised that funding might be diverted from HIV prevention and treatment programs focused on empowering women and be shifted to support circumcision rollout.

To date, studies have not found evidence that risk compensation takes place. Follow-up studies on the three research trials in Kenya, Uganda and South Africa have sustained their initial results, showing that the HIV rate for the men who got circumcised has remained about 70 percent lower than for the men who did not. Condom use has not been shown to decrease among men who get circumcised. One study found that there was a greater increase in condom use among the non-circumcised group, but it also revealed that both the circumcised and uncircumcised groups used condoms more than at baseline. Another reported that sexual behavioural risks (inconsistent condom use, casual and multiple sex partners) decreased over time, in both study arms.^{135,136}

Slow roll-out of MMC

Despite the encouraging outcomes of all MMC trials, the WHO/UNAIDS recommendation and the resulting national MMC policies, the rollout of safe and affordable circumcision services has been slower than expected in most countries. This is largely due to lack of political will, shortage in funding, already overburdened and under-funded public health care systems and fear of risk compensation, despite the fact that there is little to no

evidence that risk compensation is occurring on a scale that would offset the gains offered by MMC. Only in 2010 did this begin to change. By mid-2010, many African countries have developed national rollout plans for MMC – even though many are still in draft format – and ambitious initiatives are finally underway to dramatically increase provision of MMC.

***...Men who were circumcised
were between 55 and 76 per cent
less likely to become HIV positive
than the men who did not receive
medical circumcision***



STRATEGIES FOR ACTION

Use male circumcision programs as an opportunity to promote gender equality and health for both men and women.

Traditionally, comprehensive prevention strategies have included condom promotion, abstinence messaging, partner reduction, counseling and testing, and partner notification.¹³⁷ However, increasingly programs have come to recognize the importance of addressing underlying social and gender norms, such as attitudes supporting coercive sex, the burden of caregiving on women and girls, and men's disproportionate power in sexual and household decision-making. Male circumcision programming presents an opportunity to engage men not only around traditional HIV prevention strategies, but also to build and strengthen innovative initiatives that seek to transform social norms related to sex and gender.

Implement mass media and clinic-based approaches that integrate a focus on comprehensive prevention and gender equality education into MMC roll-out.

Because the benefit from MMC is relative and partial, it is crucial to develop communication strategies that explain this point clearly, unambiguously and consistently. Governments, international health bodies and civil society organisations should devise new and innovative communications strategies that include a focus on comprehensive prevention and gender equality. Prevention education and counseling can also be achieved within the clinic setting. The health clinic may be ideal to expose adolescent boys and young men to sexual and reproductive promotional videos, PowerPoint slideshows, and posters and fliers.¹³⁸ Clinics may also serve as a referral point for community-based prevention services. Challenges around encouraging males to access health services in general, and circumcision in particular, make broader mass media strategies essential.¹³⁹

Develop national MMC roll-out plans and integrate into HIV prevention education into these.

Many African countries have begun to develop national MMC roll-out plans and policies. Gender equality education should be included more prominently in these plans. Some countries provide examples of how this can be done. For example, Botswana's policy on male circumcision states that services "shall include education and behaviour change communication aspects, promoting shared sexual decision-making, gender equality and improved health of both women and men. The scale-up of MC services shall include the goals of changing gender norms and roles and promoting gender equality. The programme shall monitor and minimize potential negative gender-related impacts of male circumcision programmes". Such policies should be replicated in all national strategic plans on HIV.

World Health Organization Recommendations on Gender and Male Circumcision

(M)aximize the opportunity that male circumcision programmes afford for education and behaviour change communication, promoting shared sexual decision-making, gender equality, and improved health of both women and men;¹⁴⁰ (A)dopt approaches to the scale-up of male circumcision services that include the goals of changing gender norms and roles and promoting gender equality; programme managers should monitor and minimize potential negative gender-related impacts of male circumcision programmes; [Use male circumcision service provision] as an opportunity to address the sexual health needs of men. . . such services should actively counsel and promote safer and responsible sexual behaviour.

Source: WHO. *New Data on Male Circumcision and HIV/AIDS prevention: Policy and Programme Implications*. WHO. Geneva. 2007 Recommendations

6. MEN, VCT AND TREATMENT

Data collection systems in many countries remain too weak to allow for sex-disaggregated assessment of who is being reached by antiretroviral therapy programs.¹⁴¹ Further research and intervention studies are necessary to understand the full complexity of the role of gender--and masculinity in particular--in accessing treatment. Preliminary studies indicate that gender plays a significant role in both women's and men's access to treatment, with significant geographic and social variations. In some settings, men are more likely to seek VCT and antiretroviral therapy (ART), while women are more likely in other settings. In all cases, however, gendered social norms and power dimensions affect stigma associated with VCT and health-seeking patterns.

THE ISSUES

Globally, men access antiretroviral therapy at lower rates than women do, with tremendous variation by setting.

According to a 2009 WHO analysis of data from low and middle-income countries, adult women access ART in slightly higher numbers than men. About 45 percent of women in need and 37 percent of men in need received ART at the end of 2008.¹⁴² However, more in-depth analysis at the regional and country-level is necessary. In sub-Saharan Africa overall, women have greater access compared to men. Disaggregated data from 35 countries of the region show that adult men are slightly disadvantaged compared with adult women in access to ART in low-

and middle-income countries (64 percent of adults receiving ART were women, representing some 60 percent of adults in need). However, in other regions such as North Africa and the Middle East men have greater access to ART - 48 percent of adults receiving ART are men representing 55 percent of adults in need.¹⁴³ Women and men in Asia, Europe and Latin America and the Caribbean have relatively equal access, on aggregate.¹⁴⁴ However, this masks disparities within countries and regions. In South Africa, for example, men are half as likely as women to access ART. Only one third is likely to get tested and need to wait longer to access care, as evidenced by lower CD4 count at initiation of treatment.¹⁴⁵ Similarly in Malawi, women access treatment at a rate higher than men, despite relatively equal HIV prevalence.¹⁴⁶

Gender roles influence who seeks or accesses testing and treatment.

In some contexts, male health-seeking behaviour is influenced by prevailing norms of masculinity. According to a 2004 survey of 566 residents in Khayelitsha, South Africa, two-thirds of respondents agreed with the statement, "Men think of ill-health as a sign of weakness which is why they go to a doctor less often than women."¹⁴⁷ Moreover, even if men know they need treatment, stigma and blame may inhibit them from accessing services. In Malawi, a qualitative study found that men avoid accessing treatment for fear of negative consequences from spouses for having contracted the disease as a result of infidelity (which is also often the reason that women fear going for testing).¹⁴⁸



HIV/AIDS services are commonly provided in health clinics aimed primarily at women.

Furthermore, HIV/AIDS services are commonly provided in health clinics aimed primarily at women, such as family planning services, prenatal and child health clinics, and prevention of mother-to-child transmission (PMTCT) services. In Malawi, for example, women are more likely to access HIV testing through maternity services and childcare facilities.¹⁴⁹ These services usually fail to reach men or meet men's needs, resulting in lower levels of male knowledge about HIV prevention, care, treatment and support.¹⁵⁰

However, points of entry into HIV/AIDS services for men and women also differ by region. In countries with generalized epidemics such as throughout sub-Saharan Africa, women most commonly get tested as part of PMTCT services.¹⁵¹ In countries with concentrated epidemics, women may get tested and access services at a lower rate because of prevailing beliefs about what population groups are at risk. As a result, women are not diagnosed until late stages of infection, and many do not access services because of the discrimination they face from health workers.¹⁵²

Furthermore, men may influence how and whether women access services, or, in fact, whether they – or their partners – actually take the ARVs. In some societies, the health and the allocation of family resources for health care may be prioritized for men and boys over the health of women and girls. In Pakistan, for example, research has found that families seek health care more often for boys than girls and are more likely to use higher-quality

providers for boys.¹⁵³ Secondly, men more commonly control economic assets and resources, in some instances hindering women's ability to pay for services or transportation to reach services.¹⁵⁴ Lastly, some women are legally constrained from traveling or from using health services without the consent of their husband, father or other male family member.

Gender norms further influence adherence to treatment. While a large majority of women living with HIV have empathetic partners, others experience hostile environments. According to one study in Zambia, women on ART may fear the consequences of disclosure, including domestic violence and being forced to share treatment with a non-tested husband.¹⁵⁵ Moreover, studies have shown that PMTCT program uptake and adherence were significantly improved for couples engaged in voluntary HIV-counseling and testing.¹⁵⁶ For men who have sex with men and transgenders, discrimination and violence by health providers can hinder their access to HIV or other health services. Research from countries as varied as Jamaica and India has found evidence of health providers abusing transgenders through insults, breaches of confidence and outright refusal of services.¹⁵⁷

STRATEGIES FOR ACTION

Promote and support HIV testing and treatment in the workplace and other settings where men congregate.

As with HIV/AIDS education programs, strategic programming is necessary to reach men where they congregate, for example in the workplace and in male-dominated industries such as trucking and mining. For example, Lonmin Platinum, the world's third-biggest platinum group metals producer, which employs 16,000 mine-workers, provides its HIV-positive employees with ART.¹⁵⁸ Similarly, the Healthy Highways Project in India offers STI care and counseling to truck drivers, petrol pump at-

tendants, crew and sex workers.¹⁵⁹ The number of workplace programs that provide ART is growing but still limited. Only nine percent of countries with generalized epidemics confirm that workplace HIV/AIDS treatment services or referral systems have been implemented in all districts in need.¹⁶⁰

Construct outreach and media campaigns targeting men to increase uptake of HIV/AIDS testing and treatment.

Emerging initiatives are using mass media as well as group education to challenge gender norms relating to HIV/AIDS treatment and services. In South Africa, Sonke Gender Justice's Brothers for Life Project¹⁶¹ and in Brazil, the National AIDS Control Program use media campaigns to promote VCT to increase male involvement in PMTCT services. The Brother for Life campaign, a national men's campaign aims to create a movement of men that will ignite and spread throughout South Africa. This campaign uses interpersonal communication, mass media including television and radio commercials combined with print and outdoor media, and advocacy to reach its audiences.

In Brazil, campaigns have used public service announcements to promote men's health-seeking behaviour in general, and specifically to encourage them to seek VCT. At the community level, USAID's Health Policy Initiative provides treatment literacy^{vi} training in Tanzania for women and men addressing gender-related barriers to treatment, including masculine norms. Although the project originally intended to emphasize women's access to treatment, focus group discussions during

the formative phase of the project identified the need to address negative male attitudes affecting both men's and women's access and adherence to treatment.¹⁶²

Sensitize service providers and program staff around sexual diversity.

Programs targeting men who have sex with men have also expanded to include a broader range of HIV prevention-strategies, with increased focus on reducing stigma related to gender and sexual identity. Strategies now range from individually focused health promotion to improved service delivery, community mobilization, advocacy and policy change.¹⁶³ In Venezuela, for example, the Asociación Civil de Planificación Familiar (PLAFAM) trained its board members, program staff and health care providers on gender and sexual identity and the needs and rights of lesbian, gay, bisexual, transgender and inter-sex people.¹⁶⁴

Research and evaluation is needed to identify how gender roles and norms, including masculinity, act as barriers to access to testing and treatment.

Existing evidence points to the need to test and evaluate gender-related barriers to health-seeking behaviours in general, and in the context of HIV. Immediate strategies for overcoming barriers include ensuring VCT and treatment clinics are male-friendly as well as offering couple counseling, testing and treatment that ensures that women are not put at risk for stigma and violence as a result of HIV disclosure.

vi "Treatment education encourages people to know their HIV/AIDS status, explains how to get access to treatment, offers information on drug regimens, offers support and ideas for adhering to treatment and helping others to do so, emphasizes the importance of maintaining protective behaviours and healthy living, and suggests strategies for overcoming stigma and discrimination and gender inequality." (UNESCO/WHO 2005)

7. MALE NORMS AND THE CAREGIVING FOR PEOPLE LIVING WITH AND AFFECTED BY HIV/AIDS

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“You know males they are not that sensitive. Mothers can take care of so many things. Most males don’t like taking care of sick people... women are patient and caring. Men can’t be like that.”

Female home-based care volunteers in South Africa.¹⁶⁵

In the context of HIV, women and girls are the principal givers of physical and psycho-social support. While it is often taken for granted that they will continue to provide unremunerated care and support to infected and affected family and community members, men may be viewed as unwilling, or incapable of assuming on caregiving roles. However, there is important evidence to contrary. Evidence from studies and program reviews indicate that men are willing to participate in caregiving for HIV/AIDS patients,¹⁶⁶ but they lack the skills, the opportunity, and the openness and support from the community and their social networks to do so.

THE ISSUES

Women bear the overwhelming burden of care for people living with HIV.

Worldwide, more than 33 million people are living with HIV (PLHIV). Beyond the obvious toll on the health of PLHIV, the disease has palpable economic and psychological impacts on the gen-

eral population in hardest hit countries. In low and middle-income countries, 7 million out of 10 million people with AIDS have no access to treatment and are therefore, in need of intensive and long-term care.¹⁶⁷ Lack of health infrastructure, resources, and prioritization of HIV/AIDS by governments has resulted in the need for home-based care and support.¹⁶⁸ In most cases, it is women who take on these responsibilities. In South Africa, for example, a national time-use survey found that women carry out eight times more care work (for all illnesses) than men.¹⁶⁹ Another study by the Southern Africa Partnership Program found that 91 percent of caregivers in the context of HIV are women.¹⁷⁰ Furthermore, evidence from in Asia suggests that this is not a phenomenon unique to Africa.¹⁷¹

The burden of care related to HIV/AIDS impacts the health and development of women and families.

Caring for those living with HIV can be more than a full-time occupation. It involves both physical care – feeding, bathing, lifting, administering medications– as well as emotional support. In many contexts in sub-Saharan Africa, for example, this occurs in addition to women’s normal daily tasks, such as fetching water, cleaning, and farming. While this work takes an enormous physical toll, what is often unacknowledged is the psychological burden of caring for someone with HIV.¹⁷² Furthermore, social isolation, stigma and discrimination may hinder women from reaching out for support from community members, resulting in bearing

the burden of care alone.¹⁷³ Moreover, such social isolation causes great stress and increases risk for illness in women already living with HIV. This effect can be fatal, as taking care of a male partner living with HIV may cause them to neglect their own health needs.¹⁷⁴

The economic implications of care are also significant. In the immediate term, the cost of caring for someone living with HIV and maintaining a household is particularly problematic for women, who may have weaker earning power. Likewise, women who have been widowed or orphaned may lack inheritance or property rights, and thus lose their homes and belongings, further compounding their situation.¹⁷⁵ Moreover, women who remain at home to perform care work are less able to seek other forms of paid work. If they are already employed, they may have to sacrifice or balance their job obligations with caregiving. Some may resort to paid sex to pay for food and commodities.¹⁷⁶

Girls also suffer economically, as in the numerous child-headed households where parents have died of AIDS. In such cases, it is often the girl who assumes the responsibility of caring for siblings.¹⁷⁷ Girls often leave school to partake in caregiving or to save families the cost of school fees.¹⁷⁸ In Swaziland, for example, one study found that school enrolment fell by 36 percent due to AIDS, with girls disproportionately affected.¹⁷⁹ In the long-term, denying a girl schooling not only diminishes her chances of improved economic livelihood and empowerment, it also increases her risk for HIV infection and violence, including within an intimate relationship.¹⁸⁰

Because caregiving is seen as “women’s work”, men do not participate as much as they should.

Gender norms and attitudes, along with men’s generally higher participation in the formal workplace all serve to limit their participation in caregiving. Tasks related to caregiving are perceived as “light work”, part and parcel of a woman’s domain.¹⁸¹ These attitudes are sometimes supported by the

community. For example, a UNAIDS study conducted among men in Tanzania revealed that on occasion, “male heads of households would wish to do more when their partners fall ill but were curtailed by cultural definitions of maleness and the roles defined which determine masculinity.”¹⁸² Another study conducted by Kunene in KwaZulu Natal, South Africa found that a significant barrier to men’s involvement in antenatal care was opposition by female nurses.¹⁸³ Indeed, men’s historical exclusion from caregiving may mean they lack the skills in that area, thereby reinforcing caregiving as woman’s work. As one participant in a *Men as Partners* workshop in South Africa stated, “I’ve never cooked because of traditional roles especially in rural areas where as a boy I would take care of cattle all day and spend very little time at home. As a result I never learned about domestic chores.”¹⁸⁴

STRATEGIES FOR ACTION

Promote gender equity in caregiving roles and work opportunities among male and female youth.

According to research in Zambia, male and female youth have equal propensity to provide care for AIDS patients.¹⁸⁵ After undergoing training in a variety of topics relating to the needs of people living with HIV and their families, both male and female youth cared for approximately the same number of individuals. These findings echo the recommendations of similar programs that have found that working with both young men and women may be more effective in changing social norms that fuel HIV than do programs working solely with young women.

Build men’s skills to provide HIV/AIDS related care, and work with the community to encourage men’s caregiving.

Several programs have worked to build men’s caregiving roles in the context of HIV. For example, programs such as Tovwirane and World Alive Ministries in Malawi or Kara Counselling and Trust in Zambia have successfully trained men to volunteer

as home-based caregivers. World Alive Ministries trained men in both technical skills such as counseling, as well as personal skills such as bathing. Through this training program, the Ministries found that with the support of male community leaders and ongoing program guidance, men can successfully act as caregivers.¹⁸⁶ Similarly, Tovwirane found that working with community leaders was key to successfully engaging men as participants in volunteer caregiving programs.¹⁸⁷

Compensation is another important factor for men's involvement in caregiving. Men tend to perceive themselves as providers, and on average, they have aggregate higher incomes than women.¹⁸⁸ As a means of addressing this, some programs provided a small stipend, or in the case of Kara Counselling Trust, a bicycle for participants to use on and off duty.¹⁸⁹ In Lesotho, home-based care is now a paid activity, and this has proven an incentive for greater male participation in caregiving.¹⁹⁰ Such programming, however, must be very careful not to perpetuate the idea that men can and should do care work when it is paid, while women are expected to do the same work unpaid.

Conduct rigorous evaluation of programs where men provide HIV/AIDS-related care.

Few programs have been rigorously evaluated to determine sustainability, quality of care provided, impact on overall coverage of care or long-term changes in patterns of men's care-giving activities.

^{vii} Further research is needed to identify incentives to engage men in care-giving. For example, further research may be necessary to determine the benefits of offering financial compensation for male caregivers. For example, compensation may reinforce traditional gender norms or take away employment and income from women and girls.

^{vii} Generally, programs provided observations of lessons learned or a survey of knowledge, attitudes and practices of men before and after participating in trainings.

FINAL RECOMMENDATIONS

Although further research needs to be done to identify successful strategies for incorporating men and masculinities in HIV prevention and treatment, common lessons across programs have emerged. Based on these lessons, policies and programs should:

- *Acknowledge ways in which social constructions of masculinities contribute to HIV, including carrying out national household level research on men's attitudes and behaviours, using such instruments as the International Men and Gender Equality Survey (IMAGES) and the GEM Scale.*^{viii} Such information can provide powerful inputs to drive and monitor policy-level responses and to monitor changes as a result of programs and policies.
- *Include an analysis and acknowledgement of transforming inequitable gender norms as they relate to men and women in national AIDS plans and policies.* Tanzania's national AIDS program, for example, contains a detailed plan and recommendations for engaging men and addressing of masculinities as a means to improve HIV programming.¹⁹¹
- *Scale up and disseminate results of gender transformative programming that has shown evidence of effectiveness* in HIV prevention, testing and treatment and increasing men's participation in caregiving. Too often, NGOs and national AIDS programs reinvent programs that already exist.
- *Carry out a thorough gender and vulnerability analysis at the national and local level to understand how gender norms and power structures leave specific groups of women and men more vulnerable to HIV.* The analysis should pay special attention to the specific vulnerabilities of men who migrate for work, incarcerated men, men who have sex with men (MSM), especially young MSM, and men in the military.
- *Promote partnerships between national AIDS programs and strategies and civil society groups taking into consideration men's sexual and gender diversity.* For example, in some countries, networks have formed between NGOs working specifically in HIV and GBV prevention, and the small but growing number of NGOs working with men from a gender equality perspective.
- *Ensure work to engage men is supportive of and not counter to efforts to empower women and girls.* While acknowledging ways in which rigid gender norms are harmful for men and boys, it is critical to keep in mind men's comparatively greater power and income relative to women in most of the world.
- *Promote joint prevention programming that engages women, men, girls and boys.* Program planners are increasingly acknowledging the need for gender strategies that engage women, men, boys and girls.¹⁹²
- *Support programs that promote the rights of all gender identities.* Projects such as those undertaken by the Naz Foundation incorporate human-rights based approaches to HIV/AIDS programming, with emphasis on reduction of stigma and discrimination towards men who have sex with men and transgenders. These programs reported increased condom use, reduced rates of STI infection, and increased access to HIV/AIDS/STI services.¹⁹³

viii Horizons and Promundo developed the Gender-Equitable Men (GEM) Scale to directly measure attitudes toward "gender-equitable" norms. The scale is designed to provide information about the prevailing norms in a community as well as the effectiveness of any program that hopes to influence them. Available at <http://www.popcouncil.org/Horizons/ORToolkit/AIDSQuest/instruments/gemscale.pdf>.

HIV/AIDS Policies Addressing Men and Masculinities

- Promote strategies increasing equality in sexual relations, particularly in decision-making around sex, by challenging dominant gender norms and socialization processes;
- Support gender transformative prevention strategies, from education and life-skills programming that promote responsible male behaviour, to broader gender inequality awareness-raising campaigns;
- Support research about men's attitudes and perceptions regarding masculinity, sex and sexuality to inform life-skills training programs;
- Designate influential men to raise awareness and to challenge norms about men's behaviour and gender roles;
- Emphasize men's participation in VCT, reproductive and child health and related services to promote family health;
- Recognize the needs of specific groups of vulnerable men, including men who have sex with men, and decriminalize their activities;
- Promote the scale-up of safe male circumcision as a preventive measure, while safeguarding against adverse effects;
- Implement primary prevention programming in the area of ending violence against women which targets men and boys;
- Provide support for men as caregivers, including parenting courses and paternity leave policies.

Source: Adapted from Teri, Sara. 2008. *Addressing Male Engagement in Tanzania Programs and Policies: A Call for Action*; Barker, Gary, et al., 2010. "What Men Have to Do With It: Public Policies to Promote Gender Equality." International Center for Research on Women and Instituto Promundo.

APPENDIX 1

KEY RESOURCES ON MASCULINITIES AND HIV/AIDS

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