



AIDS and gender relations

**STANDING UP FOR
HIV PREVENTION**



**HIV/AIDS AND GENDER RELATIONS
– MEN MATTER! AIDS, GENDER AND MASCULINITIES**

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List of Acronyms

ABC	Abstinence, Be faithful, use Condoms
ARV	Anti-Retrovirals
CSW	Commercial sex worker
IDU	Injecting drug user
MSM	Men who have sex with men
PMTCT	Prevention of mother to child transmission
SGBV	Sexual and gender based violence
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infections

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1. Introduction

Does the AIDS epidemic, in all its destructive power, also hold the potential to transform gender relations and open up new ideas of masculinity? This question serves as an underlying theme for the present report, commissioned by Sida.

The need to redress gender inequities in relation to women's and girls' vulnerability to HIV has been on the agenda for more than a decade. Still, most programmes have focused on women, omitting men. Gradually, the importance of the participation of men, and also of focusing on men in their own right, has become apparent. Since the late 1990's, a number of efforts have therefore been made to involve men as partners in the struggle against HIV (UNAIDS 2000). In parallel, efforts to increase men's involvement in sexual and reproductive health and rights, earlier criticised as only taking funds from women-centred activities, are now widely accepted.

That the construction of masculinity and men's behaviours heavily influences the spread of HIV is beyond doubt. Men's dominance, including men's sexual dominance and male sexual behavioural patterns, can be said to be at the core of the pandemic. Prevailing cultural and societal norms of masculinity often create an environment that accepts and sometimes even encourages risk taking. "Men are less likely to pay attention to their sexual health and safety, and are more likely to inject drugs [than women] ... additionally employment-related migration, often by men, disrupts marital ties and is known to contribute to unsafe sexual behaviour" (Mane & Aggleton, 2001).

The relationship between men, masculinities and HIV & AIDS is complex and geographically differentiated. A better understanding of this relationship is badly needed, to serve the policies that address HIV transmission and – not least – to enable men to take more active roles in preventing the further spread of HIV. In that context, a closer look at the formation and transformation of masculinities and gender relations is essential.

Concepts

While 'sex' is a dichotomy based on biological differences, 'gender' is the social role of being a girl/woman or boy/man. 'Sex' and 'gender' overlap, and disentangling them is demanding. For most people, 'gender' and "sex' are the same; men 'are' their masculinities – the opposite of women.

It is important, however, to understand the differences between ‘male’ and ‘masculinity’. The term ‘male’ is closely linked to biological sex. ‘Masculinity’ is more complex. *“Masculinity’, to the extent that the term can be briefly defined at all, is simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture”*(Connell 1995). Both women and men are the producers, consumers and performers of masculinities. “Women no less than men are implicated in the construction and reproduction of existing gender relations, and the expectations and opportunities to which these give rise” (Mane and Aggleton 2001)

2. An epidemiological overview

At the end of 2006, UNAIDS estimated that there were 39.5 million people worldwide living with HIV. About 4.3 million people were infected during that year, while AIDS claimed some 2.9 million lives. Almost two-thirds (63%) of all people living with HIV, and 90% of HIV-infected children, live in sub-Saharan Africa, while adult prevalence today is increasing faster in eastern Europe and parts of Asia.

Sub-Saharan Africa is experiencing a generalized epidemic, which is characterised by extremely high HIV prevalence rates in the general population. Furthermore, women are disproportionately affected by the epidemic, due to socioeconomic and cultural disadvantages. Three-quarters of all HIV positive women globally live in this region. The HIV epidemics in Sub-Saharan Africa are attributed to sexual transmission (mainly heterosexual) in 90% of the cases. In several countries in southern Africa, more than 20% of the population is estimated to be living with HIV; with Swaziland being the most affected country in the world with an estimated 33.4% of the adult population infected (UNAIDS 2006a). As the global AIDS epidemic continues to grow, concerns are being voiced as to whether the pattern of generalized epidemics experienced in sub-Saharan countries may spread to other regions. Most experts however do not expect other parts of the world to develop generalised high level HIV prevalence rates (see e.g. Caldwell 2006, Godwin et al 2006).

There is now clear evidence of declining infection rates in some countries in sub-Saharan Africa. This development can to a large extent be explained by increases in AIDS deaths balancing new infections, but also by documented behaviour changes like later sexual debut, reductions in casual sexual relations and increases in condom use. However, these behavioural changes appear in many cases to have taken place before the scaling up of prevention programmes, which suggests that they have been influenced by other factors such as the demonstration effect of increased morbidity and mortality in AIDS.

When dealing with the 'African epidemic,' it is important to note that the countries in this region experience a number of different types of epidemics, and that countries and sub-regions cannot be lumped together as one. Southern Africa remains the epicentre of the global AIDS epidemic with prevalence rates generally stabilising at very high levels but with one country (Zimbabwe) showing solidly declining infection rates (UNAIDS 2006a). Starting off from a lower level, the epidemics of East Africa continue the trend of stabilisation or decline, but with signs of reversal of

the trend in some cases (Uganda and Burundi), while divergent trends characterise the considerably smaller epidemics of West and Central Africa. At the same time, methodological improvements have resulted in a reduction of prevalence estimates for the whole region during four consecutive years (Schmid et al 2004). UNAIDS is preparing a further downward adjustment of estimates for 2007. In spite of these repeated adjustments of prevalence estimates, the main message for all working with HIV & AIDS programmes is that the numbers themselves still are very high, and millions are becoming infected with HIV and dying of AIDS every year.

Epidemics in other parts of the world are developing quickly. The fastest growing epidemic worldwide is currently among injecting drug users (IDUs) in eastern European countries, with Estonia, the Russian Federation and Ukraine now having reached an adult prevalence in excess of 1%. The main risk groups in the concentrated HIV epidemics outside of sub-Saharan Africa include, in addition to IDUs, prostitutes¹ and their clients (both of whom often inject drugs as well) men who have sex with men (MSM), some mobile populations, and male prisoners. Differences in the Asian epidemics can be exemplified with China experiencing an epidemic sparked by overlapping risk behaviours of unprotected commercial sex and injecting drug use, while in India 80% of transmissions are estimated to be through heterosexual contacts – prostitutes and their male clients, who in turn infect their wives. India is also the country with the highest number of HIV cases globally (5.7 million), while its national adult prevalence is as low as 0.9% (UNAIDS 2006b).

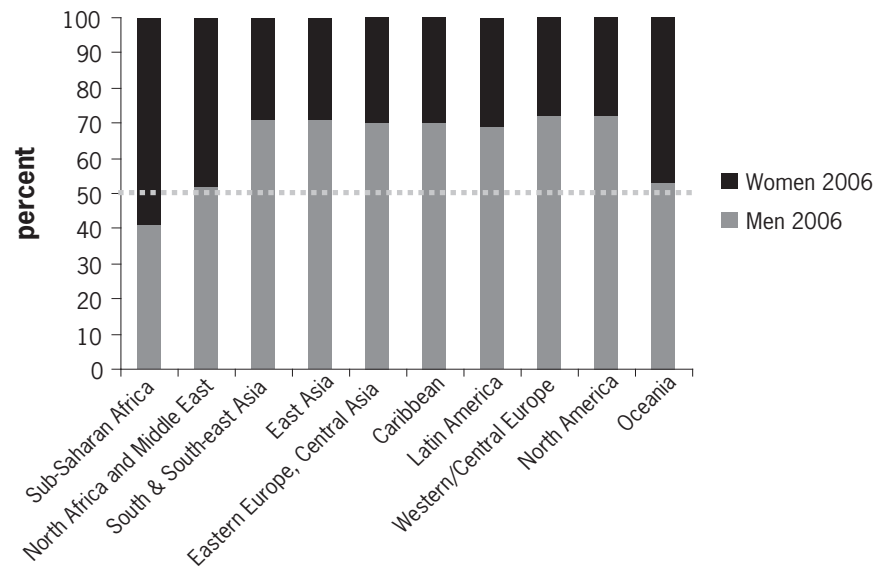
Western Europe and the USA have in recent years experienced rises in incidence among men who have sex with men, as a result of increasingly risky behaviour such as unprotected anal intercourse. The availability of antiretroviral therapy – turning AIDS into a chronic rather than a deadly disease – may be a reason for increased sexual risk-taking behaviour. Furthermore, there are many overlaps between male and female prostitution and injecting drug use. Similar, but hidden, epidemics are thought to be underway in Latin America, eastern Europe and Asian countries, where stigmatization of gay men and drug users is intense. However, these are concentrated epidemics, with high or very high prevalence rates among risk groups, while HIV infection in the general population remains low.

Although prevalence levels among women in sub-Saharan Africa are increasing drastically, especially among young women, in most other regions the epidemic continues to develop primarily among men (see Fig 1).

Since the epidemics worldwide largely are unconnected, as verified by viral strain analysis, progress in managing the epidemic in sub-Saharan Africa alone is likely to have very little or no effect on the spread of HIV in the remaining 150 countries around the world. The epidemic is expected to continue to spread in these countries, though in different patterns. For this reason, the fundamental strategy to control HIV globally is to address the pandemic everywhere with contextually appropriate and proportionate efforts, addressing any and all modes of exposure and transmission. This strategy has been elaborated by the United Nations as universal access to HIV prevention as well as to AIDS treatment and care services (UN 2006).

¹ Sweden officially uses the term 'prostitute'. UNAIDS, on the other hand, employs the term 'sex worker'. This is intended to be non-judgmental, focusing on the conditions under which sexual services are sold. Alternate formulations are: 'women/men/people who sell sex'. Clients of sex workers may then also be called 'men/women/people who buy sex'. (UNAIDS editor's notes, May 2006)

Figure 1. Portion of Women/Men living with HIV (15–49) 2006



Source: UNAIDS Epidemic Update, Geneva, December 2006, table 2.

2.1 Male Circumcision

One epidemiological aspect of the AIDS pandemic that recently has been given much attention is male circumcision. The background is, that by the end of 2006 trials both in South Africa (Auvert et al 2005), in Uganda (Gray et al 2007) and in Kenya (Bailey et al 2007), testing the impact of male circumcision on HIV transmission had been conducted and stopped earlier than planned due to high efficacy (WHO/UNAIDS 2006). The findings were striking: the intervention groups showed a 50 to 60% decrease in the risk of HIV transmission, in comparison with control groups. While these results have been welcomed, the question remains how best to address such a “complex cultural, human rights, ethical and programmatic issue” as expanding male circumcision as an HIV prevention method (UNAIDS 2007a).

Risks and concerns

Complications connected with male circumcision depend on the age of the patient, level of training of medical staff, availability of instruments and the level of sterility (Sawires et al 2007). Studies from various places in sub-Saharan Africa have documented unacceptably high levels of severe complications, including HIV infection, associated with the procedure (Brewer et al 2007, Bailey & Egesha 2006). A large-scale rollout of male circumcision can only be justifiable if sterile conditions can be ensured; otherwise it may advance the spread of HIV rather than prevent it (Brewer et al 2007).

Neonatal circumcision, practiced in many part of the world, significantly reduces risk of complications (and costs) compared to interventions on adult males. However, circumcision of non-adults raises human rights and integrity concerns (UNAIDS 2007) and will only have long-term preventive effects (Sawires et al 2007). The issues of consent and freedom of choice must also be addressed in communities where male circumcision is a part of cultural and religious tradition. On the other hand, circumcision may provide new opportunities for dialogue in communities that are

opposing other forms of HIV prevention, such as condom use. Moreover, it provides an entry point to working with men on sexual and reproductive health and rights.

There are important gender dimensions to address in the context of expanding male circumcision for HIV prevention. To date, no reduction of male-to-female transmission of HIV related to male circumcision has been proven, although models suggest a positive indirect effect by lowering HIV prevalence among men. There is, however, a risk that male circumcision may create a false sense of security and undermine existing preventive behaviours and strategies to reduce HIV infection, such as consistent condom use (WHO 2006). Male circumcision should therefore be accompanied by comprehensive communication strategies and be mainstreamed with other HIV prevention methods.

A major concern, related to male circumcision as an HIV prevention measure, is the considerable scale-up of human and financial resources that is needed. In health systems with very limited resources, it is crucial that male circumcision is not promoted at the cost of other disease prevention strategies (Sawires et al 2007). While WHO estimates that male circumcision can save up to 200 000 people a year from infection, it is evident that it does not provide complete protection and must be expanded only as a component of a comprehensive prevention strategy (WHO 2006).

WHO and UNAIDS have held a series of technical meetings to discuss the policy, programmatic and research implications of the new findings on male circumcision and HIV prevention. At the concluding meeting in the beginning of March 2007, the organisations decided to endorse male circumcision as an HIV prevention method. The concerns and risks raised above are addressed in detail in a document issued after the meeting, containing a number of conclusions and recommendations (WHO/UNAIDS 2007). The role of male circumcision for HIV prevention is at the time of writing still under considerable debate in a number of fora.

3. Men, Gender and Masculinities

The global human rights and reproductive health agendas have contributed to placing unequal gender relations and the need for change at the centre of the development agenda. By bringing sexuality issues into the public domain, the AIDS epidemic has added weight to the gender debate, not least on male gendered behaviour. Wherever they facilitate HIV transmission, dominating norms and stereotypical expectations of gender relations are increasingly challenged at all levels.

The risk of getting infected by HIV can be linked both to the *individual's* knowledge and behaviour and to a *societal* vulnerability resulting from cultural norms, laws, politics and social practices that influence the actions of the individual (UNAIDS 1997). Gender roles constitute part of the societal pattern and can be described as expectations or norms of appropriate female and male behaviour, and as such they also have an influence on what is expected concerning sexuality and sexual behaviour.

When discussing gender roles globally, men as a group are referred to as the dominant sex, putting women in an inferior social and economic position where they may be exposed to unsafe and unwanted sexual relations. While this is true, blaming men as being the sole root of inequality is to oversimplify social structures. Men are also a 'product' of the ideas and notions on how they should act, and what may be called the *dominant, hegemonic masculinity* influences men's behaviour and actions (Mane and Aggleton 2001). Manhood and masculinity concepts guide boys and men in the world of gender relations. To find ways to stimulate necessary changes requires a clear understanding of how they work. It should be noted that the possibility of change is always there; some men and boys feel obliged to live up to the dominant forms of masculinity, while others struggle to find alternative and more gender equal identities.

The concept of 'hegemonic masculinity', first mentioned by Kessler et al 1982 and further developed by Connell (1995) came as a critique of the 'male sex role literature'. The notion of 'male and female roles' conflated social structure with biological differences and thus did not give room for inequality and power issues. Instead the concept of hegemonic, or dominant, masculinities is based on a model of multiple masculinities and power relations where masculinity varies with geographical location, social class, ethnicity, sexuality, age and time (Connell, 1995; 1998; Connell & Messerschmidt 2005). Thus, it appears

more appropriate to talk of ‘masculinities’ than of ‘masculinity’, since there is more than one way of becoming and being a man. It is the socially dominant construction of masculinity at a given time and place that subordinates femininities as well as other forms of masculinity, and shapes men’s relationships with women and other men (Courtenay 2000).

“There is no typical young man in sub-Saharan Africa and no single African version of manhood. There are numerous African masculinities, urban and rural and changing historically, including versions of manhood associated with war, or being warriors and others associated with farming or cattle-herding. There are indigenous definitions and versions of manhood, defined by tribal and ethnic group practices, and newer versions of manhood shaped by Islam and Christianity, and by Western influences, including the global media.”

(Barker and Ricardo 2005).

Masculinities are collective, sustained not only by individuals but also by groups and institutions (for example through workplace, sport and military cultures). They are actively constructed through social interaction, and they are dynamic – they change over time. Masculinities are also tied to hierarchy and power relations; there are dominant and more subordinate forms of masculinities.

The concept of masculinities is useful in the sense that it can be applied in various fields including men’s health practices and risk-taking sexual behaviour. “It is men’s and boys’ practical relationships to collective images of masculinity ... that is central to understanding gendered consequences in violence, health and education” (Connell and Messerschmidt 2005).

Examples of social constructions of masculinities that play a central role in HIV-transmission are:

- That men should be strong – leading to not visiting health clinics as it is a sign of weakness
- That homosexuality does not conform with ‘being a man’ – leading to silence and stigma around homosexuality
- That men’s sexuality drives them to have multiple partners, or drives them to abuse and rape women/men

Connell suggests that hegemonic masculinities can be analysed at three different levels; locally, regionally and globally. These often overlap and interplay. A practice at local level, for example men engaging in sports, can construct ideas of masculinity at regional level (reproducing an ideal of the athlete for the local level to admire).

As shown in Table 1, dominant constructions of masculinity in different settings can be *and are* questioned. Concerns about HIV can play a part in changing some of the dominant masculinities that are pro-HIV. In South Africa, a country with very high HIV prevalence, there is intensive research and debates on men relating not only directly to HIV and masculinity (Morrell 2003, Luvu 2003, Walsh and Mitchell, 2006) but also to signs of more profound change of gender relationships (see box).

Table 1: Three levels of analysis of hegemonic, dominating masculinities: examples

Level	Arena	Examples of prevailing masculinities that are 'pro-HIV' directly or indirectly	Examples of responses
Locally constructed	Face-to-face interaction in families	The underlying assumption among male family members (fathers, uncles etc) in discussions with teenagers that it is OK for a boy to have sex at an early age, but not for a girl.	Men and fathers engaging more in the care of children from the early childhood.
	Face-to-face interaction among peers	A young man needs a lot of sexual experience – to visit a prostitute shows that you are an adult.	Peers discussing male identity and sexual health
	Interaction in community	Male authority rule; male teachers 'harassing' female students by subtle sexualizing of different every-day situations	Students deal with and oppose sexual harassment. School based education on sexuality includes discussions on male roles.
Regionally constructed	Nation/state	Men cannot be totally responsible for raping a woman who is dressed in a sexy, provocative way.	Laws and implementation of laws that see rape and sexual violence as a severe crime, irrespective of circumstances.
	Culture, politics	Implicit recognition of male rights to extra-marital sex reinforced through films, magazines etc	Actions focused on combating inequitable gender norms.
Globally constructed	Transnational world politics, media	Leaders do not speak out about the masculinity norms and HIV & AIDS	Pressure from surrounding world media to recognize the problem, 'break the silence' and 'know your epidemic'.

Source: Adapted from Connell and Messerschmidt 2005

Changing gender relations in South Africa

“In a remote corner of South Africa a group of men is negotiating more caring and equal relationships with their wives and children. It is not remarkable that there are caring men in Nkomazi, where they live. What is notable is that these individuals are mindful of their intimate relationships and define themselves as different to other men. They are concerned about how they treat women and children, reflect on their roles in family life, consciously attempt to create more equal ways of sharing domestic tasks and decisions, and explicitly reject violent methods of resolving conflicts. Yet they live in a social context where traditional notions of the family hold sway.”
(Sideris 2004).

3.1 Men's sexual networking

Sexual patterns and practices are at the core of sexual HIV transmission. Such behaviours are socially determined – by e.g. up-bringing/maturation, gender roles, social context, alcohol use and poverty – and are to a large extent driven by male sexual behaviour. Sexual patterns involve issues such as serial monogamy versus concurrent sexual relationships, and frequency and nature (condom use) of occasional sexual encounters including commercial sex. Even though some research has been carried out in the area of sexual patterns, our knowledge is still rudimentary in many settings.

A recent thesis (Hanson 2007) summarizes what is known from Africa. In parts of Africa concomitant sexual relationships appear to be common, and this contributes to HIV transmission through large groups (Kalichman 2007). For instance, the one published complete analysis of sexual patterns in a population – from an island in Lake Malawi – revealed that 85% of the adult population could be linked to a single sexual 'web' (Kohler and Helleringer 2006).

Patterns of age disparate sex are also common in the region. For example, the phenomenon of 'sugar daddies' where older men maintain sexual relationships with younger women, in return for material favours, social status and 'protection'. A study, including 14 focus group discussions with in- and out-of-school youth, female sex workers, adult men, adult women and health workers was carried out in south-western Uganda. It was found that sexual activities outside of marriage are usually linked to exchange of favours or gaining something. It was explained as a wide variation from cookies for younger girls to financial agreements for sex workers. For example, it was mentioned that if a male youth is paying for drinks, he is expected to get sex in exchange. It was stated independently in all focus group discussions that it is common that young girls have a sugar daddy. The result also showed that it was not uncommon for boys to have relations with sugar mummies (Agardh et al 2004)

Sex with the implicit assumption of gain can be equated with prostitution. Studies from sub-Saharan Africa show that young women involved in transactional sex do not identify themselves as prostitutes (Caldwell et al 1989; Jewkes et al 2001). Even if relations include several partners, gifts and cash, those involved often relate to each other as girlfriends and boyfriends and the women also tend to trust their boyfriends when it comes to supporting them (Agardh et al 2004). Women who take part in transactional sex do not see themselves as passive victims, but rather as engaged in getting access to resources in ways that both challenge and reproduce patriarchal structures.

3.2 A key factor – men's violence

Violent men exist in all cultures and in all social classes. Male, gender-based violence is more common among men who have been abused or witnessed domestic violence as children, men with excessive alcohol use, men in impoverished societies/families, and men in societies where conflict resolution through violence is common (Heise et al 1999). WHO's recent multi-country study on Women's health and domestic violence (WHO 2005) also clearly shows how sexual violence is a common ingredient of male violence.

Sexual and gender based violence (SGBV) is closely linked to HIV transmission. Coerced sex in all its forms – from rape to age disparate sex to transactional sex – is usually perpetrated by men. It facilitates, inter alia,

transmission of sexually transmitted infections including HIV. Sexual violence may cause damage to vaginal tissues and also thereby facilitate infection. Men hoping to avoid infection by sex with younger, possibly virgin, partners might be already HIV positive and infect the women.

One example, among many, of the intersects between male violence and HIV is the following study from South Africa (Jewkes et al 1997). Among 191 teenage mothers attending an antenatal clinic outside Cape Town (average age 16), many had experienced violence in several different forms: 32% of the young mothers reported that first intercourse was forced, 72% reported sex against their will, 11% reported having been raped, 78% said they would be beaten if they refused sex, and 58% said that their partner had beaten them.

It is important to realise that women and girls are not the only victims of male violence. Male to male acts of violence impacting on HIV transmission are, for example, rape in prisons and rape of boys.

In recent years, systematic efforts are being undertaken in many countries to reduce sexual and gender-based violence through a wide range of actions at various levels. Introducing and implementing new legislation, female staff at police stations, anti-violence hot-lines, women's shelters, coordinated responses by public services, targeted poverty reduction schemes, and focused NGO collaboration, are just some examples. Country level efforts to reduce sexual and gender based violence, by local actors, governments and NGOs, in turn help to reduce HIV transmission through its direct effects on sexual transmission and through its encouragement towards gender equity.

A recent report comments that the “ultimate failure [of governments and donors] to address the linkages of violence against women and girls and HIV & AIDS means that they also fail to articulate and execute an agenda that gives priority to securing the human rights of women” (Susana 2007).

4. Men at Risk

Men constitute the majority of HIV infected adults in most regions of the world, except for Sub-Saharan Africa (Fig.1). They play multiple roles in HIV transmission, thereby strongly influencing further transmission of the virus. It is therefore important to identify key groups of men with high vulnerability to becoming infected with HIV, such as MSM, migrant/mobile men, male injecting drug users and men in prisons.

4.1 Men who have sex with Men

While a not yet recognised heterosexually transmitted AIDS epidemic was rapidly evolving in Africa, AIDS was first identified as a life threatening syndrome among gay men in the USA in the early 1980s. Three decades later unprotected sex between men remains one of the main risk factors for HIV transmission in many parts of the world. These groups often have considerably higher infection rates than the general population. 'Men who have Sex with Men' (MSM) includes men who also have sex with women and overlaps with other risk groups, men who sell and/or buy sex and men engaged in unsafe injecting drug use, which constitutes an important bridgehead for HIV into the general population. This makes it crucial to reach this group with effective HIV preventive interventions. In many parts of the world, efforts in this respect are severely hampered by widespread stigmatisation and denial of homosexuality, and even criminalisation of same-sex acts.

As a global average, an estimated 5–10% of all HIV transmission is through MSM (UNAIDS 2004). This proportion is certain to be considerably higher in some regions. In most Latin American countries MSM plays a prominent or even dominant role in national AIDS epidemics. This category accounted for a quarter of all new HIV infections in Latin America in 2005 and even more in some of the major countries in the region (UNAIDS 2006a). In Mexico over half or 57% of accumulated HIV infections is believed to have occurred through unprotected sex between men (Bravo-Garcia et al 2006). Studies in the region show that a significant part, in some countries as much as half, of the men who have sex with men also have sex with women (Cohan, 2006), and in one study from Guatemala half of MSM regarded themselves as heterosexual or bisexual (MSPAS 2003). Overlap between injecting drug use and male prostitution fuels the epidemic in several countries.

In Western Europe, HIV prevalence levels among MSM varies between 10% and 20%. Unprotected sex between men remains the principal infec-

tion risk factor in the region (UNAIDS Dec 2006), and one third of new infections in 2005 is attributed to this transmission route (EuroHIV 2006a). In the still dominantly male epidemic in USA, some 65% of new HIV cases in 2004 was attributed to sex between men. In the most affected group, male Afro-Americans, half had been infected by unprotected intercourse with men (USCDC 2006a, 2006b). National AIDS epidemics in Canada, Australia and New Zealand, as well as Japan, are also dominated by MSM. As already mentioned (see ch. 2), the incidence of HIV among MSM has been rising recently in many Western countries, prompting a strengthening of preventive interventions targeted on this group.

In the epidemics of South-East Asia, MSM play less prominent but still important roles. The latest UNAIDS Epidemiological Update mentions serious HIV outbreaks among MSM in Thailand, Cambodia and Vietnam. The problem appears to be most serious in Thailand, where a study has shown a drastic increase of infection rates among MSM in Bangkok, from 17% to 28% between 2003 and 2005 (Van Griensven et al 2006). In many parts of the region, widespread sexual risk behaviour, as well as the overlaps with other risk groups, underline the importance of upgrading efforts to reach MSM with effective interventions.

Lack of information

Considerably less is known about the role of sex between men in the AIDS epidemics in Eastern Europe, Asia, the Middle East, and Africa. The lack of information is related to denial, intense stigmatisation and criminalisation of same-sex relations. However, existing studies show significantly higher HIV prevalence among MSM than in the general population. UNAIDS (2006a) has highlighted recent outbreaks of HIV among men who have sex with men in China, India, Nepal and Pakistan. In South Asia a significant proportion of MSM also sell sex. A survey of male to male prostitutes in Pakistan showed that one in four also brought from – or sold sex to – women (Ministry of Health et al 2005). Combined with overlap with unsafe drug use, high levels of STI and low condom use, such connections obviously further fuel national AIDS epidemics.

In sub-Saharan Africa, studies from Kenya, Ghana and Senegal show that MSM in addition to high rates of HIV and STI, also suffer from serious stigmatisation, including harassment and violence (Niang et al 2003, Attipoe 2004, Onyango-Ouma 2006). A recently published study from six urban areas in Senegal reports a 22% HIV prevalence in the studied MSM group, of whom 94% also had sex with women (Wade et al 2006). This shows MSM to be a bridgehead for transmission of HIV to women who otherwise would be at low risk of infection. Clearly, more information on the role of MSM in African AIDS epidemics is urgently needed.

Some advances have been made in the acceptance of same-sex relations over the past decade, and in reaching MSM with HIV prevention, as well as with AIDS care and treatment services. However, in many parts of the world resistance and denials mean that a great deal remains to be done to adequately address the issue. Lack of information, in itself compounded by stigma and discrimination, and also lack of harmonisation of legal and public health policies and practice, are serious constraints. The socio-economic heterogeneity of such groups, their geographically varying composition, and overlaps with other risk groups are further complicating factors. The threat of the pandemic is now gradually creating more pragmatic approaches to local realities. In, for example, China, where stigmatisation of MSM is strong (Liu & Choi 2006), the authorities face a 54% increase of HIV infections among MSM since 2004.

An ambitious prevention programme focused on MSM was launched in April 2007 (Kaisernetwork 2007).

4.2 Mobility, HIV and Men

“Being a migrant is, not in and of itself a risk factor for HIV infection, but changed circumstances may lead to increased personal risks, for example separation from family, sexual partners and the stresses and vulnerabilities associated with the migration process”

(Jolly 2005).

There are close and complex links between migration and HIV transmission. Crush et al (2006) point out four key ways by which migration is connected to the rapid spread and high prevalence of HIV:

- Higher than average rates of infection are often found in ‘migrant communities’ who often are socially, economically and politically marginalized;
- Migrants’ multi-local social networks create opportunities for mobile sexual networking;
- Migration *per se* can encourage or make people vulnerable to high-risk sexual behaviour;
- Migration makes people – particularly illegal immigrants – more difficult to reach through interventions, whether for preventive education, condom provision, HIV testing, or post-infection treatment.

Both men and women migrate, but men tend to dominate in long-distance and cross-border migration in most world regions. It is also male migrants and groups of mobile men who have been in the focus for research and interventions on migration and HIV & AIDS. Long-distance lorry drivers are one such male migrant group, often having exceptionally high HIV prevalence; a study from South Africa (Ramjee & Gouws 2002) reported over 90%. Lorry drivers, as well as communities living along transport corridors, have been particularly targeted with HIV prevention interventions (see e.g. IOM 2005, Wilson et al 2001).

In sub-Saharan Africa, and particularly in Southern Africa, the links between migration and HIV transmission have been firmly established (see e.g. Williams et al 2002, Lurie 2004). The problem has also been given considerable attention in other regions, such as South-East Asia (Simonet, 2004, Skeldon 2000) and lately in China (Wang B et al. 2006).

Regulated single male migration systems, such as the supply of workers to the mines of South Africa, create particularly good conditions for transmitting HIV and other STIs (Williams 2002). Living conditions in such male-only migrant communities encourage high-risk sexual behaviour including commercial and transactional sex with multiple partners of both sexes. When visiting home these migrants also, of course, have sex with wives and girlfriends.

The role of migration in the AIDS epidemic has conventionally been understood as men migrating, becoming infected through sexual relations while away from home, and infecting their wives or regular partners when they return. Research generally confirms this picture but, as shown in the box below, it also gives a more complex picture underlining that prevention interventions consider both ends of the migration process, and also differentiate between different groups of migrants.

The migration process has two ends

A study in KwaZulu Natal, South Africa, reports: 'Migrant couples were more likely than non-migrant couples to have one or both partners infected with HIV (35% versus 19%) and to be HIV-discordant (27% versus 15%), meaning that one partner is infected and the other is not.

'The discordance data challenge one of the central assumptions about the role of migration in the spread of the epidemic: it has long been assumed that it is returning migrant men who infect their rural partners. This is far from always the case: among HIV discordant couples, 30% of the time it is the woman who is HIV-positive and her migrant partner who is negative. Clearly, an HIV-positive woman whose migrant husband is not infected must have been infected by someone else. These findings highlight the importance of working not only with migrants at their place of work, but also with their rural partners who stay at home.'

(Lurie 2004)

Migrating Maasai men abstain

A study of Tanzanian Maasai men working in Arusha underlines the need to differentiate between migration groups, and to consider local conditions when planning HIV prevention or other interventions: ...the migrant population studied here regulates its behaviour in a way that reflects local understandings of the disease. This finding is important, not least because it challenges the view that HIV in sub-Saharan Africa is largely transmitted to rural areas by return migrants. Maasai rural-urban migrants in Tanzania—both married and unmarried—are not having sex in town.' (Coast 2006)

The military, and men and boys in conflict and post-conflict situations

It has often been claimed that military forces in sub-Saharan Africa have high HIV prevalence due to soldiers' mobility and steady pay. A recent study gives a different picture. *First*, military populations do not necessarily have a higher prevalence of HIV than civilian populations. *Second*, armies in general are well placed to withstand the threat. Focused educational programs have been shown to be effective. *Third*, evidence that soldiers' behaviour in war situations contributes to the spread of the virus is relatively thin. It might well be that the risks entailed in displacement or repatriation of populations and consequent changing sexual networks are more important risk factors. *Lastly*, the hypothesis that AIDS has the potential to disrupt national, regional and international security remains speculative (Whiteside and de Waal 2006) as has also been recently argued elsewhere (Lazarus et al 2007).

However, armed conflict and societal unrest often *do* involve both rape, even systematic rape as part of 'ethnic cleansing', and increased demand for prostitution and transactional sex. Both the military forces and paramilitary groups are perpetrators. Somewhat surprisingly, HIV prevalence often increases more rapidly during a post-conflict period than during the conflict itself. During war, the concentration of people in refugee camps etc might impede HIV spread, while post-war free mobility in the country – including demobilisation of soldiers – can lead to rapid transmission. This appears to have been the case in Mozambique in the early 1990s.

Responses

Crush et al (2006) identify four broad categories of migrant or mobile populations in need of different forms of response:

Migrant or immigrant communities of people who have left one place

to settle in another, either long-term or permanently. They require focused interventions in their new location until such time as they become fully integrated into their new societies. Special efforts have to be made to reach illegal immigrants.

Trans-migrants who live in more than one location. They require interventions at both locations as well as in transit between them.

Itinerant or mobile populations, who either have no 'home' or who spend most of their time away from home (truckers, seafarers, sex workers, construction workers). These are perhaps the most difficult to reach, as they do not constitute a spatially fixed community. They require interventions that mirror their movements, for example condoms at truck stops, education material on buses and mobile clinics etc.

Temporarily displaced communities such as refugees and internally displaced persons. Interventions require rapid response in highly mobile form, especially in conditions where the very circumstances forcing people to move, such as war, simultaneously expose them to the threat of HIV infection.

Apart from interventions focusing on these different categories, there is a range of actions available, among them –

- Legislation to introduce and enforce workplace AIDS policies that include temporary (contract) workers
- Facilitating for families to accompany workers or enabling the latter to make frequent visits to home.
- Revision of government policies to reduce reallocation of teaching staff, health staff and others within a country.
- Stimulating local economic growth and thus reducing people's need to go for work elsewhere
- Specific policies and educational efforts within military forces, as well as for international staff working in post-conflict situations

4.3 Injecting drug users

In most eastern European countries, more than 70% of injecting drug users (IDUs) are male (Lazarus et al 2006), and this is also the case in several South Asian countries. Injecting drug use, when needles and syringes are shared, is a very efficient way of spreading HIV. It is also sometimes linked to prostitution, i.e. to women and men who finance their drug use by prostituting themselves or begin taking drugs when becoming a prostitute (CEEHRN 2005). Much of the rapid HIV spread in eastern Europe as well as in eastern and South-East Asia is currently associated with injecting drug use and intricately linked to prison settings.

The main HIV prevention strategies for IDUs have been needle and syringe programmes (harm reduction) as well as drug treatment/opioid substitution therapy with methadone, buprenorphine or other substitutes. One method of harm reduction programmes is to collect contaminated needles and syringes from IDUs and provide clean ones in exchange.

In many countries, such programmes has been met with hostility from governments, as drug use is illegal and harm reduction is seen as promoting drug use. However, it has to be recognized that addicted IDUs will continue their injection practices with or without clean needles. It is therefore clearly better to provide drug users with the means to protect themselves and sexual partners – this way the rates of HIV transmission as well as hepatitis B and C can be reduced signifi-

cantly. Without this kind of interventions, it would be difficult to maintain good adherence to ARV treatment among IDUs and help them maintain the necessary nutritional standard for effective application of the medicine.

As a result of the social stigma and the criminalization of drug use, there are also major difficulties in ensuring the sexual and reproductive health needs of this group. Contraceptive and STI care for IDUs are clearly of major importance – whether they HIV infected or not – as well as ante and post natal care for female IDUs. Such efforts combine the need to contain HIV transmission, with a human rights approach of having access to basic health care in spite of an illicit drug habit. Sadly, much remains to be done in this area.

Response – IDUs

The scale-up of antiretroviral therapy should be effectively used to make basic reproductive health services and harm reduction available to IDUs, in addition to voluntary counselling and testing. Approaches must recognise IDUs as people who need such services in their own right, as well being potential transmitters of HIV, and they must balance the effects of criminalization and reduce stigma.

4.4 Men in prisons and HIV

HIV prevalence is generally much higher among prison inmates than in the general population. In a high-prevalence country like South Africa it is twice as high, and in eastern Europe it can be as much as 5–10 times higher than in the general population. In western European prisons HIV prevalence ranges from 14% to 31% in some regions (Stöver & Lines 2006). The majority of the inmates is male. HIV thus presents a severe health threat to prison populations in many countries (Lines et al 2006) and as the vast majority of prisoners return to their community after their prison sentence, their partners and families are at risk of infection. Managing HIV infection within prisons is therefore an important part of managing the HIV epidemic at national level, and presents a significant challenge in the response to HIV & AIDS worldwide. Additionally, the state is fully responsible for the health of the prison population, as they are in its care.

WHO/UNAIDS outline two main scenarios that cause high levels of HIV in prisons. The first is in countries that have high HIV prevalence among injecting drug users, who are likely to spend time in prison at some point. This scenario exists in many eastern European countries, where in some cases injecting drugs continues inside prison walls. The second scenario is particularly African and concerns countries in which there is high HIV prevalence in the general population driven by unsafe sex. This is reflected within prisons and further transmission is related primarily to unsafe sex between men, including rape.

While some prisoners have contracted HIV before arriving in prison, many get infected during their incarceration. Risk behaviours, such as unsafe sex and injecting drug use, occur widely in prisons, and approximately 5–10% of all injecting drug users start injecting during their time in prison (Stöver et al 2006). Yet prison populations often do not have free access to condoms or clean needles and syringes that would enable them to protect themselves against HIV. Extremely poor prison conditions in certain regions further exacerbate this situation. Thus eastern European prisons have ominously been termed ‘HIV incubators’ (UNDP 2004).

Response – HIV prevention in prisons

WHO/UNAIDS' international guidelines recommend that prison health services uphold a standard equal to that of community health services. It is the right of all prisoners to enjoy the highest attainable standard of health. Despite this situation, most governments have not implemented adequate health services, including HIV prevention, in their prisons.

Prison authorities must make condoms freely available to prisoners. Whether it is condoned or not, prisoners have sex with each other and sometimes with the prison guards, and they have the right to be able to protect themselves from HIV and other STIs.

HIV prevention in prisons should also include harm reduction for injecting drug users, such as opioid substitution therapy and needle and syringe exchange, already discussed in the previous section.

Such responses are even more controversial when it comes to prison inmates than to people outside, and can hardly be seen as realistic in many poor countries. Much remains to be done in this respect even in high income countries.

5. Men and the fight against HIV and AIDS

To engage men as actors in relation to the AIDS epidemic, they need to be seen not only as perpetrators or irresponsible transmitters of HIV, nor only as victims of societal changes that confront and threaten their masculinities and manhood identities. Men are also subjects and actors in constructive actions directed at reducing the epidemic and mitigating its impacts. The challenge in all organised efforts to tackle AIDS is to widen – scale up – the participation of men in these efforts, whether as decision-makers and power-holders or as individual members of society. Most community work related to HIV & AIDS is carried out by women volunteers and to engage men at grassroots level is essential. To make more men willing to engage in collective responses to AIDS requires that debate is opened about men and gender, gender-based division of work, and men's roles in caring – basically about the need for change in gender relations.

5.1 Men and HIV prevention and care

Reviewing the experiences of working with men on HIV, or gender and masculinity issues expected to influence HIV & AIDS, two important aspects emerge. Firstly, in recent decades more attention has been given to the involvement of men in sexual and reproductive health in general. Formal evaluations of programmatic efforts have been fairly few, until the very last few years, however. The main reviews are summarized below. Secondly, addressing masculinity will depend on gender relations in a society in general, i.e. the roles of men depend strongly on the roles of women. It is not possible to look at the social roles of men in isolation, the wider gender relations picture is necessary in every setting.

With this background, it is important first to review outcomes and impact of *broad-based programmes* to reduce gender inequities; then to look at efforts of working with *men as partners* on issues related to gender and HIV; and finally to summarize programmatic experiences focusing on *male sexual health – including HIV*.

5.1.1 Broad-based programs to reduce gender inequity

“To promote equality between women and men it is necessary to adopt a gender approach. Rather than exclusively focusing on either women or men, we must consider the situation of both women and men” (Sida 2003). This kind of approach, or gender mainstreaming, typically entails a power analysis, an understanding of factors that influence gender

inequalities; and systematically addressing them, in social structures, values and belief systems.

The systematic work of gender mainstreaming has a long timeline – decades – and should address a host of different issues through many channels. A national strategic plan is important for such long term work. Common components are aspects of pre-school, primary and secondary education, multi-sector poverty reduction schemes, micro-credit schemes for women, employment policies, legal protection and social and family policies. For instance, the entrance of women into the labour market in Bangladesh, through opportunities in the textile industry, is a clear sign of the changing gender relations in that country. It has in all probability also influenced family planning choices.

Family policies also have strong links to sexual and reproductive health issues, such as access to information and services on issues of sexuality and family planning, as well as social policies to create and encourage equality between women and men in relation to jobs and family responsibilities. Current differences in fertility rates among EU member countries reflect income tax policy and provision of social services (Economist 2007).

Men and the empowerment of women

A question that arises, in the course of more or less conscious efforts of gender mainstreaming, is how men are affected by women's increased empowerment. Helping to shape a positive, new role for men is clearly very important. Both at an individual and societal level, efforts towards increased gender equity may suffer if many individual men, or male-dominated structures, do not see the change as a win-win situation but rather feel disempowered or confused. Do men see increased family prosperity as positive, when women contribute to household income? Do they see the potential for more rapid national development? Or do they more commonly resent not being cared for at home by their partners and women infringing on male traditional rights in decision making? What are the messages given by national (often male) decision makers; by important stakeholders such as faith based organizations; press and media; by women's rights groups (men's groups for gender equality are rare); and to what extent are human rights approaches effectively utilized? Men's possibility of positively accepting female empowerment will also depend on their own social situation. Marginalised men, with their capacity as breadwinners undermined, are usually more reluctant to accept changing gender roles. When addressing gender inequalities, it must also not be forgotten that unequal gender relations are sometimes also supported by women.

Working with young people

Broad-based, society-wide efforts aiming at gender equity require long time frames. At the same time, the urgency of responding to the AIDS pandemic offers opportunities for focused, accelerated action, for instance with young people.

In programmatic efforts to modify masculinity in general, arguably the most important group to work with is young men and women. Young people are continually forming and questioning their identities, which makes them both accessible and vulnerable to change. Identity formation is closely linked to the selection of norms and behaviours for their future lives. This combination makes young people the most important and cost-effective to target.

Current debate focuses on cognitive individual approaches, e.g. ABC, (Abstinence, Be faithful, Condom use), versus approaches related to socio-cultural context and group norms. However, both individual and group approaches have some common grounds. Young people everywhere are influenced by friends, family, media, health services and school.

Programmes mediated by networks of friends are well-known today. Such 'peer projects' have a good degree of cost-effectiveness provided key prerequisites are in place. Significant effort is needed to ensure youth participation in project design and implementation. Groupings of young people, where peer education projects have the chance to work, include secondary schools, colleges and universities. A good overview of peer project methodology and requirements is available in e.g. Harden et al (2001).

Families have a big role to play in bringing up boys (and girls) with values of gender equity. It is difficult to design a programmatic approach to changing family values however, even though faith-based organizations have potentially a much larger role to play.

Media plays a rapidly increasing role in the lives of young people across the globe. A recent study among adolescents in Tanzania shows how media is the most important source for information on sexuality (Masatu 2003). Gender roles are often conservatively or stereotypically portrayed on screen, in video games, advertisements, or through pornographic material. It is essential to be able to guide young people to sources where age-appropriate, gender-sensitive, culturally acceptable and correct information on sexual issues is available. This should be both in written form and through internet sources e.g. www.sexuality-andu.com. Countries that have been successful in addressing issues related to sexuality, gender and HIV & AIDS, such as Brazil, have often systematically combined the potential of mass media (especially designed soap operas – so-called edutainment) with educational material (schools, youth groups) with information and counselling given at individual/clinic level.

School-based programmes on sexuality and HIV & AIDS, if possible combined with programs for young people out of school, should be framed in a context of 'life skills' that also addresses gender issues (UNESCO, FRESH).

Youth friendly health services. Health staff often have a degree of trustworthiness in the eyes of young people. Apart from the evident need to provide adolescent friendly health services, there is also an important challenge in maximizing the impact on young men through the encouragement for HIV-testing now that ARV treatment is increasingly available.

The above should of course address both boys/young men and girls/young women, in gender-sensitive ways. In addition to the mentioned approaches – each of which has a vast literature – a number of limited projects or programs have specifically been targeting masculinity, in young men/boys. Such efforts, with separate funding and evaluation, tend to show positive effects. This is largely understandable: boys are also interested in developing caring and loving relationships, if correctly approached. One well-known such project, implemented in Brazil by the Instituto Promundo, not only successfully promoted more gender-equitable behaviour among young men, but by doing so also significantly reduced sexual risk behaviour (Pulerwitz et al 2006). So far, broad-based national efforts on gender equality that also include promoting positive aspects of masculinity are disappointingly rare, however.

5.1.2 Working with men as partners

Experience has been gathered in working with men as partners in key fields of SRHR: STIs transmission – including HIV & AIDS; fatherhood and safe motherhood; gender-based violence, and family planning (WHO 2002, UNFPA 2003, 2004, WHO 2007). The evidence shows that with the right approach, men can be effectively engaged in all these areas, and change attitudes and behaviour. The current challenge is to go to scale with such initiatives so that a broader impact can be achieved.

100% condom

Of the aforementioned areas, men's involvement in family planning has the longest history. Directly building on those experiences, the 100% condom campaign in South-East Asia was developed to target men as clients of commercial sex workers in Thailand, Cambodia, Philippines, China, Lao PDR, Viet Nam, Myanmar and Mongolia (Rojanapithayakom 2006). This programmatic approach – involving a host of stakeholders – works effectively to reduce HIV transmission in connection with sex work. In Cambodia and Thailand the program is seen as the main contributor to HIV decline; in the other six countries the program is still expanding.

Peer education

An HIV prevention project focused on encouraging a positive male involvement in SRHR is the Sida supported 'Young Men as Equal Partners' project in Tanzania and Zambia (2000–2003). Through peer education, gender awareness workshops and other activities the project motivated young men to adopt healthier, more responsible and gender equal sexual behaviour. Among results were considerably increased condom use and increased mutual decision-making on condom use (Laack 2003).

Safe motherhood programmes

Men's constructive involvement in connection with the prevention of vertical transmission of HIV also appears to be increasing, partly as an extension of male involvement in safe motherhood programs. Clearly, this requires concerted efforts, to turn the risks of male discriminatory attitudes towards HIV positive wives into effective secondary prevention, as well as care and treatment strategies. The current massive antiretroviral therapy scale-up facilitates male involvement in prevention of mother to child transmission (PMTCT). Increased PMTCT programming encourages testing among women, and can be expected to reduce stigma around AIDS and treatment. Support is needed in these efforts to women to reveal their status to their husbands, as they may be beaten or thrown out of the home. Couple counselling and testing, both in relation to pregnancy and other reproductive health services, needs to increase, as a part of the anti-retroviral therapy scale-up.

STI care

Broader male involvement as partners in STI care has so far not proven terribly effective. Men tend to seek care for their own STI symptoms and symptomatic STI treatment works well for men. However, contact tracing, screening and treatment of male partners of women treated for STIs have not been shown to be very effective.

Violence

Experience is currently being gathered on men as partners in community programs against sexual and gender-based violence (UNFPA 2004, Peacock & Levack 2004). Whilst limited to pilot studies, male involvement has been shown to be important. Much more needs to be done in order to develop and scale up programs that help combat gender-based violence, sexual violence, and coercive sex. Male involvement needs to be an integral part of these responses and related to training and capacity building of health and welfare service providers, the police and judiciary.

Care

Women provide most of the largely un-paid home based care of AIDS patients. There are exceptions however. In a recent study from South Africa, (Montgomery 2006) showed how men contributed significantly to home-based care of their relatives. This promising finding can certainly be developed further in selected settings.

Further work is needed to increase men's engagement in the care and bringing up of orphans. While 'adoption' of related orphans is common in Africa, the day to day care often falls on the shoulders of women – usually poor, aged or widowed. Studies also show that single and elderly women relatives are more likely to take in orphans.

An increasing number of projects systematically involve men as partners in community-based HIV prevention and AIDS care. For instance, in Cambodia, a broad-based project, involving nine rural and peri-urban Cambodian NGOs used a set of participatory tools to increase male involvement in HIV & AIDS work and address gender relations. Outcomes over a two year period included increase in condom use, decrease in domestic violence in some projects, men became more able to resist peer pressure to drink alcohol and have commercial sex, and women became more able to negotiate condom use. Important lessons learned were ensuring that timing of group sessions did not conflict with income generating activities; that community communication networks were important to target vulnerable groups; and that training and mutual support for group facilitators was essential (Sellers et al 2002).

5.1.3 Men's sexual health and HIV

A broad based sexual and reproductive health and rights approach is needed that includes gender sensitisation and is targeted on both girls and boys. In terms of current responses for HIV and AIDS in relation to men's sexual health, one finds interventions to reduce HIV transmission among groups with high risk behaviour. Since the very beginning of the pandemic, gay rights organisations have effectively promoted safer sex practices in many countries. Outreach organisations have also been significant in reducing risk among injecting drug users. The current upsurge of new HIV infections among MSM in Western Europe calls for a revitalization of these approaches. MSM in Africa, and also other parts of the world, are sorely neglected groups as already noted in this report. Responding to male demands and needs in the field of their own sexual health in itself constitutes an entry to gender-sensitive approaches. If promoted explicitly as such, it can also potentially contribute to a wider understanding of gender equality.

The positive experiences in addressing men as clients of sex workers and men with STI symptoms have been discussed above.

Focused efforts with men as truck drivers, in armed forces and as migrant labourers have had significant impact (see e.g. Matthew &

Watson 2006). As mobility and relative wealth are driving forces of heterosexual HIV transmission, analysis of groups of men with high risk needs to continue, as well as efforts targeted on these groups.

Groups of men that have been largely neglected until recently include incarcerated men, and drug abusers among the urban poor in most countries. Prisons in low income countries rarely have the resources necessary to prevent HIV transmission and provide ARVs with the same service levels available on the outside. These groups need more focus. In Eastern Europe the rapid HIV transmission among IDUs, of whom the majority is male, requires multi-sectoral efforts for effective control. The combination of poverty, unemployment, illicit drug use, and very limited access to reproductive health services serves as a breeding ground for sub-epidemics. Unfortunately, the governmental response in many countries of Eastern Europe is still very fragmented.

Combined approaches

In addition, a few organizations attempt to combine aspects of the three approaches mentioned. For example, the Sida supported International HIV & AIDS Alliance in all its country projects attempts to combine gender issues, including masculinity, with HIV prevention and care (see e.g. International HIV/AIDS Alliance 2003a, 2003b). Another example of this kind of broad based approach is the work of TAI (Targeted AIDS Interventions) in Kwazulu Natal, South Africa, aiming at changing the behaviour and attitudes of young men and boys (le Grange 2004). A Sida supported 'Men As Partners' project in South Africa, implemented through Engender Health, provides another example. (Peacock and Levack 2004).

There are also efforts to deal with the underlying causes for HIV transmission such as poverty and gender inequality. Interestingly, a recent randomized trial in South Africa showed how intimate partner violence and unprotected intercourse in a high-prevalence HIV area declined as a result of a micro-credit scheme for women in combination with a gender and training curriculum (Pronyk et al 2006). More such interventions are needed – but also including men.

6. Implications for research, policy and practice

The connections between unequal gender relations and vulnerability to HIV transmission raise many important research issues. A few of these are outlined below.

FIRSTLY, more needs to be known about the ways in which gender relations and the dynamics of the AIDS pandemic interact. *That* they interact has been pointed out in various places in this report. While unequal gender relations facilitate the transmission of HIV, the pandemic affords an opportunity to challenge established norms of masculinities and femininities. We need to improve our understanding of how men and women not only reproduce social norms but also challenge and change them.

SECONDLY, another area for research focus is the gender cultures of institutional actors from state to civil society organisations, and their influence on AIDS-related policies and programmes. One particular aspect of organisational behaviour is the way non-heterosexual orientations are treated.

THIRDLY, more research is needed on intervention experiences. While much innovative action has been taken in recent years to involve men in efforts to address HIV and to modify harmful aspects of masculinity, there is still limited documented experience of these efforts. One way forward is better monitoring and evaluation of existing efforts to engage men and boys as partners in HIV and SRHR work; and as active participants in projects that redress gender inequity and attempt to shape new 'softer' masculinities.

7. Conclusions and recommendations

The advent of AIDS has brought 'sexuality' into the public domain. It has opened up discourses barely touched a few decades back, when the concept of 'sexual health and rights' was adopted by Sida as a corollary to 'reproductive health and rights'. The vital role of sexual relations in the transmission of HIV has brought into the open debates on men, women, sexuality and gender relations. These debates link to the wider field of human rights, women's rights, and the rights of sexual minorities. AIDS thus give us an entry point to put gender relations, as well as male involvement and responsibility in sexual and reproductive health firmly on the political and developmental agenda.

Men matter. A foregone conclusion, many would say. Still, much remains to be done in terms of understanding and responding to male risk behaviours, for real progress to be made in rolling back the AIDS epidemic. Even as we write, legal constraints, prejudices, or simply ignorance in public institutions and wider society constrain efforts to bring about real social change.

Many important initiatives, pilot interventions and educational efforts have been carried out, which show that change is possible. But change equals taking a risk; whether you are a member of a youth group or an executive director, you have a face to save, an honour to defend, what would be the cost of deviating from expectations?

A quote from the dynamic scene of changing gender relations in South Africa gives a good illustration of the current situation:

"If there is any reason to think that the shape of gender politics and especially the men's movement will change, it is because AIDS is now killing predominantly heterosexual African men and women. This is providing a tragic bridge between a range of gender organisations and those hitherto undisturbed by gender politics."

(Morrell 2005:281)

Strategically, two widely different target groups need to be addressed to support positive changes in gender relations. One consists of the young, men and women forming their gender identities, while living in fear of becoming HIV positive. Many need guidance not only in their private lives, but also in how to 'mainstream' AIDS within their social and professional roles. The other consists of the structures and organisations whose work embodies practices of gender relations, but not yet adapted to the

world of AIDS. Government departments and public service providers, culture and media producers, marketing agents, religious organisations, NGOs – all should be aware of the need for gender sensitive responses and how to revise policies and priorities accordingly.

Men's violence is but one aspect of the complex relations between men's conduct of their lives and HIV & AIDS. Numerous initiatives have been taken to empower women and strengthen their abilities to withstand health threats such as HIV. There is a need for similar work in relation to men. A special 'UN World Conference on Men' – at par with the UN conferences on women – was seriously considered in the 1990s. Efforts on this level would open the international arena for more determined work on men, gender equality and AIDS.

Similar meetings should be arranged at regional and national levels, targeting relevant issues on men and gender. The purpose would be to give publicity and status to the issues of male involvement as partners and as key actors, and commitment to change from both women and men.

Specific recommendations to be considered on the basis of this report are therefore:

- To put more efforts into developing appropriate gender training, challenging dominant masculinities in favour of 'new equitable masculinities' that can be mainstreamed into policies and programmes.
- To highlight the key role of men in HIV prevention and AIDS care, both as responsible partners and as vulnerable groups and individuals.
- To specifically address in projects, programmes and research, how the rapidly expanding access to antiretroviral drugs can be used for increased male involvement in HIV prevention and AIDS care, not least vis-à-vis female partners.
- To emphasize the intersects between work against sexual and gender-based violence, prevention of HIV and involving men as partners and community stakeholders
- Through all channels increase the attention to the vulnerabilities to HIV infection of groups such as men who have sex with men, injecting drug users, men in prison and migrant workers – groups who currently are often neglected due to social or cultural marginalisation.
- Consider planning for regional and country level meetings to highlight, discuss and advocate for the male issues most relevant in the respective context.
- Strongly lobby for high level action globally on the crucial role of men as decision makers on issues related to gender equity and male awareness, support and involvement

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