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I CARE.....DO YOU? : WORLD AIDS CAMPAIGN INVOLVING MEN FOR GREATER PARTICIPATION IN CARE AND SUPPORT, CONTROL, AND PREVENTION OF HIV/AIDS

The HIV has thrown enormous challenges that vary from place to place depending on how fast the virus is spreading and whether those infected with HIV have started to fall ill or die in large numbers. In all parts of the world except sub-Saharan Africa, there are more men infected with HIV and dying of AIDS than women. Altogether, an estimated 2.5 million men aged 15-49 yr got infected during 2000, bringing the number of adult males living with HIV/AIDS at year's end to 18.2 million. Men's behaviour is often influenced by harmful cultural beliefs about masculinity that makes them the prime targets of the epidemic. Male behaviour also contributes to HIV infections in women, who often have less power to determine where, when and how sex takes place**.** Men make a difference – the theme of the year 2000 World AIDS campaign recognized the great potential of men to make a difference when it comes to curbing the transmission of HIV through caring for infected family members and looking after orphans and other survivors of the epidemic. The spread of HIV infection in married monogamous women with no reported risk behaviour of their own is reported to take place through the husbands[1]. I care…...do you? – the theme for the year 2001 World AIDS Day campaign covers both genders and addresses different age groups and aims to involve men specially by focusing on the needs of the young men who are more at risk than the older ones; with about one in four people with HIV being a young man under 25 years[2].

There are sound reasons why men should be fully involved in the fight against AIDS. According to UNAIDS campaign document (2001) over 70% HIV infections world-wide occur through sex between men and women, and another 10% through sex between men. Another 5% infection occur in injecting drug users, four-fifths of whom are men. Epidemiologists cannot predict with certainty how fast a given epidemic will expand and when it will peak, although short-term predictions can be made on the basis of HIV trends and information on risk behaviour.

All over the world, men tend to have more sex partners than women, including more extra-marital partners, thereby increasing their own and their primary partner's risk of contracting HIV. The stigma, and related secrecy and shame surrounding HIV infection compound the effects of all these risk behaviours. The social issues surrounding HIV stigma may further prevent many women and men from acknowledging that they are infected. Majority of the transmissions occur through heterosexual and homosexual routes in all countries. It is the individual's responsibility to prevent further spread of infection if already infected and if uninfected remains to be so and prevent acquiring an infection. Information on HIV/AIDS improves knowledge and brings a change in attitude. This

This issue commemorates the World AIDS Day (December 1, 2001)

INTERPLAY OF FACTORS DRIVING SEXUAL TRANSMISSION OF HIV

The key factors that play a role in kick-starting sexually transmitted HIV epidemic and driving it to higher levels are:

A. Behavioural and social factors:

- Little or no condom use
- Large proportion of the adult population having multiple partners
- Overlapping (as opposed to serial) sexual partnership – individuals are highly infectious when they first acquire HIV infection and thus more likely to infect any concurrent partners
- Large sexual networks (often seen in individuals who move back and forth between home and a far-off workplace)
- Age-mixing, typically between older men and young women and girls
- Women's economic dependence on marriage or prostitution, robbing them control over the circumstances or safety of sex

B. Biological factors

- High rates of sexually transmitted infections, especially those causing genital ulcers
- Low rates of male circumcision in majority of communities
- High viral load – HIV levels in the bloodstream are typically highest when a person is first infected and again in the late stages of the illness.

While all factors help spread the virus, it is not exactly known how much each of them contributes and to what extent they need to be combined in order to fan the flames of the epidemic. Fortunately, there is strong evidence to suggest that countries will ultimately reduce their new infections if they carry out effective prevention programmes encouraging abstinence, fidelity and safer sex. A crucial factor is promoting condom use for both males and females, and making good quality condoms cheaply and conveniently available.Condoms are protective irrespective of the age or mobility of the partners, the scope of their sexual networks, or the presence of another sexually transmitted infection.

Adapted from: AIDS Epidemic Update: UNAIDS-WHO, December 2000

subsequently leads to behaviour change. This is a process that takes time and requires sustainable interventions that aim at empowerment through responsible decision making regarding sex and motherhood: the basic instincts of human beings, thereby making the task more challenging.

The World AIDS Day-2001 theme has wider applicability globally, nationally, and further at the community, family and the individual level. This involves a dyad relationship across the countries, between governmental and non-governmental organizations (NGOs), between employers and employee, high risk and no risk partners (homosexual or heterosexual), between faithful and multiple partners, friends who share needles for intravenous substance use, *etc.* The dyad relations of care are seen through the bond of mother in mother-to-child transmission, between parents and their young children, *etc*. These dyad relationships of care and trust should be emphasized and encouraged through interventions at varied levels globally which should be carried out through the national programmes and imparted

to the affected and infected individuals and their families with well coordinated efforts of NGOs and the community based organizations. The important role that men can play needs to be specially highlighted.

SOME PRIORITIES INCLUDED AT UN GENERAL ASSEMBLY

- Ensure that people everywhere, particularly the young know what to do to avoid the infection.
- Stop the most tragic of all forms of HIV transmission: the mother to child transmission.
- Provide treatment to all those infected.
- Redouble the search for a vaccine, as well as a cure.
- Care of all whose lives have been devastated by AIDS, particularly more than 13 million orphans.

These priorities point to the urgent need of a vaccine and a cure through intensive research efforts. While that goes on, it is important to continue massive prevention efforts especially for the young and also prevent mother-to-child transmission. It is also pertinent to focus attention on those who are infected for treatment, care and support, with an emphasis to orphans.

SOURCE: UNITED NATIONS DECLARATION OF COMMITMENT ON HIV/AIDS : UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON HIV/AIDS, JUNE 25-27, 2001.

I Care.....Do You? The National Level

India's epidemic marked by heterogeneity, is not a single epidemic, but made up of a number of distinct epidemics, often co-existing in the same state. The most recent estimate of HIV infection for the country is of 3.86 millions at the end of 2000. Aggregate figures for India, however, conceal widely contrasted levels of prevalence across states. In Maharashtra, the most affected state of India, HIV has reached 60% in Mumbai's sex workers, 14-60% in sentinel STD clinics and over 2% among women attending antenatal clinics[4,5].

In other parts of the country the overall levels of HIV are still low. While it is pertinent to understand that the high levels of other sexually transmitted diseases (STDs), the evidence of migrations and sexual networks and the existence of severe gender bias all point to the existence of vulnerability. The predominant mode of transmission of infection in AIDS patients is through heterosexual contact (80-86%), followed by blood transfusion and blood product infusion (5.5%), injecting drug use (5.3%), perinatal transmission (0.72%) and others (7.6%). The males account for 77% of AIDS patients and females 23%, a ratio of 3:1. Population migration is a key factor in the spread of HIV in India with over 180 million migrant workers, many of whom are single men or who live apart from their wives and families. Migrant men comprise 30-40% of the population in large cities where they also account for much of the clientele of the 'red light' areas[5].

HIV infection in India, primarily driven by heterosexual transmission is moving steadily beyond its initial focus among commercial sex workers and their clients into the wider population. At the same time, important sub-epidemics are evolving with potentially explosive spread among groups of injecting drug users (IDUs), and among men having sex with men (MSMs). These have a critical role in relation to the wider heterosexual epidemic and require careful monitoring.

India's epidemic appears to be following the so-called type 4 pattern, first described in Thailand. The epidemic shifts from the highest risk groups (sex workers, drug users) to bridge populations (clients of sex workers, STD patients, partners of drug users) and then to the general population. The shift usually occurs where the prevalence in the first group reaches 5%. There is a time lag of 2-3 years between the shift from one group to the next. The following indicate the rapidly evolving epidemic[4].

- The HIV epidemic also continues to shift towards women and towards young people with 25% of all HIV infections in India now estimated to be women with an accompanying increase in vertical transmission and paediatric HIV; women's greatest risk is their own partners[6,7.]
- Migration both within and between states is a major factor, though a poorly studied and understood source of transmission of HIV between urban and rural populations. Majority of the migrants are reported to be men.
- Gender bias and especially unequal power in decision making between men and women and

the latter's lack of ability to negotiate safer sex, as well as difficulties faced in communicating openly on sexual matters between generations represent and remain major obstacles to prevention.

- Indications are that a sharp increase in injecting drug use is underway with drug users switching from inhaling to over-the-counter injecting drug use.

- Indications of HIV among the MSM groups are based on informal estimates that suggest rapid increases may be taking place in this particular vulnerable community, however, little reliable data are available.

The new national programme has renewed efforts to combat HIV not as a health issue alone but as a threat to India's development. Such programmes acknowledge the importance of social and structural factors in creating vulnerability to infection. As a response to address these vulnerabilities, efforts through a multi-pronged approach are required. The focus of these programmes should be to minimize the factors that contribute to inequality of gender and age relations as they reduce power to negotiate safer behaviours related to basic instincts of sex and procreation.

These programmes include a major task of mobilizing and co-ordinating a considerable range of partners, facing many new legal and ethical issues that HIV raises, calling for involvement of new actors and strategies including those that can lead to the involvement of the affected group themselves.

Five major challenges identified as crucial under the National AIDS Control Programme Phase II (1999-2004) are[4]:

(i) *The need to build capacities within the state rapidly :* This included the NGOs and community based organizations (CBOs) to carry intervention projects.

(ii) *Ensuring impact of targeted interventions :* A package of information, services and support and care must reach the high risk groups enabling them to adopt safer behaviours, ensuring that the groups with risk are not marginalized (this would avoid vulnerability). The creation of such an enabling environment for these groups should also include empowerment processes like negotiating power to bring a behaviour change. While it is significant to focus on people engaging in highest risk behaviour, there is increasing need to work with 'bridge' populations like male clients of sex-workers, STD patients, *etc*. to ensure the impact of targeted interventions.

(iii) *Achieving behaviour change beyond high risk :* Addressing behaviour change in general reproductive age-group and include young people, women, disadvantaged slum populations, migrant workers who need to be empowered to protect themselves.

(iv) *The need to confront discrimination and stigma :* It is critical that interventions are launched that counter misconceptions and 'normalize' the presence of HIV positive individuals in the community. These specially affect the women and children.

(v) *Addressing the urgency of care and support:* With the large numbers already infected, providing large scale non-institutional care becomes one of the greatest challenges of the unfolding epidemic.

I Care.....Do You? The Societal Level

" Every one of us has a talent, and we should all use our talents to help overcome the threat of HIV/ AIDS that affect us all". ***Ricky Martin, singer***

"Stop, listen and learn all you can about HIV/ AIDS. Prevention and life – It's your choice"[1]. ***Joey DiPaolo, AIDS educator living with HIV.***

Special circumstances of men

A number of circumstances put men at high risk of contracting HIV. Social conditions often put men as main earners and create situations where men have to migrate for work and often have to leave their families behind. In such situations they have to work hard to make enough money to carry back home and may have to depend on use of substances like drugs and alcohol and may pay for sex as a way to cope with the stress and loneliness of living away from home. The culture of an all male environment such as military may reinforce its strong influence of risk taking behaviours including unsafe sex. Further, in still other circumstances and some all-male situations, men who normally prefer women as sex partners may have sex with other men.

Men are often less likely to seek health care than women. In most countries men have lower life expectancy at birth and higher death rates during adulthood than women. Boys brought up to believe that real men don't

get sick often see themselves as invulnerable to illness or risk. This is reflected by the under-utilization of health services by men. Greater attention must be given to the men's health needs that include their well being, sexual and reproductive health, including those living with HIV/AIDS. Globally, the family planning programmes have generally ignored the crucial role of men, and have been designed to maintain gender norms dictating that reproduction and fertility control are women's responsibility.

It is now well recognized that social inequalities and power relations have an important impact on HIV transmission. It is also recognized that men need to take responsibility for their own sexual behaviour as well as respect and support the rights and health of their partners[8-11]. However, systematic examination of men's multiple role in the epidemic, the many factors that influence them as well as the obstacles that prevent more men from becoming involved have been few. While many men have responded to HIV with a sense of urgency, responsibility, compassion, they appear to be the exceptions rather than the norm in their communities or professions[12].

Another factor is male violence in the form of wars and the resultant migrations and forced sex that they cause, which further drives the spread of HIV. Also, each year millions of men are violent towards women, girls, and other men sometimes in their own family or household. According to a report of UNICEF (2000), world-wide at least one in three women has been beaten, coerced into sex or otherwise abused in her lifetime, and in few countries up to a half of all women and girls have experienced physical violence at the hands of an intimate partner or family member. This report seeks to overturn the prevalent assumption that domestic violence is insoluble because it takes place within the private sphere of the family. Violence against women is a significant public health problem that affects women, men and children. This specially impacts on women as protecting from STDs, HIV and unwanted pregnancy is difficult in such circumstances[13-16].

Men are key to reducing HIV/AIDS

The social position and the advantages that men enjoy over women are varied but these are now putting them in a riskier situation in the context of their sexual health, which also impacts on their family. While the impact of cultural beliefs and expectations on men is well known, it is less recognized that these same beliefs heighten men's own vulnerability to HIV/AIDS. Men have to take a proactive role to avoid their own risk and the risks of their partners.

I CARE……..DO YOU: CAMPAIGN TARGETS BELIEFS ABOUT MASCULINITY

"Part of the effort to curb AIDS epidemic must include challenging negative beliefs and behaviours, including the way men view risk and how boys are socialized to become men." "Men are expected to be strong, robust and virile, but these very expectations may translate into behaviours that can endanger both men and their partners…. Men are the key to reducing HIV transmission and have the power to change the course of the AIDS epidemic" ***Dr. Peter Piot, Executive Director, UNAIDS, at VI International Congress on AIDS in Asia and the Pacific at Melbourne: October 5-10, 2001.***

This years slogan I care……do you spotlights the many ways men can bring their influence to bear on the epidemic and includes :

- Making sure HIV is not brought into the family
- Caring for those infected within the family
- Talking to partners about sex and HIV prevention
- Educating children about their sexual health
- Greater leadership on part of men, both in political and family arenas.

Source: World AIDS Campaign: Men Key to Reducing HIV/AIDS. UNAIDS Press Release October 2001.

Men, culture and HIV/AIDS

Men are influenced by cultural norms regarding manhood, some of which are very negative in the context of HIV. However, men have a stronger position in their relationship with women and thereby can be good advocates for behavioural change and social responsibility. As community leaders men have a critical role to play in HIV/AIDS prevention and care through promoting positive

images of masculinity, inspire social responsibility among boys and men, as fathers caring for their families, and men with a sense of responsibility and reliability towards themselves and their partners. Certain traditional practices and values exists but needs to be relooked and put in the perspective of risk to HIV infection. This happens where women are at low risk of infection from their own behaviour as a result of their traditional role, but their greatest risk is from their own husbands. The responsibility of negotiating safer sex as joint responsibility becomes pertinent[7,17-20].

I Care.....Do You? Research Needs

Research studies to understand issues of men sexuality are few and there is a need for such studies to pave the way for planning interventions. A few ongoing studies indicate unprotected sex just before marriage by young men who continue multiple partners even after marriage. The study highlights the need for specific interventions for young men in rural areas to prevent future risks in the youth.

There is also a need of development of infrastructure for prevention programmes that are directed at men and through them the women. This includes counselling and testing, condom availability and AIDS information. Most HIV positive individuals do not know about their HIV status; creating a support network where people volunteer for a test and are provided counselling and psychological support is a crucial responsibility[22].

Policy makers on the other hand have to create an ambience to open a debate where men and women work together. This would have to be done by overcoming cultural barriers to public discussions of sexuality that challenge double standards in men and certain norms which put a section of the population at risk to HIV *eg*. domestic violence, sexual abuse in women, polygamy, negotiating safe sex, abuse of human rights, *etc*. The very rigid gender norms based on unequal power-relations make it difficult for women to think about the risks for HIV transmission, condom use, or responsibility about sex[2, 6, 8, 23].

Concerns about Impact of HIV/AIDS

The stigma and discrimination associated with HIV/AIDS puts a greater burden on those infected and affected

Sex Among Rural Young Men: How Soon? How Risky?[21]

Empirical evidence on some critical sexual parameters of Indian rural male youths (842 men aged 18-24 yrs: 403 unmarried and 439 currently married) drawn from 50 villages in five states :Haryana, Karnataka, Orissa, Rajasthan, and Uttar Pradesh shows the following:

- While penetrative sexual activity does not begin very early, it tends to peak around the time the young men are about to get married *ie.* around 16-18 years of age.
- A significant proportion begin sexual career with other men/boys.
- Heightened sexual activity during the period between marriage and consummation, particularly in cultures with the tradition of *gauna* when marriage is consummated.
- Current marital status of young men matters a great deal in what they report about their sexual behaviour.
- The need for using shorter reference period and current experience for exploring sexual behaviour. The need for treating married and unmarried youths as two separate groups for intervention purposes.
- About 56 to 60% of those with ever-extramarital sexual relations also had premarital sexual relationship; significantly those who had had extra marital sex are also the ones who start early sexual activity.

About half of those (48.6%) who had sexual relations with any woman other than the ones whom they subsequently married, continued high-risk sexual behaviour into the married life.

by it. The lack of policies to guide these patterns of behaviour is now being realised. At present there are no specific laws for individuals infected and affected by HIV/AIDS, but the rights of individuals related to basic needs: to marry, to procreate are affected, adding to their vulnerabilities. Thus adopting policies to protect and promote the full spectrum of the human rights are required. Similarly, a concerted effort to accelerate progress and more effectively address the causes of poverty, inequality in accessing and distribution of resources, social injustice in the context of HIV AIDS is required[24]. The rights of men and women in vulnerable/ marginalized groups *eg* prisoners, MSMs, sex workers, *etc* must be protected. Special measures should be taken by the Government to prevent and minimise the impact of HIV/AIDS caused by inability to negotiate sex, sexual exploitation, sexual abuse, use of injective drugs, sexual violence, *etc*.

Educational efforts should consider the effects of cultural gender norms as they relate to risk taking *eg.* female condoms and other methods still under trial like microbicides can give freedom to women to some extent in negotiating safe sex, since women will have some control in wearing condoms or applying a microbicide. While for men, that the male condoms are also highly effective when used correctly and consistently would require ongoing counselling. As adults they have additional responsibilities that safe sex practices are adopted by their partners–both female and male, regular and casual partners. For the married partners men can make a difference by being responsible for the health and reproductive needs of their partners and the family. As parents it is important that they take care of their children. For accepting this responsibility men and women would require attitudinal changes that may have to be addressed through intervention programmes[17,24].

I Care.....Do You? Men as Care-giver

"Like you, I thought HIV would never touch me… until I tested positive". ***Clint Walters, Founder, Health Initiatives for Youth***.

"We must involve young people with HIV/AIDS in the struggle against the epidemic. They, after all, know best what it means to live with HIV". ***Kofi Annan, Secretary General of the United Nations.***

Men as care givers

World-wide studies have shown that men generally participate less than women in caring for their children. In terms of the AIDS epidemic, which has left 13 million children orphaned, there is an urgency for both men and women to provide love and practical needs such as food, housing, clothing and education for children who have lost their parents. A man's worth is enhanced, not compromised, by actively caring for his partner's and children's well being. Men can care for their partners and families by not bringing HIV into the household through maintaining faithful relations and initiate a dialogue with their partners about sexuality, contraception and HIV.

Research suggests that when fathers and other male family members are positive role models, boys develop a more sensitive vision of manhood and are more respectful in their relationships with women. Men need to protect their children from the risk of contracting HIV and contribute to their children's education including sex-education. Yet, men can participate in raising their children, discussing relationships, offering advice on how to respond to sexual advances, and acting as possible role models.

Raising awareness of father-to-mother-to-child transmission of HIV can help in protecting men, their partners and their future children as mother-to-child transmission is by far the most common cause of HIV infection among young children. Many women who test positive for HIV face the twin prospects of coping with their diagnosis and finding a way to informing their husbands and face the wrath of being accused of bringing HIV to the household. In extreme cases women with HIV may be evicted from their homes by the husband or by husband's family after his death.

In such situations men should be encouraged to plan for the future of his family and should be involved in promoting planned fatherhood as a masculine ideal. Similarly men can be encouraged to talk about their concerns regarding care for their families and help them develop the skills to talk and listen to their partners and children. Also, encouraging HIV-positive men, or those affected by HIV, in planning for the future care of their children paves the way for meaningful lives[24].

I Care.....Do You? Boys, Young Men and HIV/ AIDS

"Every one of us has a talent, and we should use our talents to help overcome the threat of HIV/AIDS that affect us all" ***Ricky Martin, singer***

"Listening to and playing with children, seeing them

suffer, I have learned to be strong, abandoning pity and fear" ***Silvia, volunteer working with HIV positive children.***

In most societies that are traditionally influenced by the patriarchal system, the upbringing of a male child becomes important where family values are inculcated, while the female child has to follow the traditional role governed by the men. This, thereby leads to formation of stereotype images of boys and girls which in the context of HIV/AIDS can lead to certain behaviours of men like pre-marital and extra-marital sex that can put them to risks and through them to their partners. Sexuality and sexual health education is important for young boys and girls and youth and this should start at a young age starting at home and school to enable in becoming responsible decision-makers regarding their own health as well as concerned about their future well being[15,25]. Increased condom usage has been reported in the USA from 1988 to 1995 while the proportion of the 15 year old boys who were sexually active fell from 33 to 25% during the same years[26]. On the other hand in Asian countries most men initiate sex around the age of 20 years, although studies in India have reported an earlier age of about 16 years[21,27,28].

I Care ..... Do you? Men Who have Sex with Men and HIV/AIDS

"Do your part and educate people in your own community starting with friends and family; and message will spread all over the World". ***Jessica Fei, peer educator and Asian and Pacific Islander Coalition on HIV/AIDS.***

At least 5-10% of HIV infections world-wide are due to sexual transmission between men and this varies from country to country. According to UNAIDS the figure could be closer to 70% in Australia, New Zealand, North America and Western Europe. Sex between men is the main route of HIV transmission in some parts of the world, while in other regions other routes are more common. Nearly everywhere, however, sex between men cannot be ignored

BOYS, YOUNG MEN AND HIV/AIDS: KEY MESSAGES

- Young men put themselves and their partners at risk of HIV infection by:
  - (i) Having unprotected sex with a man or woman.
  - (ii) Sharing needles and syringe or drug solutions for drug injecting.
- Being able to talk about their problems, including concerns about sexuality is an important first step for boys and young men in learning how to protect themselves from HIV infection.
- Boys and young men do have control over their health.
- Many young men are particularly vulnerable to HIV infection because, when they socialize, they often drink to the point of intoxication and experiment with sex.
- Drinking alcohol often leads to unsafe sex because it becomes more difficult to say no to sex, to use condoms and to practice safer sex.

IDEAS FOR ACTION

- Provide boys and young men with information and life skills that will enable them to ensure their reproductive health, based on wise, responsible choices that include abstinence and delayed sexual activity, as well as safer sex.
- Bring boys and young men together to talk about their concerns regarding care for their families, and help them develop the skills for talking with, and listening to, their partners and children.
- Target boys and young men with messages about alcohol and drug use, on telephone cards and matchbooks, as well as through the use of other creative outreach strategies such as theatre, art, sports, and in places where men gather.
- Within the community, foster the attitude that drunkenness is no excuse for unsociable behaviour or unsafe sex.

Source: I Care…. Do You? World AIDS Campaign 2001: Boys, Young Men and HIV/AIDS. UNAIDS, Geneva 2001

Harm Reduction Among MSMs in India[33]

Issues

In India there are a significant number of men who have sex with men with varied reasons for their behaviour. Among these men are the self-identified kotis who have feminized behaviour and often the receptive partners. Receptive anal sex has highest risk of STD/HIV infection, making kotis and hijras (eunuchs) the most vulnerable. In addition some MSMs inject drugs that range between 8-11% in the respondents covered in Hyderabad and Bangalore, while 7-12% also used drugs. Poverty, female gender identification, low self-esteem, stigmatization, violence and harassment configure these risks.

Description

A model of MSM service delivery where MSMs are providers was developed. It explores issues of community building, empowerment in safe non-sexual spaces and found that:

- Community networks promote safer sex behaviours
- Empowerment through peer-support for risk reduction
- Promoting regular condom usage
- Promoting alternate forms of sexual practices that reduce risk

Lessons learnt

Harm reduction does not mean abstinence but risk reduction and the following issues need to be addressed though intervention:

- Promoting knowledge of the level of risk for STD/HIV transmission in MSMs
- Regular practice of safer sex
- Regular practice of safe needle use (through needle exchange)

Conclusion

Providing technical assistance to support low income networks of *kotis* to develop own service agency and working on IDUs within the context of MSMs through integration into general education programmes has been demonstrated.

and is a significant and interconnected part of the epidemic. Studies carried out by NGOs have demonstrated that acknowledging the existence of such networks is the first step that has been positively used for prevention programme[27,29-33].

Many men who have sex with other men may not regard themselves as homosexual or bisexual, as many may be married; the unmarried may have sex with women as well as men. The sex between men is often covert in societies wherein marriage is strongly promoted by society and the family. In India homosexual activity is considered illegal and thereby government support to NGOs working in the area is essential if prevention of HIV is to be carried out. The emphasis should be acceptance of people who engage in this behaviour and then address the preventive issues of risk related behaviour [16,29-32]. Although most MSM activity is conducted only by choice, under certain circumstances where men have to spend long periods in all males company like in army, prisons, hostels, such male to male sex is reported to occur and may contribute to the countries' epidemic, both through drug injecting and male to male sex.

Effective responses : MSMS and HIV/AIDS

(i) Breaking down social and cultural barriers to the discussion of male-to-male sex.

(ii) Educating health staff, including those in STD clinics, to overcome ignorance and prejudices about MSMs.

(iii) Ensuring the commitment of national AIDS programmes and donor agencies to include the issue of MSM in their programmes and funding priorities.

(iv) Scaling up peer education among MSM.

(v) Promoting high-quality condoms and water-based lubricants, and ensuring their continuing availability.

(vi) Reviewing and formulating laws that protect the rights of MSM[32].

I Care.....Do You? Injecting Drug Users and HIV/AIDS

The sharing of contaminated drug injecting equipment and drug preparations is a highly efficient means of spreading HIV. Small amounts of blood enter the needle and syringe when drugs are injected. This small amount of blood is enough for the virus to pass from one drug user to another, thereby any type of equipment sharing

poses a high risk of HIV transmission.

Countries should not become complacent since levels of drug use can quickly and dramatically change. In South-east Asia region there has been a trend of injecting amphetamine-type stimulants, and heroin injecting is replacing opium smoking in many parts of Asia. IDUs are at risk of HIV infection through sexual transmission particularly when they have unsafe sex while intoxicated; in such cases safer sex is less likely to occur. Whereas IDUs are often able to change their drug-using behaviour to reduce HIV risks, they may be less able to modify their sexual behaviour. Young, occasional and new drug users are difficult to be reached to convince them that they are at risk[35,36].

Injecting drug use in most countries is an illegal and covert activity, which adds to the marginalization of IDUs and increases their risk of imprisonment. This marginalization limits their access to treatment and prevention services. HIV prevention services are best delivered to IDUs in their community through outreach programmes whereby trusting relationships are established between IDUs and outreach workers. In India most HIV seropositives IDUs have been detected in state of Manipur in north-eastern India. Harm reduction programmes must have at least the facility for needle/syringe exchange and needle sterilizing equipment. These need to be sustained through outreach programmes[16, 35.36].

Key Messages

HIV epidemic among IDUs can be prevented, stopped and even reversed through implementing programmes that:

- Provide IDUs with information on ways to prevent or minimize the risk of HIV infection;
- Deliver outreach services to IDUs in their own community;
- Ensure ready access to sterile injecting equipments through needle and syringe programmes and pharmacy sales; provide drug dependence treatment, such as methadone for heroin users;
- Promote condom use among IDUs and make condoms readily available;
- Involve IDUs in the planning and implementation of all HIV prevention activities;
- Promote the adoption of policies and legislation to create a supportive environment for implementing HIV prevention programmes and decrease the marginalization of, and discrimination against, IDUs.

Source: I Care……Do You? World AIDS Campaign 2001: IUDs and HIV/AIDS. UNAIDS, Geneva 2001

I Care……Do You? Condoms and HIV Prevention

Since the beginning of the AIDS epidemic, condom distribution has greatly increased. In most urban areas, and in many rural communities, men and women can obtain good quality condoms free or at low and subsidized costs. Recent analysis of condom use for HIV prevention in developing countries shows that there is a growing but unmet demand for male and female condoms. It is pertinent to point out that just because a condom is given free or its price is low it does not mean that it is of lower quality than a condom that is bought from a shop/pharmacy. Similarly the high price is not an assurance of good quality. The important thing to look for in a condom is its quality that specifies the date of manufacture and the correct condom usage.

Quality-assured male latex condoms, when properly used, are a proven effective means of preventing the sexual transmission of HIV, some other STDs and pregnancy. Male condoms are inexpensive, highly reliable, life-saving devices with no side-effects. However, for many people, access to male condoms is difficult and although condoms are relatively inexpensive, the cost is still prohibitive for low-income groups.

As a result of increasing awareness about STDs and AIDS , many people are changing their sexual behaviour through postponing sexual relations after marriage, remaining faithful to partner and still others have started using condoms regularly and consistently for protection. However, a large number of people have yet to adopt safer sexual behaviour through correct condom use. The spread of HIV/AIDS would be slowed if more people used condoms[37].

While the latex based male condoms cannot be used with oil-based lubricants at it weakens them and causing break. The female condoms are made of polyurethane and can be used with both oil and water based lubricants. They are available only in seventy countries and to only a few. Studies have shown that the female condom is accepted by men and women and by its very design is a women controlled method offering protection against STD,

HIV and pregnancy[37].

Condom use is an important barrier method, and at present the only option accessible for most people. Decision making for using condoms can take varied forms and need to be put in the context when condom use is discussed with the clients, *eg*. for making casual sex safe for avoiding pregnancy/ HIV and STDs, as a spacing method among the married couple, also for negotiating safe sex by a woman in prostitution, or condom use by a migrant worker, and efficacy of condoms when used under the influence of drugs. Thus condom use requires thought process with a responsible behaviour that is taken with social and cultural sensitivities by men and women. These need to be addressed for meaningful interventions planned for a desired impact[16, 26, 37-42].

Issues in Condom Use

- Reluctance to use condoms because some believe it reduces pleasure.
- Social disapproval, including cultural beliefs and norms that stigmatize condoms.
- Lack of control over condom use due to unequal power relations between men and women.
- Fear of condoms introduced into a stable relationship may bring the issues of fidelity and trust between partners as experienced in couples where one partner is adopting a permanent method: vasectomy or tubectomy .
- Inadequate, inaccessible, or inappropriate health counselling facility.
- Lack of awareness especially in young about the effectiveness of condoms.
- Poor quality condoms, or improperly stored condoms may give false security as they can break
- Sufficiently strong condoms for anal sex are not easily accessible.

Conclusions

All over the world except the sub-Saharan Africa, there are more men infected with HIV and dying of AIDS than women. An estimated 2.5 million men aged 15-49 yr became infected during 2000 bringing the total number of male living with HIV to 18.2 million. There is a loss of the economic and reproductively active male population that adversely affects the economy and health of the family, community and the country as a whole thereby necessitating creating a response at these varied levels.

IDEAS FOR ACTION: CONDOM USE IN THE CONTEXT OF HIV/AIDS PREVENTION AND CARE

- Personal questioning: Reaction to someone who wanted advice about condom use.
- Reaction if wife/husband/girlfriend/boyfriend wants to use a condom.
- Encourage couples to talk to each other about HIV and reproductive health.
- Train doctors to talk with, listen to, and advise, their patients about sexual behaviour, sexuality and safer sex.
- Promote condom use as an acceptable and responsible behaviour, and as an essential part of HIV/AIDS knowledge, sexual health and sex education.
- Make condoms more widely available, ensuring privacy and confidentiality at the point of acquisition and, where appropriate, use peer distribution.
- Advocate condom availability in prisons, barracks, lodgings and other places where men are kept confined for long periods.
- Review and, if necessary, revise policies and legislations that in any way restrict safer sex, condom awareness, or condom distribution or use by sexually active people.
- Advocate advertising and radio/TV/press campaigns to encourage condom use.
- Encourage national and international reproductive health, family planning and AIDS programmes, as well as donor agencies, to include condom provision and distribution in their programming and funding priorities.

Source: I Care……Do You? World AIDS Campaign 2001: Condoms and HIV Prevention. UNAIDS, Geneva 2001

A large number of infected people are the male migrants who move away from the family and put themselves in risky situations and subsequently as a bridge population they infect their spouses in the rural areas. Men's behaviour is influenced by cultural beliefs that ignore or sometimes accept certain behaviours of men that can be harmful to them in the context of STD/HIV/AIDS, *eg.* acceptance of superior images that engage in multiple partners, a cultural practice that now can put the men and through them their partners at the risk of STDs/HIV. Stigma, the related secrecy and shame surrounding HIV compound the effects of these risk behaviours that affects both men and women. The related psycho-social and sexual issues surrounding this stigma may further prevent many men and women from acknowledging that they have become infected and thereby deprive themselves from accessing treatment.

Global and national efforts are directed to control the epidemic through preventive efforts that address behaviour change for those at low and high risks and prevention of mother-to-child transmission. These efforts also promote research to develop a vaccine and a cure and also implement programmes through government organisations and NGOs to take care of the people already infected/ affected with the virus, incluidng orphans, women, and the men. It is now well recognized that the potentials of men can be better utilized to make major contribution in HIV/AIDS programmes. Also the two-year campaign for men has identified the vulnerabilities of men in this epidemic that requires to be urgently addressed through their involvement.

In India the predominant mode of transmission of infection in AIDS patients is through heterosexual route accounting for 80-86%, followed by blood and blood products (5.5%) and IDUs (5.3%), with only 0.72% through peri-natal transmission and the rest by other modes. Amongst the infected, 77% are males and only 23% females. Population migration is a key factor with 180 million migrant workers in the country. The migrants constitute about 30-40% of the population of large cities and also account for the clientele of red light areas. The national HIV/AIDS programme for the next five years is planned to address these challenges where the HIV epidemic is focussed as a developmental issue and not limited to being a health problem. This is planned to be carried out at varied levels. These include building capacities within each state and ensuirng that targeted interventions for those with risky behaviour achieve impact through the planned behaviour change interventions. Also, behaviour changes in the general population need to be addressed through empowerment of women; sexual health education for boys and girls to be initiated early enabling responsible decision-making and planning a safer future. On the ethical front, it is important to confront stigma and discrimination among those infected and address the urgency of care and support in health care settings for the already infected.

Social inequalities and power relations have an important impact on HIV transmission and men need to take the responsibility for their own sexual behaviour as well as support the rights and health of their partners. It is important that men protect women from violence, unwanted pregnancy, STD and HIV. Men can use their advantageous social position by ensuring that HIV is not brought to the family by using safer sex practices and relationships based on mutual fidelity. They need to talk to their partners about sex and HIV prevention and ensure their partners remain uninfected.

There is a need for programmes for men that focus on sharing of the responsibilities in the house with women. These include taking care of the infected in the family, promoting values in young boys that respects women and talking openly about sexual health to avoid young from experimenting. Men who have sex with men and men who take drugs must ensure that safer practices are followed through condom use and needle exchange. Inculcating these habits must start at a young age. A man's self-worth is enhanced, not compromised, by actively caring for his partner and children's well being.

The greater leadership that men enjoy in both political and family arenas must be usefully tapped to ensure the meaningful contribution of men within the community and also to their family. As heads of households they should be saying loud and clear: ***"I care …do you?*** **And should we not be starting it early to make the family, community and the country free from the burden of HIV/AIDS. It's time to start!"**

References

1. UNAIDS. AIDS epidemic update: UNAIDS/WHO, December 2000.
2. UNAIDS. World AIDS campaign 2001. *www.unaids.org/wac/2001*.
3. *United Nations Declaration of Commitment on HIV/AIDS* : United Nations General Assembly special session on HIV/AIDS,25th-27th June 2001.
4. NACO-UNAIDS. India responds to AIDS: A strategic response to the HIV epidemic by the Government of India, the UN and

its development partners in India, 2000.

5. *HIV/AIDS in India*. UNAIDS India Country Office, Delhi (Undated).

6. Norr, K., Tlou, S. and Norr J. The threat of AIDS for women in developing countries. In: *Women, Children and HIV*. Ed. F. Cohen and J.D. Durham, Springer Publishing Co., New York, p. 263, 1993.

7. Gangakhedkar, R.R., Bentley, M.E., Divekar, A.D., Gadkari, D., Mehendale, S.M., Shepherd, M.E., Bollinger, R.C. and Quinn, T.C. Spread of HIV infection in married monogamous women in India. *JAMA 278:* 2090, 1997.

8. UNFPA. Reproductive health and reproductive rights: Male involvement and responsibility. In: *The State of World Population 1999*, UNFPA Publication, Ch 3, 1999.

9. Rivers, K. and Aggleton, P. Men and the HIV epidemic. UNDP 1999. *"http://www.undp.org/hiv/publications/gender/mene.htm"*.

10. Rivers, K. and Aggleton, P. Adolescent sexuality, gender and the HIV epidemic. *http://www.undp.org/hiv/publications/gender/adolsce.htm.*

11. Panos Institute. Young men and HIV: Culture, poverty and sexual risk. *http://www.panos.org.uk/aids/young_menHIV.htm*.

12. Carovano, K. HIV and challenges facing men. *http://www.undp.org/hiv/publications/issues/english/issue15e.htm.*

13. *Domestic Violence Against Women and Girls.* Innocenti Digest No.6, UNICEF Florence, Italy, 2000.

14. Men and AIDS – A gendered approach:2000 World AIDS Campaign. UNAIDS, Geneva, 6th March 2000.

15. Coker, A.L. and Richter, D.L. Violence against women in Sierra Leone: Frequency and correlates of intimate partner violence and forced sexual intercourse. *Afr J Reprod Health 2:* 61,1998.

16. Tripathy, S.P. and Mawar, N. A. World AIDS campaign where men make a difference: A challenge for the men in the third millennium. *ICMR Bull 30:* 131,2000.

17. I care.....do you? World AIDS campaign 2001: Men,culture and HIV/AIDS. UNAIDS,Geneva 2001. *http://www.unaids.org*.

18. Das, R. Male involvement as an important strategy in the prevention of STDs especially HIV/AIDS. International Conference on HIV/AIDS. Mumbai 2001 Abstract No P-18.

19 Benara, S.K. , Pandey, A. and Singh, P. AIDS infection: Perceptions about HIV/AIDS infection: Some preliminary findings from base-line survey. International Conference on HIV/AIDS. Mumbai 2001 Abstract No P-29.

20. Korlagunta, S.K. and HemantKumar, K.S. How safe is sex with condoms: A study in South India. International Conference on HIV/AIDS. Mumbai, 2001. Abstract No P-53.

21. Verma, R.K. Sex among rural young men: How soon? How risky? International Conference on HIV/AIDS. Mumbai, 2001. Abstract No S-87.

22. Mawar, N., Bagul, R., Tripathy, S.P., John, J.K. and Paranjape, R.P. Issues surrounding HIV/AIDS counselling at a referral clinic to establish good practices in counselling. VI Intnational Conference on AIDS in Asia and Pacific, Melbourne, 2001. Abstract No 1513 .

23. Nath, N. Gender focused responses to address the challenges of HIV/AIDS. International Conference on HIV/AIDS. Mumbai, 2001. Abstract No S-83.

24. I care…...do you? World AIDS campaign 2001: Men as care givers and fathers in a world with AIDS. UNAIDS,Geneva 2001. *http://www.unaids.org*.

25. I care…...do you? World AIDS campaign 2001: Boys, young men and HIV/AIDS. UNAIDS, Geneva 2001. *http://www.unaids.org*.

26. Murphy, J.J. and Boggess, S. Increased condom use among teenage males, 1988-1995: The role of attitudes. *Fam Plann Perspect 30:* 276, 1998.

27. *Country Scenario 1998-99*. National AIDS Control Organization, Ministry of Health & Family Welfare, Government of India. (Undated).

28. Mawar, N., Tripathy, S.P., John, J.K., Sinha, S.K., Quraishi, S.Y., Bagul, R., and Gadkari, D.A. Youth sexuality study for behaviour change interventions for AIDS/HIV in college youth, Pune, India. XII International AIDS Conference, Geneva, 1998. Abstract No. 13561.

29. Kavi, A.R. Why we need to look into sexuality issues. *AIDS Res Rev 2:* 39, 1999.

30. Kerr Pontes, L.R., Gondim, R., Mota, R.S., Martins, T.A.and Wypij, D. Self-reported sexual behaviour and HIV risk taking among men who have sex with men in Fortaleza, Brazil. *AIDS 13:* 709,1999.

31. Khan, M.M., Menon, S.C. and Kumaramangalam, L. The significance of married MSMs in HIV/AIDS prevention. XIII International AIDS Conference, Durban 2000. Abstract No. WePeD4770.

32. I care..…do you? World AIDS campaign 2001: Men who have sex with men and HIV/AIDS . UNAIDS, Geneva 2001. *http://www.unaids.org*.

33. Jafer, A. Harm reduction among MSMs and IDUs. International Conference on HIV/AIDS. Mumbai, 2001. Abstract No. S-32.

34. I care…...do you? World AIDS campaign 2001: Injecting drug-users and HIV/AIDS. UNAIDS, Geneva 2001. *http://www.unaids.org.*

35. Singh, N.B., Panda, S., Naik, T.N., Agarwal, A., Singh, H.L., Singh, Y.I. and Deb, B.C. HIV-2 strikes injecting drug users (IDUs) in India. *J Infect 31:* 49, 1995.

36. Sarkar, S., Das, N., Panda, S., Naik, T.N., Sarkar, K., Singh, B.C., Ralte, J.M., Aier, S.M. and Tripathy, S.P. Rapid spread of HIV among injecting drug users in north-eastern states of India. *Bull Narc 45:* 91, 1993.

37. I care…...do you? World AIDS campaign 2001: Condoms and HIV prevention. UNAIDS. Geneva 2001. *http://www.unaids.org*.

38. Weiss, E., and Nastasi, B. Reducing gender-related barriers in HIV prevention efforts: Findings from ICRW's women and AIDS research program. XII International AIDS Conference, Geneva, 1998. Abstract No. 203/14262.

39. Caceres, C.F.. Reingold, A. and Watts, D. Sexual cultures and sexual health: Young people and their current discourse, practice and risks regarding sexuality in Lima, Peru XI International AIDS Conference, Vancouver 1996. Abstract No. Th.D.440

40. Spencer, B., Jeannin, A., Dubois Arber, F. Whose turn tonight ? An appropriation of the circumstances of condom use (purchase, proposal, donning) by gender. XII International AIDS Conference, Geneva 1998. Abstract No. 208/33103.

41. Gold, R.S. Addressing heat of the moment thinking that leads to unsafe sex. Focus 13: 1,1998.

42. The male comdom. UNAIDS Technical Update, UNAIDS, Geneva. August 2000.

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