Are HIV/AIDS Prevention Interventions for Heterosexually Active Men in the United States Gender-Specific?

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Although gender-specific theories are often deployed in interventions to reduce women's HIV risks, the same is often not true for interventions among men. Theories of masculinity are not guiding most US research on the risky sexual behavior of heterosexual men or on what can be done to intervene.

We first assess the extent to which evidence-based HIV-prevention interventions among heterosexually active men in the United States draw upon relevant theories of masculinity. Next, we introduce a useful framework within masculinity and gender studies that can be applied to HIV-prevention interventions with heterosexually active men.

Finally, we make suggestions to improve the gender specificity of HIV-prevention interventions for heterosexually active men in the United States. (*Am J Public Health.* 2009;99:981–984. doi:10.2105/AJPH.2008.149625)

ALTHOUGH THE FIRST AIDS cases in the United States were attributed to men who had sex with men, more than 70% of HIV infections worldwide are now estimated to occur as a result of heterosexual sex.[1] Most HIV-positive women were infected through heterosexual sex.[2]

Despite wide regional variation in the percentage of cases attributable to heterosexual transmission, it is clear that the proportion of women with HIV is rising in many parts of the world. In Asia, 30% of adults living with HIV are women, and in Sub-Saharan Africa, 60% of adults living with HIV are women.[2] Globally, increases in the proportion of women infected with HIV have occurred in a relatively short period of time: in 1985, 30% of infected persons were women; this percentage now stands at approximately 50%, and the absolute numbers of infected women, as well as the percentages, are increasing in many parts of the world.[2]

In the United States, where the main subgroup affected by HIV/AIDS is men who have sex with men, heterosexual transmission is the primary means of transmission among women.[3] Among women diagnosed in the United States, heterosexual transmission as the identified source of transmission more than tripled from 1985 to the present, and the Centers for Disease Control and Prevention has reported that 80% of cases of HIV infection among women are diagnosed as being heterosexually transmitted.[3,4] Of this 80%, approximately one third are the result of having sex with a male partner who is an injection drug user.[3,4] Combined, these facts suggest that sexual behavior change among heterosexually active men will be key to controlling the HIV epidemic for both heterosexual men and women.

Analyses of why these trends are occurring have come to the same conclusions: gender and gender inequality in particular have been identified as a major "root cause" of what shapes and exacerbates the course of the epidemic.[5–8] Some argue that these findings underscore how HIV studies need to "adequately address the contextual issues of heterosexual relationship dynamics"[6(p873)] on a domestic and global level. It seems clear that the structure of gender relations needs to be examined and challenged for both women and men.

To what extent has this examination already occurred? Very little, it appears. Indeed, HIV-prevention interventions for heterosexually active adults have largely targeted women, as they are said to need structural, cultural, institutional, and technologically based empowerment and protection. But what do heterosexually active men need? What do gender relations have to do with HIV prevention? Because women and men are equally shaped by gender, how can we use theories of masculinity to understand what puts men at risk for HIV infection and to guide researchers in creating effective prevention interventions?

Ten years ago, Exner et al. underscored that:

> While many HIV risk reduction interventions have been focused among women, heterosexual men have less frequently been the focus of such efforts . . . yet it is imperative that heterosexually-active men be included in strategic efforts to reduce heterosexual transmission because sexual behavior is dyadic and men are the partners of women.[9(p348)]

To examine the state of the field, Exner et al. reviewed HIV-prevention interventions from 1981 to 1998 that focused on reducing risky heterosexual behavior among North American men. Intervention programs were described as "informational" (e.g., providing HIV/AIDS, alcohol, and sexuality information), "condom skills" (e.g., ensuring consistent and correct condom use), "relational skills building" (including negotiating safer sex, assertiveness, and communication), and "individual risk counseling" and "community street outreach" (for injection drug users). Of the 20 interventions they found to meet rigorous methodological standards, seven were for injection drug users. Of the remaining 13 interventions, three targeted men exclusively, whereas the remainder focused on both women and men. At that time, the authors made a call to bolster prevention efforts for heterosexually active men.

How far have we come since then? Lyles et al.[10] carried out a systematic review of the intervention literature from 2000 to 2004 and detailed 18 interventions that met rigorous criteria for best

evidence. Of the six best-evidence interventions that were designed for sexual risk reduction among heterosexually active HIV-negative adults, four were for women, two were for both women and men (of which one focused on those receiving outpatient psychiatric care and the other on couples communication), and none were designed for heterosexually active men only. Although one of the two interventions among both women and men focused on issues of gender norms and gender power, all of the women-only interventions focused on these topics. The women-only interventions also emphasized the need to infuse women with more safer-sex negotiating power vis-à-vis a male partner.

Notably, in both of the previously mentioned reviews—and even in a third review from 2002 that focused on interventions with heterosexually active men[11]—despite the large number of interventions, the word *masculinity* was not mentioned once. The reviews included no overt discussion about the ways in which men have gender or are affected by a system of gender inequality. There was also no mention of how masculinity and gender relations should be a guiding theoretical framework to understand—and intervene about—what puts heterosexually active men at risk for HIV infection.

GENDER AND HIV/AIDS

Public health and HIV/AIDS studies have only recently started to make an otherwise common and important disciplinary shift in the study of gender relations. This shift is one that moves away from the common conflation of gender with women and women's oppression to the recognition of gender relations, or the ways in which both women and men are affected by gender inequality. Such an emphasis is needed because of the way in which women and men are differentially positioned in and affected by gender norms and gender inequality.[12,13] This type of shift is also urgent because masculinity as a set of beliefs and social practices and as an institutionally supported set of structures definitively shapes both men's and women's health outcomes.[14–16]

An emphasis on masculinity and gender relations within the United States would move HIV prevention further in the direction in which key masculinity scholars have progressed for decades and public health scholars have started to shift to more recently.[12-15] One useful framework comes from a leading US masculinities scholar, Mike Messner, and can be easily applied to HIV/AIDS prevention. In his 1997 work,[13] Messner offered a three-part framework to explain the experiences of men as a group relative to women as a group and relative to groups of differently positioned men.

The first part of the framework stipulates that men as a group experience institutional and cultural privileges over and above women as a group. As applied to HIV/AIDS, two examples are that (1) men have greater access to assets, income, education, and property rights, and women's lack of these key resources leaves them more vulnerable to HIV infection and its negative effects, and (2) there is a sexual double standard that allows men to have multiple partners but stigmatizes women for the same behaviors.

The second part of the framework clarifies that men face negative and harmful effects from gender inequality and experience great costs for adhering to narrow definitions of masculinity (referred to as "costs of masculinity") that hurt both men's and women's health. As applied to HIV/AIDS, examples include not getting tested for HIV, not asking for help, taking on multiple partners as a signifier of masculinity, and taking or inflicting life-threatening risks in the name of constituting masculinity.

The third and final part of the framework underscores that not all men equally experience the cultural and institutional privileges of manhood because there are differences and inequalities among men. For example, race- and class-marginalized men do not have easy access to the structural benefits (e.g., access to the occupational system) associated with masculinity and are disproportionately at risk for HIV infection.

A key question therefore remains: In the third decade of the HIV/AIDS epidemic, are any of the domestic evidence-based prevention interventions designed to reduce sexual risks for heterosexually active men informed by theories of masculinity?

HIV-prevention interventions for women have been theoretically informed by gender-related theories and have advanced domestically from gender-neutral to being more gender-sensitive and gender-transformative over time.[7] This important point was made by Geeta Rao Gupta[8] at the International Center for Research on Women in her plenary address at the XIII International AIDS Conference in Durban, South Africa, in 2000. Gupta underscored how prevention interventions could be categorized as:

- Damaging—Programs that reinforce harmful gender stereotypes, such as those that put forward that men are violent, promiscuous, or predatory.
- Do No Harm—Programs that suggest abstinence, faithfulness, or condom use without taking gender inequality into account.
- Gender-Sensitive—Approaches that respond to the different needs of women and men but do not change the contextual or structural aspects of gender relations.
- Transformative—Interventions that challenge gender roles, culture, and gender structures, and create more gender-equitable relations. Such programs also allow critical examination of norms of masculinity and femininity and how these impact both women's and men's health.

Applying these terms to Lyle et al.'s study[10] of the six best-evidence interventions that were designed to provide sexual risk reduction for heterosexually active HIV-negative adults, we find that two were gender-neutral (none were for heterosexually active men),[17,18] two were gender-sensitive,[19,20] and two were a mix of gender-sensitive and gender-transformative.[21–23] One of the latter interventions was for women only and the other was for couples. No changes in gender relations were attempted at the structural or institutional level, and all of the "transformation" was at the level of individual- or couple-level gender roles. None of the interventions deployed relevant theories of masculinity.

WHY DOES GENDER SPECIFICITY MATTER?

Do gender-sensitive and gender-transformative HIV-prevention interventions make a difference? The answer has been yes for women, and the answer is yes for men. In 2000, Wingood et al.[24] innovatively applied Connell's

theory of gender and power[25] to HIV/AIDS prevention. In the years that followed, several rigorous HIV-prevention programs have deployed this theory, which elaborates the relationship between labor, power, and cathexis. Additionally, researchers have modified gender-neutral social–psychological models. All these HIV-prevention programs have had successful risk reduction outcomes.[21–23,26]

There is also international evidence that behavioral interventions carried out among men and boys transformed the attitudes and practices that are related to HIV risk. In South Africa, the Medical Research Council evaluated an HIV-prevention program called Stepping Stones that combined gender equity, HIV prevention, and antiviolence work.[27] This evaluation showed significant changes in men's attitudes and practices. At the two-year follow-up point, men who participated in the intervention reported fewer partners, higher condom use, less transactional sex, less substance abuse, and less perpetration of intimate partner violence.[28]

In Brazil, Instituto Promundo's intervention with young men promoted healthy relationships and HIV and sexually transmitted infection prevention and showed significant shifts in gender norms at six and 12 months. Young men with more equitable norms were between four and eight times less likely to report sexually transmitted infection symptoms, and additional improvements were noted at 12 months after an intervention.[29]

In 2007, the World Health Organization released a report endorsing the efficacy of working with men to achieve gender equality and improve health, describing the key aspects of successful interventions.[30] From this meta-analysis, the authors found that programs that were rated as gender-transformative were more effective than gender-neutral and gender-sensitive interventions.[30]

What results when domestic HIV-prevention researchers include heterosexually active men in prevention programs without providing a theoretical framework that offers gender specificity or a transformation in gender relations? Men are assumed (1) not to have gender,[31] (2) to experience HIV risks that are not related to gender relations, or (3) to be privileged and harmful to women without considering how gender inequality structures both women's and men's HIV risks. Merely providing men with information and skills within prevention programs and predicting that they will enact changed behaviors once they receive these negates that gender relations profoundly shape men's enactment of risky behaviors.[14–16,30–37]

The points made in this section are particularly important among economically disadvantaged men, who may be race or class oppressed and are frequently kept from traditionally defined masculine success (e.g., work). As a result, marginalized men may be more reliant on enacting narrow definitions of hegemonic masculinity as a resource to construct status.[13,35] Put another way, what some scholars call "the signifiers of 'true' masculinity" (e.g., sexual conquest, physical forms of masculinity) are "readily accessible to men who may otherwise have limited resources for constructing masculinity."[14(p1392)] For these men, critical reflections on the role of masculinity in shaping both men's and women's HIV risks is paramount. Of course, such trends are not limited to heterosexually active men.[37]

CONCLUSIONS AND SUGGESTIONS FOR RESEARCHERS

Very little work in domestic HIV-prevention programs that include men has been theoretically gender-specific, although some progress has been made on the gender-transformative front for women on domestic and international levels and much more progress has been made on work with heterosexually active men on an international level.[27–30,36,38–40] The US evidence-based HIV-prevention agenda lags far behind despite a solid body of work that examines the intersection of masculinity and HIV or includes men as partners in reproductive health.[36–44]

At minimum, we urge prevention researchers to consider these recommendations:

- Do not assume that gender-neutral HIV-prevention strategies with men adequately take men's HIV risks into account.
- Develop HIV-prevention interventions that are more gender-sensitive and gender-transformative and that focus on the needs of heterosexually active men. Allow safe spaces where men can reflect upon and critically discuss the costs of adhering to narrow definitions of masculinity.
- Create a domestic think tank with wide international participation to consider the ways in which prevention interventions can simultaneously tend to race and class inequalities, gender equity, and the costs of masculinity for marginalized men who are disproportionately affected by HIV/AIDS.
- Encourage interdisciplinary research teams within the HIV-prevention field that draw on experts in masculinity and gender relations. Ensure that synergies are maximized by working across disciplines such as public health, global health, sociology, epidemiology, political economy, psychology, law, medicine, and anthropology.
- Develop gender and HIV policies for future national plans. The ways in which gender relations impact both women's and men's risks and health should be included.
- Conduct research on the ways in which men make sense of abstinence, faithfulness, and condom use messages and how these messages impact men's preventive behaviors.
- Support innovative work focused on the creation of evidence-based prevention interventions that are theoretically informed by theories of masculinity.
- Identify and implement strategies to take gender focused interventions with men to scale by integrating this work into broader organizations, institutions, and policies.[45]

It is time to shift HIV/AIDS discourse and prevention practice focused on heterosexually active men from gender-neutral to gender-specific and gender-transformative. It is time to ensure that prevention interventions with heterosexually active men in the United States are gendered. Their health—and the health of women—depends on it. ■

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