PROJECT H

Sexuality and Reproductive Health

Fatherhood and Caregiving

From Violence to Peaceful Coexistence

Reasons and Emotions

Preventing and Living with HIV/AIDS

section 5


project
violence

MODULE 1

What and Why

PREVENTING AND LIVING WITH HIV/AIDS

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OVERVIEW

This chapter provides an introduction to the issue of young men and HIV/AIDS. In most of the world, the attitudes and sexual behavior of men of all ages are at the core of the HIV/AIDS epidemic. On average, young men have more sexual partners than young women. And it is most often men, including young men, who determine when and where sex will take place and whether a condom will be used. Ensuring that new generations of young men develop more gender-equitable and safer sex behaviors from an early age is essential in reducing HIV transmission.

Young men also constitute a high risk group in their own right. In most countries they have lower perceptions of their own risk of contracting the disease and are more likely to use injectable drugs than are young women. In addition, young men are more likely than older men to get involved in sex work and are more likely than older men to be in closed institutions, such as the military or in prisons, where unprotected sex, sometimes forced, may be common place. In sum, young men are themselves at risk for HIV/AIDS and, by their behavior, place their partners – male and female – at risk. In spite of these realities, young men have seldom been the subject of specific HIV/AIDS interventions.

Note: Portions of this text were taken with permission from "Men and AIDS: A Gendered Approach", UNAIDS, to which Gary Barker contributed. Other portions were taken from a text writting by Gary Barker for Population Council and UNFPA, "Engaging Boys in Sexual and Reproductive Health: Lessons, Dilemmas and Recommendations for Action" (2001).

Why Focus on Young Men and HIV/AIDS?

Worldwide, the behavior of many men – adult and adolescents – puts themselves and their partners at risk of HIV. HIV infection among women is spreading more rapidly than among men in some regions, but the number of men infected worldwide is higher. Young men are at particular risk: About one in four persons infected with HIV/AIDS in the world is a young man under age 25 (Green, 1997). And because both young and older men on average have more sexual partners than women – and because HIV is more easily transmitted sexually from man to woman and man to man than from woman to man – an HIV-infected man is likely to infect more persons than an HIV-positive woman. As UNAIDS stated, "the HIV epidemic is driven by men... worldwide women may be more affected by the consequences of HIV/AIDS, but it is the sexual and drugtaking behavior of a large minority of men which enables the virus to spread" (Forman, 1999, p.8).

Current UNAIDS data finds that in some regions, HIV prevalence rates among young women are higher than young men, while in other regions, including Latin America, young men have higher rates of HIV prevalence. In 11 population-based studies in Africa, the average HIV prevalence rates for teenage girls were five times higher than for boys. Among young people in their early 20s, the rates were three times higher in women (UNAIDS, 2000). In Asia, HIV prevalence rates among young people 15-24 tend to be similar between men and women. In Thailand, for example, the reported HIV prevalence rate for young women 15-24 is estimated to be 1.89% (high estimate) versus 3.1% for young men in the same age range. In Latin America and the Caribbean, young men have consistently higher HIV prevalence rates than young women, generally two to three times higher. In Haiti, for example, which has the highest reported prevalence in the region, the HIV prevalence for young women 15-24 is 3.26% (high estimate) compared to 5.83% for young men (UNAIDS, 2000). In Brazil, 25% of the estimated 400,000-500,000 men with AIDS are under the age of 25. In the U.S., among 15 to 24 year old men HIV is now one of the leading causes of death (American Journal of Public Health, Oct. 1998 in www.thebody.com/cdc/condom.html).

In addition to involving young men to reduce HIV risk to women, young men also have their own vulnerabilities to HIV/AIDS that have not been thoroughly examined. Research is helping us understand how societies often reinforce rigid ways of what it means to be men and women. Studies show us how boys feel obliged to prove themselves as "real men" through unprotected sex, how male peer groups may encourage men's violence against women, and how men may be discouraged from talking about their feelings or from seeking health services. Research is also helping us think about young men's roles as fathers, and how most boys and men are not encouraged to take care of children or family members with AIDS, issues that we discuss in this section and in the other sections of this series.

Rethinking young men and HIV/AIDS also requires discussing men who have sex with men (MSM), an issue that has too often been hidden. Discussion of sexual activity between men is often distorted by simplistic assumptions that only men who have "effeminate" behavior, or men who define themselves as gay or bisexual have sex with other men. But sexual behavior seldom corresponds neatly to identities of being heterosexual, homosexual, or bisexual. For this reason, UNAIDS and WHO generally use the terms "same-sex sexual behavior" or men who have sex with men (MSM) rather than saying gay or homosexual men. Prejudice, hostility, denial and misconceptions toward men who have sex with men, and with men who define themselves as gay or homosexual, is directly responsible for inadequate HIV prevention measures.

Why Focus Attention on Young Men and HIV/AIDS?

1. Young men's behavior puts women at risk. On average, men have more sexual partners than women. HIV is more easily transmitted sexually from man to woman than from woman to man. An HIV-infected man is likely to infect more persons than an HIV-positive woman. Engaging men more extensively in HIV prevention has a tremendous potential to reduce women's risk of HIV.

2. Young men's behavior puts themselves at risk. While HIV among women is growing faster, men continue to represent the majority of HIV infection. Young men are less likely to seek health care than young women. In stressful situations – such as living with AIDS – young men often cope less well than young women. In most of the world, young men are more likely than women to use alcohol and other substances – behaviors that increase their risk of HIV infection.

3. The issue of young men who have sex with men (MSM) has been largely hidden. Surveys from various parts of the world find that between 1%-16% of all men – regardless of whether they identify themselves as gay, bisexual or heterosexual – report having had sex with another man. Hostility and misconceptions toward MSM have led to inadequate HIV/AIDS prevention measures.

4. From a developmental perspective, there is evidence that styles of interaction in intimate relationships are "rehearsed" during adolescence. Viewing women as sexual objects, delegating reproductive health concerns to women, use of coercion to obtain sex and viewing sex as performance generally begin in adolescence (and even before) and may continue into adulthood. While ways of interacting with intimate partners change over time, context and relationship, there is strong reason to believe that reaching boys is a way to change how men interact with women.

5. Men need to take a greater role in caring for family members with AIDS, and to consider the impact of their sexual behavior on their children. The number of men affected by AIDS means that millions of women and children are left without their financial support. Caring for HIV-infected persons is mostly carried out by women. Both young and adult men need to be encouraged to take a greater role in this caregiving. Young men who are fathers must consider the potential of their sexual behavior to leave their children HIV-infected or orphaned due to AIDS.

6. Finally, there is a pragmatic, and cost-effective reason: Boys and younger men are often more willing and have more time to participate in group educational activities than do adult men.

Adolescent Boys, Sexuality and Intimate Relationships

The roots of many of young men's sexual and HIV/AIDS-related behaviors – whether they negotiate with partners about condom use, or whether they take care of family members living with AIDS – are found to a large extent in the ways that boys are raised. We sometimes assume that the way that boys and men behave is "natural" – that "boys will be boys." However, the disrespectful behavior of some men toward women, their lack of involvement in sexual health issues, and their greater number of sexual partners stems from how families and societies raise boys and girls. Changing how we raise boys is not easy, but it is a necessary part of changing some young men's behaviors.

By the age of two or three, children imitate the behavior of same-sex family members. Families usually encourage boys to imitate other boys and men, while discouraging them from imitating girls and women. Boys who observe fathers and other men being violent toward women, or treating women as sex objects, may believe that this is "normal" male behavior. A study in Germany found that young men who were disrespectful in relationships with young women often had observed similar relationships in their homes (Kindler, 1995).

Most cultures promote the idea that being a "real man" means being a provider, a protector and sexually aggressive (Gilmore, 1990). They often raise young boys to be aggressive and competitive – skills useful for being providers and protectors – while sometimes raising girls to accept male domination. Boys who show interest in caring for younger siblings, who have close friendships with girls, who display their emotions or who have not yet had sexual relations may be ridiculed by their families and peers.

Boys generally go through puberty during the ages of 10-13, when hormonal changes drive physical changes, including the production of sperm. Most boys have their first nocturnal emissions or "wet dreams" during this period. These changes and sexual energies are a natural part of life, but also bring confusions and doubts for boys and girls. Boys are generally not encouraged to talk about pubertal changes (Lundgren, 1999). In some cases boys may be given more information about women's bodies than about their own. When we discourage boys from talking about their bodies and sexual health at early ages, we may be starting lifelong difficulties for men in talking about sex.

In some parts of the world, boys have earlier reported ages of first sexual experience than girls, while in other regions girls have earlier reported ages at first sexual intercourse. In much of sub-Saharan Africa, girls tend to become sexually active earlier than boys, while in Latin America boys tend to become sexually active earlier, and in Asia the trends are mixed. Worldwide trends suggest that there has been a general approximation between the median age of first vaginal intercourse between boys and girls (Singh, et al, 2000). For many adolescent boys, as we will discuss in the next section, regardless of whether they identify themselves as heterosexual, homosexual or bisexual, homosexual activity may be part of sexual experimentation.

What do we know about the first sexual experiences of adolescent boys? Studies from around the world find that young men often view sexual initiation as a way to prove that they are "real men" and to have status in the male peer group (Marsiglio, 1988). A survey with secondary school youth in Argentina found that boys more frequently mentioned "sexual desire and physical necessity" (45%) as their motivation for having sex, while girls mentioned desire for a deeper intimate relationship (68%) (Necchi & Schufer, 1998). Boys often share their heterosexual "conquests" with pride with the male peer group, while doubts or lack of sexual experience or same-sex sexual experience are often hidden. In a study in Guinea, boys said they worried that if they did not have sex with a girl, their reputation would suffer among their male peers (Gorgen, Yansane, Marx & Millimounou, 1998). In Peru, boys said they had to constantly prove their manhood through sexual activity, or risk being seen as "not men" (Yon, Jimenez &

Valverde, 1998).

Some adolescent boys have their first sexual encounter and subsequent sexual encounters with a sex worker. In Thailand, 61% of young men report having had sex with a sex worker (Im-em, 1998). In Argentina, 42% of secondary school boys said their first sexual experience was with a sex worker (Necchi & Schufer, 1998). In India, between 19-78 % of men report having had sex with a sex worker (Jejeebhoy, 1996). Boys may be encouraged to have sex with sex workers by male family members or peers; some boys may not be ready or may not want this kind of sexual initiation. Early sexual experiences with sex workers may contribute to lasting patterns in which men believe that women's role is to serve them sexually.

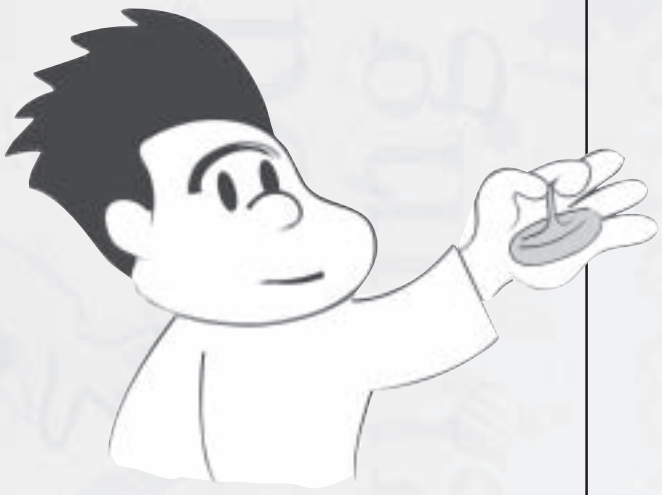
Some young men's sexual relationships with women also include anal intercourse which, because of increased friction and the fragile tissues in the anus, represents a higher risk of HIV transmission than vaginal intercourse. Surveys from various countries confirm the extent of anal intercourse between men and women. In various studies in Africa, Asia and North America, 16-19% of women report anal intercourse (PANOS, 1998). In some settings, anal intercourse among young men and women may be practiced to preserve "virginity" or to avoid pregnancy. There has been little discussion or research on forms of non-penetrative sex that may be satisfying to young men and women, or as alternatives when condoms are unavailable.

When talking about sex and HIV/AIDS, boys often pretend they know much about sex, when they are frequently uninformed or misinformed. In surveys in 15 cities in Latin America and the Caribbean, fewer than a quarter of young men 15-24 could identify the female fertile period (Morris, 1993). Adolescent boys largely rely on the media and their self-taught peers for information about sex. In Jamaica, young men ages 15-24 were more likely to get information on sexuality from peers than were girls, who were more likely to talk to parents and health personnel (National Family Planning Board, 1999). In Kenya, girls were more likely to discuss sex with parents than were boys (27% versus 16%) but friends were the main source of information for both (Erulkar, et al, 1998). Even in countries where open discussions about sex are common, such as Denmark, nearly half of young men ages 16-20 say they never talk to their parents about sex (Rix, 1996). Boys may view sex education as irrelevant because it focuses on contraception, which they see as being for girls.

If we sometimes give the impression that all boys are insensitive toward young women, this is not the case. Many young men are respectful in their relationships with women. In Argentina, 27% of young men said they had their first sexual encounter with the intention of establishing a deeper relationship with a partner, and with negotiation over contraceptive use (Necchi & Schufer, 1998). In Brazil, one or two out of every 10 young men interviewed in one urban setting did not approve of violence against women and believed that reproductive health was just as much their concern as it was women's (Barker & Loewenstein, 1997). In Peru, young women said that while many boys were insensitive toward them, some boys were "sincere" and "respectable" (Yon, Jimenez & Valverde, 1998).

Experiences in working with adolescent boys have found the importance of listening to boys, and of having trained and sensitive staff who can deal with their sometimes aggressive energy. In sexuality education, boys often want – and should be given – opportunities to discuss other concerns they often have related to sexuality, including potency or penis size. The tendency for young men to see reproductive health as a "female" concern means that even when specific services exist for youth, the majority of clients are young women. Public health workers may perceive that young men are disinterested in reproductive health issues and target their efforts to young women. In adolescent reproductive health centers in Ghana, adolescent women represented 76%- 89% of all clinic users. Young men may view clinics as "female" spaces, given that most clients and staff are women (Glover, Erulkar & Nerquaye-Tetteh, 1998). Additional information and ideas for working with young men on sexuality and reproductive health are found in section 1 of this series.

Young Men and Condom Use



Condom use among adolescent boys and young men has increased in many countries over the last 10 years but is still inconsistent, and varies according to the reported nature of the partner or relationship (e.g., occasional, regular, sex worker). In Jamaica, 69% of sexually active young men, 40% in Guatemala City and 53% in Costa Rica reported having used condoms in the last month in their sexual relations (Morris, 1993). In 1995, 67% of sexually active adolescent males in the US reported using condoms in their last sexual encounter, up from 57% in 1988. Overall in the US the proportion of adolescent boys who say they always use condoms rose from 33% in 1988 to 45% in 1995 (Sonenstein, et al 1998). Similarly in Brazil, in 1986 fewer than 5% of young men reported using a condom during first sexual intercourse, compared to nearly 50% in 1999 (UNAIDS, 1999).

In many parts of the world, young men's self-reported condom use is more frequent with an occasional partner, including sex workers. In Thailand, 54% of young men who had their first sexual experience with a sex worker reported using a condom on that occasion, compared to only 20% who said they used condoms on their first sexual experience when the partner was not a sex worker (WHO, 1997). Similarly, in a study with urban youth in South Africa, 14.3% of young people interviewed said they always used condoms with a regular partner, compared to 33% who said they always used condoms with occasional partners (MacPhail & Campbell, 2001).

Other research suggests that young men's condom use and support of their partners' contraceptive use may be higher when there is more communication or negotiation between partners, suggesting the importance of promoting communication about condom use. A study of young men using family planning clinics in the U.S. found that contraceptive use was higher when couples agreed on use, suggesting the importance of involving young men in contraceptive selection and decision-making even if a female contraceptive method is used (Brindis, et al, 1998).

Studies on condom use among adolescents confirm that knowing about condoms and HIV/AIDS is not enough. Studies from various countries have concluded that most young people are aware of the need to use condoms yet condom use is still inconsistent. Why? Barriers to young men's greater use of condoms include cost, the sporadic nature of their sexual activity, lack of information on correct use, reported discomfort, social norms that inhibit communication between partners and rigid sexual scripts or norms about whose responsibility it is to propose condom use. The "sexual script"[1] for young men in many settings is that since reproductive health is a "female" concern, women must suggest condom use or other contraceptive methods. At the same time, the prevailing sexual script frequently holds that it is the male's responsibility to acquire condoms, since for a young woman to carry condoms would suggest that she "planned" to have sex which

[1] By "sexual script" we refer to the common or prevalent ways that sexual activity takes place in a given setting. By using the word "script", we do not imply that such common patterns are fixed or the same for all young people. Nonetheless, from qualitative data we know that there are common ways in which sexual activity is viewed and practiced in a given setting.

is often seen as "promiscuous" (Webb, 1997; Childhope, 1997). A review of data from 14 developing countries suggests that for both adolescent boys and girls, their sexual activity is sporadic, particularly among adolescents who change partners with frequency, among young people who migrate for work (Singh, et al 2000). This sporadic nature of sexual activity implies that many adolescents do not perceive themselves as "sexually active."

In another study in 14 countries, the most common reason men reported for not using condoms was reduced sexual pleasure (Cited in Finger, 1998). At the same time, some men and women believe that men's need for sex is uncontrollable. Research from Mexico and Brazil finds that some men believe they cannot turn down any opportunity to have sex, even if the do not have a condom with them (Aramburu & Rodriguez, 1995; Barker & Loewenstein, 1997). Many young men believe that only penetrative sex "counts" and that other forms of sexual expression are not as satisfying. For some men, having unsafe sex may be appealing precisely because it is risky and spontaneous. Still for other young men, access to condoms, or not having condoms with them when they needed one, is cited as a barrier to condom use. In a recent study with young men in a low income neighborhood in Brazil, among sexually active young men who did not use condoms the last time they had sex, the single most frequent reason (25%) was because they did not have access to condoms at the time (Barker, et al 2001).

Promoting condom use among young men is important in the short term, but is also important for their future condom use. Research from the U.S. has found that teens who used condoms at first intercourse were 20 times more likely to use condoms in subsequent acts. Furthermore, learning about condoms even before starting sexual activity was found to be important, suggesting the need to work with boys even earlier on these issues (American Journal of Public Health, Oct 1, 1998, www.thebody.com/cdc/condom.html).

All of these studies confirm that working with young men to promote condom use is much more than just offering information. It requires discussing deeply-rooted ideas and values about men and women and how sexual relations take place, and encouraging young men to pay attention to their sexual behavior and hygiene – issues we promote in various activities in this manual.

The Female Condom

The female condom – although available in only a few countries and at a relatively high cost – is another option for preventing HIV transmission in vaginal intercourse. Initial studies with the female condom find that the men involved in the trial studies generally accept it and in some cases even prefer it over the male condom. Some men and women found inserting the female condom to be erotic. A few women in Kenya and Brazil said that their male partners were not even aware that they used the female condom. Men in Kenya said that while they felt confronted when a female partner suggested using a male condom, with the female condom, they did not feel confronted. For some couples, discussions about the female condom led to increased negotiation about sex. These initial studies with the female condom suggest that many men are open to their use, and hence the importance of increasing distribution and reducing the price (Ankrah & Attika, 1997). Some researchers have suggested that the female condom may be a tool to promote women's sexual confidence and autonomy that may in a small way open up the possibility of greater equality in sexual relations. To date, however, there have not been studies on young men's attitudes about the female condom, nor has it been widely promoted among young people in general.

Young Men and STIs

Because of their role in increasing the risk of HIV infection, STIs deserve special attention. Research in various parts of the world is finding that young men have increasing rates of STIs and that they frequently ignore such infections or rely on home remedies or self-treatment. Worldwide, there are 330 million cases of STIs (other than HIV) per year among adults, the majority in developing countries (Drennan, 1998). Young and older women suffer the most complications from STIs, including infertility, cervical cancer, pelvic inflammatory disease and ectopic pregnancies. As in the case of HIV, men play a major role in the transmission of STIs to women. For many STIs, men have no symptoms.

An increasing number of young men are contracting chlamydia, which has no symptoms for men in 80% of cases. Studies in the US have found that 10-29% of sexually active teenage women and 10% of boys tested had chlamydia. Prevalence studies on chlamydial urethritis in Chile with 154 asymptomatic adolescent males found that 3% of sexually active males tested positive

An estimated 10 million women worldwide have human papilloma virus (HPV), the virus that causes most cervical cancer. Men typically have no symptoms from HPV, which means that they infect women without knowing it. Studies also find a growing rate of HPV in gay-identified men. In the US, up to 95% of HIV-positive men have HPV, which is associated with anal cancer when transmitted via anal sex (WHO, 1995; Alan Guttmacher Institute, 1998; Groopman, 1999).

Many young men go untreated, delay treatment or use home remedies when they have an STI. Some men may even be proud of having an STI. Young men interviewed in Bolivia say they saw having an STI as a "badge of honor" and proof of their sexual conquests among their male peers and family members (Barker, 1999). A study among men truck drivers in India found that more than half had had an STI at least once, but 50% either went untreated or sought unqualified care (Bang, et al, 1997). In Cameroon, half of men who had a urinary tract infection did not seek treatment from trained medical providers (Green, 1997). In the US 30% of adolescent boys treated for STIs tried to treat themselves before eventually seeking medical attention (Green, 1997).

It is also important to call attention to young men's roles in informing their partner when they have an STI. A study in Brazil with men ages 15-60 found that 15% of all men reported having had an STI at least once, but only 42% said they informed their partner (Barker, et al 2001). Reducing men's and women's risk of HIV infection requires providing adequate testing and treatment for STIs, promoting greater sexual hygiene and convincing young men to seek testing and treatment for STIs even when they have no symptoms.

Male Circumcision and HIV Risk

Male circumcision is the surgical removal of all or part of the foreskin of the penis and is practiced in some countries and cultures. In recent years, researchers have begun studying the possibility that male circumcision leads to reduced risk for HIV (generally only when the circumcision is performed during infancy). Some researchers have concluded that the foreskin of the penis has a high density of Langerhans cells, which present a possible source of initial cell contact for HIV infection. In addition, the foreskin may provide an environment for survival of bacterial and viral matter and may be susceptible to tears, scratches and abrasions which can heighten the chances for a many to become infected with HIV and/or other STIs. However, if circumcision may reduce the likelihood of HIV infection, it does not eliminate it. A study in South Africa found that two out of five circumcised men were infected with HIV, compared to three out of five uncircumcised men. UNAIDS and WHO have urged caution regarding promoting male circumcision as a way of preventing HIV infection, particularly since this may lead to abandoning other safer sexual practices, such as condom use. Furthermore, if practiced in unsterile conditions, circumcision itself can be a health risk (and HIV risk) to boys and young men.

Source: UNAIDS, 2000. Report on the Global HIV/AIDS Epidemic, June 2000.

Young Men who Have Sex with Other Men (MSM)

The realities of men, younger or older, who have sex with men (MSM) have often been repressed because of deep-seated taboos about homosexual behavior. Men's sexual activity with other men is often clouded by simplistic assumptions that only men who identify themselves as or "act" gay or bisexual have sex with other men. However, the reality of MSM is far more complicated.

Some young and older men prefer other men sexually, some men have both male and female sexual partners, while many men have only female sexual partners. In almost every known society – past and present – some men have sex with other men. For some young and adult men, regardless of whether they identify themselves as heterosexual, homosexual or bisexual, homosexual activity is a part of their sexual experimentation or their current sexual activity. Research from numerous countries finds that many adolescent and adult men report having had both heterosexual and homosexual experiences, including 10-16% of boys and men in Peru, 5-13% in Brazil, 0.5-3% of men in Mexico, 3% in Norway, 10-14% in the US, 15% in Botswana and 6-16% in Thailand (PANOS, 1998; Lundgren, 1999; Barker, 1999).

In some settings, homoerotic play between boys is common and tolerated during adolescence, while adult homosexual behavior is socially condemned. In societies where boys and girls are segregated during adolescence, sexual experimentation between boys may be even more

commonplace. In many developing countries – particularly in Asia and Africa – men's sexual activity with other men has been widely denied; in some countries, it is illegal. By repressing and outlawing such behavior, HIV prevention becomes even more difficult.

Some MSM may identify themselves as gay or homosexual and have long-term or casual relationships with other men; others may be married or have long-term relationships with women but occasionally have sex with men; other men may have sex with men because it is the only sex available, as in the case of men in prison or in single-sex institutions. In some places, a man who takes the penetrative or "active" role in anal and oral sex may not be considered gay, while the man who receives penetration is. In other settings, men may be "allowed" to have homosexual relationships if they fulfill their traditional "male" obligations by marrying and having children (Rivers & Aggleton, 1998).

The sexual practices of MSM are varied, but anal sex is often a component, practiced by 30%-80% of MSM (PANOS, 1998). Anal sex represents the highest risk of sexual transmission of HIV. The social denial of men's sexual activity with other men means that in some cases we do not know how much HIV transmission may be related to MSM, and this hinders HIV prevention efforts.

The social stigma attached to homosexual activity often creates anxiety for young men who identify themselves as gay. A study in Australia found that 28.1% of youth who identified themselves as gay had attempted suicide compared to 7.4% of heterosexual youth (Nicholas & Howard, 1998). Research in the U.S. found that 30% of gay and bisexual adolescent boys interviewed report having attempted suicide (American Academy of Pediatrics, 1993). Gay-identified youth may feel isolated from or excluded by peers. While heterosexual boys share their "conquests" with pride with the peer group, gay-identified young men often hide their sexual experiences. Because of prejudices, gay young men sometimes have their first sexual experiences in secretive or anonymous situations and may feel unsure if this is "normal."

Engaging men in HIV prevention and adequately responding to the challenge of HIV requires confronting widespread examples of homophobia, or prejudice toward MSM. Homophobia serves both to keep homosexual behavior and young men of homosexual or bisexual orientation hidden, hindering prevention, but also serves as a way to reinforce rigid views about manhood for heterosexual men. In many settings, boys who act in non-traditional ways – for example participating in domestic chores or having close friendships with girls – may be teased by calling them "gay." Using homophobia as a way to "educate" boys both reinforces rigid views of what men believe they can do and promotes prejudice toward MSM.

Young Men in High Risk Settings

Around the world some young men live in settings or face disadvantages that put them at higher risk of HIV/AIDS. Young men who migrate for work and live away from their wives and families may engage in sex with sex workers and use substances, including alcohol, as a way to cope with the stress of living away from home. For young men living or working in all-male settings, including the military, the male peer group may create a "macho" culture that reinforces risk-taking behaviors. Some men working in mines in South Africa said that sex with sex workers and drinking were the only "fun" available. The men also believed that the risk of HIV was small compared to the risk of death in the mines. The migration of young men from Mexico and Central America to the U.S., and their encounters with sex workers is cited as a possible reason for the increase in HIV prevalence rates along the US-Mexico border (Bronfman, M., 2001).

Young men in the military are also at increased risk of HIV and other STIs. Away from home and from their regular sexual partners, sexual activity – both consensual and coerced – may increase. Between 40-50% of Dutch and US military personnel report having casual sex while on mission. Several studies confirm higher rates of HIV infection among military personnel than among the general population: 4% of military personal tested HIV positive in Thailand (compared to 2% in the overall population), as did 22% in the Central African Republic (compared to 11% among adults overall). Unprotected homoerotic sexual activity in the military may also contribute to HIV transmission, but is generally hidden. In some places MSM are expelled from the military. (PANOS, 1998).

The mobility of young men who work away from home, including those in the military, and their travel across borders, means that they sometimes play an important role in introducing HIV into an area. Young men away from home may have a limited choice of sexual partners, including sex workers. Frequent and unprotected sexual contact with a limited number of partners increases the chance that one HIV-infected partner can infect a whole group.

Millions of men, many of them young, are in prison and jail – at rates far higher than women. Prison conditions in much of the world include sex between prisoners and between prisoners and guards – both forced and consensual – as well as unprotected sex, or sex in degrading conditions with the men's female partners or sex workers. A few studies on HIV prevalence among men in prisons have confirmed high rates of HIV among prison populations.

Young women's exploitation in sex work has received increased attention in recent years, but there has been less attention to young men involved in survival sex. It is difficult to estimate how many young men are involved in sex work or sexual exploitation because such activity is

hidden.[1] Young men involved in survival sex – like young women – often lack power in their sexual encounters with clients to negotiate safer sex. In parts of sub-Saharan Africa, young men report that the concept of "Sugar Daddies" (older men who pay or exchange favors with young women or girls for sex) works in reverse with adult women ("Sugar Mommies") paying boys for sex (Barker & Rich, 1992). In Brazil, one study found that some young men involved in survival sex ended up on the streets because they were rejected or expelled from their homes because of homoerotic behavior (Larvie, 1992). Among youth and children living on the streets around the world – the majority of whom are boys – unprotected sex, both forced and consensual, is a common fact of life. Studies with street youth in some countries have confirmed high rates of STIs and forced sex (Childhope, 1997). Most HIV prevention programs with young men in high-risk settings have learned that in addition to promoting safer sex, they must also address the men's general living conditions and human rights.

Young Men and Substance Use

The connection between substance use and HIV has long been confirmed. Injectable drug use is responsible for 10% of HIV cases in the world. The use of substances is also associated with higher rates of unsafe sexual activity. Worldwide, young men are more likely than women to use substances, including alcohol. Worldwide, an estimated 6-7 million persons inject drugs; 80% of those are men.

Men and boys also use other substances at higher rates than women and girls. In Ecuador, 80% of users of all narcotics are men (UNDCP & CONSEP, 1996). In Jamaica, marijuana use by men is two to three times greater than for women (Wallace & Reid, 1994). In the US, boys are more likely to say that they use drugs to be "cool" than are girls (Schoen et al, 1998). In Kenya, boys are more than twice as likely to have tried alcohol and marijuana than girls (Erulkar, et al, 1998). The manual on "Reasons and Emotions" included in this series contains a series of activities and additional information on young men and substance use.

For many adolescent and adult men, using alcohol or another substance helps prove manhood or helps them fit in with the male peer group. Using drugs and alcohol is also part of risk-taking, including unprotected sex. Young people interviewed in Brazil say they smoke marijuana or drink before going to parties to give them the "courage to find a partner" (Childhope, 1997). Young men interviewed in Thailand said they frequently drink before going to brothels with their peers. In one study with youth in Thailand, 58% of young men who had had sex with a sex worker said they were drunk before visiting a sex worker the first time (WHO, 1997). In one study in the US, 31% of young men said they "are always or sometimes high on alcohol or drugs during sex" (Brindis, et al, 1998). Engaging men in discussions about substance use and considering how men view substance use must also be part of efforts to engage men in HIV prevention.

[1] Young people under the age of 18 who engage in sex for money or favors are considered to be sexually exploited. Over the age of 18, engaging in sex for money is legal in some countries and illegal in others and is generally referred to as sex work.

Young Men, Violence and HIV / AIDS

In addition to the multiple forms of structural violence that enable the spread of HIV/AIDS, millions of men, including young men, are sexually violent toward women every year. In South Africa, which has the highest reported rate of sexual violence in the world, there are 3 million rapes every year – roughly one rape for every 9 sexually active men (PANOS, 1998). In India, some men equate "manhood" with forced sex with their wives; 37% of men in one study in rural India said that they had the right to have sex with their wives even if their wives did not want to (Khan, Khan & Mukerjee, 1998). In another study in rural India, 70% of women said their husbands forced them to have sex (Khan, 1997). In Chile, nearly 3% of young women say that their first sexual experience was rape (PANOS, 1998).

Sexual violence by men against women, and against other boys and men, increases the risk of HIV transmission. Women and men who have been victims of sexual violence, particularly when they are young, are less likely to believe they can negotiate safer sex practices with a sexual partner. A study of sexual violence during adolescence in South Africa, Brazil and the US found that the use of sexual coercion and violence in adolescent dating relationships is associated with lower condom use (Personal correspondence, Maria Helena Ruzany, State University of Rio de Janeiro, 1999). Forced sex also leads to injuries in the genital tract and the anus that increase the risk of HIV infection and other STIs.

While girls are more likely than boys to be victims of sexual abuse or sexual coercion, many boys are also victims. A nationwide survey in the US found that 3.4% of males and 13% of females had experienced unwanted sex (Barker, 1999). Among youth ages 16-18 in the Caribbean, 16% of boys reported being physically abused and 7.5% reported being sexually abused (Lundgren, 1998). In one study in Canada, one-third of men reported having experienced some kind of sexual abuse (Lundgren, 1998). In Zimbabwe, 30% of secondary study students reported that they had been sexually abused; half were boys being abused by women (FOCUS, 1998). Having been a victim of sexual abuse, or of violence, increases chance that boys will be violent. In section 3 of this series, we offer additional background on violence and its implications for unsafe sex.

Young Men, Voluntary Testing and Counseling and Use of Health Services

Numerous studies have confirmed that young men are less likely than women to seek health services. Research from numerous settings finds that boys and men often see themselves as being invulnerable to illness or risk, and may just "tough it out" when they are sick, or seek health services only as a last resort. In other cases, men may believe that clinics or hospitals are "female" places. In Thailand, adolescent boys and girls reported nearly equal levels of illness, but a third of adolescent girls versus about one-fifth of boys reported seeing a doctor in the past month (Podhisita & Pattaravanich, 1998). A nationwide survey of boys ages 11-18 in the U.S. found that by high school, more than one in five boys said there had been at least one occasion when they did not seek needed health care (Schoen et al, 1998). A national study in the UK found that men ages 16-44 visited a doctor or health care provider less than twice a year on average, while women visited a doctor more than four times per year (Wilson, 1997).

Young men may cope less well than women when infected with HIV. While some women also hide their HIV status because of the stigma, men may deny their HIV status because they believe that "real men don't get sick" or that seeking help means admitting weakness or failure. In some settings, men may have more assistance when they are HIV-positive – particularly in regions where HIV is transmitted man-to-man and special support networks for MSM have been started. In other settings, support networks may be providing more care for women with HIV than men (Rivers & Aggleton, 1998).

How can young men be encouraged to use health services and to seek help and support when they need it, including seeking voluntary testing and counseling for HIV? When asked what they want in health centers, young men often want the same things that women ask for: a high quality service at an accessible price; privacy; staff who are sensitive to their needs; confidentiality; and clinic hours that are compatible with their schedules. Many young men also prefer male doctors and nurses. The fact that there is no specific health professional trained to deal with young men's needs – the way that gynecologists or some nurse practitioners specialize in women's health – may also be a barrier to attracting men to health facilities. In terms of seeking help when they face stress, including living with AIDS, discussion groups in which young men interact with other men who have similar needs have been effective.

Voluntary counseling and testing (VCT) has been a key strategy in HIV/AIDS prevention and treatment, with the rationale that offering such services would lead to increased help- and health-seeking behaviors among all or segments of the population. In some settings, VCT centers have carried out outreach efforts to encourage young men to use the services.

Young Men's Roles in Families in the Face of HIV / AIDS

Men generally do not participate as fully in caregiving for children nor for family members with AIDS as women do. A review of studies worldwide concludes that fathers contribute about one-third as much time as mothers in direct child care (Bruce, Lloyd & Leonard, 1995). Similarly, care for family members with AIDS generally falls to women. Even in the gay community in some countries, MSM with HIV often return to their families of origin and are cared for by their mothers or other female relatives. Studies from the Dominican Republic and Mexico find that married women with HIV often return to their parents' home because they are unlikely to receive adequate care from their husbands (Rivers & Aggleton, 1998).

Why don't men take a greater role in caring for children, and in caring for family members with AIDS? Young men clearly are capable of taking care of children and of family members living with AIDS. The section on fatherhood and caregiving in this series provides information on the importance of young men being involved with their children, and examples of working with young men to promote greater caregiving.

Looking specifically at HIV/AIDS, men's roles in children being orphaned by AIDS, and children infected by AIDS from their mothers, has seldom been considered. Both in the case of children who are orphaned because one or both parents dies from AIDS, and in the case of children infected by mother-to-child transmission, men as fathers are indirectly involved. In the vast majority of these cases, men became infected with HIV in their outside sexual relationships and passed HIV to women who subsequently died from AIDS, or passed HIV to their children during childbirth. How might men as fathers, including young fathers, be engaged to consider the potential impact of their sexual behavior on their current or future children? Do young men consider the consequences of their sexual behavior for their children? Greater involvement of fathers in their children's lives may reduce their likelihood of practicing unsafe sex.

What about HIV-positive men who are not fathers, but want to become fathers, even knowing of their HIV status? Fatherhood is an important and rewarding role for men and a form of status in many societies, regardless of HIV. Should men who are HIV-positive seek to become fathers? What factors go into this decision-making? A few programs are beginning to offer counseling about parenting to couples in which one or both are HIV-positive.

Young Men Living with HIV/AIDS

As previously mentioned, young men ages 15-29 represent one of the populations most affected by HIV/AIDS (UNDAIDS, 2000). Furthermore, as discussed, with advances in treatment for HIV/AIDS and greater understanding of the virus, the quality and in some cases the life expectancy of persons living with HIV/AIDS has increased substantially in the last years. The AIDS "cocktail" (called anti-retrovirals, or ARVs) is currently provided free of charge in Brazil, and in limited cases in some other countries in the region. In spite of this increased understanding of the HIV virus and advances in treatment, there are still many myths and misconceptions about being soropositive. Many persons continue to believe that HIV can be transmitted by hugging, kissing, or via casual contact in public spaces (public bathrooms, swimming pools, etc.). Stigma and prejudice toward persons living with HIV/AIDS are still common in many parts of the world – a fact which motivated UNAIDS to dedicate its current World AIDS Campaign to the issue of stigma.

Although the issue is often given secondary attention, HIV prevention for persons living with HIV/AIDS is an important topic; indeed practicing safer sex for a young man who is HIV-positive is as important as for a young man who is not HIV-positive. In the case of young men living with HIV/AIDS, using condoms in all sexual relations protects partners and also protects the soropositive young man himself from increasing his viral load or exposure to other STIs that can be even more debilitating in the case of a weakened immune system. Every soropositive person has a particular viral load, that is the quantity of the virus in his/her system. Additional contact with another soropositive person can increase the viral load. These issues make it important for individuals living with HIV/AIDS to communicate and negotiate with their partners – whether soropositive or not.

Given the spread of HIV/AIDS, and the advances in treatment, there are more and more couples and relationships that are sorodiscordant (that is when one person is HIV-positive and other is not), both homosexual and heterosexual. In some cases, HIV-positive men have also sought to become fathers. Studies are going on in some countries on the possibility of treating sperm (that is removing the virus via in vitro fertilization), but so far results are limited.

Finally, as AIDS has become a chronic disease rather than an immediately fatal disease, persons living with HIV/AIDS increasingly require various kinds of long-term support (medical, psychological, social, legal, etc). Due to these changes, there are now young men who have reached adolescence and adulthood having been born HIV-positive, and who know no other reality than being soropositive. Young men living with HIV/AIDS continue to have their dreams, to live their lives and to have relationships – like any other young men. For this reason, young men living with HIV/AIDS need special help and support networks. Some of the activities presented in Module 2 of this section are useful for promoting a discussion about these issues with young men.

Recommendations

Based on our experience in working with young men in HIV/AIDS prevention, research presented here, and experiences from other organizations, we confirm the importance of carrying out multiple activities if we hope to promote true attitude and behavior change with young men. This includes:

- Carrying out broad-based informational and educational campaigns;
- Carrying out discussions with young men (and/or young men and young women in mixed groups) in health posts and other spaces;
- Taking our activities to where young men are, including military barracks, schools, sports groups and facilities, bars, etc.
- Designing strategies to attract men to use existing health services, including carrying out activities to train and sensitize public health staff on the needs and realities of young men;
- Using and reinforcing non-sexist and non-discriminatory language, and considering the diversity of young men (in terms of sexual orientation, religion, social class, ethnicity, etc.);
- Promoting integrated health services for young men, and not dividing their needs into various sectors;
- Promoting or holding up examples of young men and adult men who demonstrate solidarity and more gender-equitable attitudes;
- Demonstrating and modeling peaceful conflict resolution and alternative, non-violent forms of expression for young men;
- Engaging young men who are fathers are soon-to-be fathers; and
- Engaging young men as health promoters for reaching other young men.

Conclusions

Engaging young men in HIV/AIDS prevention is central to reducing the spread of the disease, both for their current sexual activity and their future activity. However, engaging young men in open and honest discussions about HIV/AIDS, as we have emphasized must go beyond the mere provision of information. Yes, young men need more information about the disease – and we have included some of that information here. But they also need group activities in which they can discuss issues such as sexual violence, their use of health services, the rights of persons living with AIDS, and negotiating condom use. The activities in the next section were selected and tested to touch on all of these themes. We also recommend combining these activities with others in the other four manuals.

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MODULE **2**

Educational Activities

PREVENTING AND LIVING WITH HIV/AIDS

Reviewed by

OMS

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In this activity the facititator can pass on information about AIDS, and at the same time reflect about prejudices that exist in relation to persons living with HIV/AIDS.

Activity 1

Case Study: The Story of Rodrigo

Purpose: To provide accurate information about what HIV/AIDS is, the forms of transmission, prevention and anti-retroviral medication. One to discuss the issue of HIV testing.

Material required: Script of the Case Study: The story of Rodrigo for the group of volunteers.

Time: 2 hours

Planning tips/notes: This activity requires previous contact with the group in order to ensure respect for the young men that are playing the female roles. It is also a good opportunity to discuss prejudice and what lies behind making fun of somebody.

Procedure

1. At least one week in advance, inform the group that you need eight volunteers to take part in a work activity.

2. When the volunteers are gathered, inform them that the proposal is to prepare a short play called "The Story of Rodrigo", which is to be presented later to the other members of the group. Ask them to keep the story a secret so as not to lose the impact.

3. On the day it is to be presented, announce that a play, "The Story of Rodrigo", will be presented and ask everyone to pay careful attention to the story line.

4. After presenting the play, explain that it will be presented repeatedly until the group as a whole finds a satisfactory ending. Tell them that to come up with this ending, they will have to change the dialogue of some of the characters. Thus, when someone in the group thinks that he should take the place of some character, he should say: "Freeze the scene, I'm taking the place of ...." and the story resumes where it stopped. For example: if someone thinks that the health professional is poorly informed, that person should take their place and give the correct information. The play will be repeated until the group is satisfied.

Discussion questions

- What did you feel when the play was presented for the first time?
- What did you think of the changes that were made?
- What is HIV and AIDS?
- How can a person be contaminated by the AIDS virus?
- How do you protect yourself from HIV?
- Do young men seek HIV testing? Why or Why not?
- How do you think people are treated when they seek HIV testing?
- How do you think they should be treated?
- What happens in the health service when someone is suspected of having contracted the AIDS virus?
- What fantasies do people have when they are waiting for the result of the HIV exam?
- Do you know where HIV testing is carried out in your town?
- Is there any medication to treat people who are HIV-positive?
- Do people usually show solidarity with persons who are HIV-positive?

CLOSING

- It is vital to have up-to-date information about the ways of transmitting the HIV virus, the historical background of the disease, the distinction between being HIV-positive and PLWA, and the treatments that exist (see box).
- One basic point in this work is to foster solidarity with people that have contracted the disease. Discuss with the young men the social discrimination and prejudice which people who are HIV-positive and People Living With AIDS (PLWA) are subjected to.
- Emphasize that the idea that AIDS is a disease related to deviant behavior or a punishment, still leads heterosexual men and women to believe that they are free from the possibility of contagion. Show statistical data that disproves this idea;
- Explore the fact that, although HIV/AIDS is constantly being discussed by the media, including accounts of experiences of people living with the virus for more than a decade, prejudice toward HIV-positive persons is still strong. Explore what the prejudices are and why they are still so strong in our society;
- Remind them that prejudice is also related to the idea that someone with HIV/AIDS is promiscuous, a homosexual or a drug addict. All these qualifications are discriminatory.

Resource Sheet - The Story of Rodrigo

Narrator: Rodrigo is 18 years old, studies at night and during the day works as an office-boy in a accounting firm. A colleague at work had an accident and needed a blood donation. Rodrigo went to the clinic, donated blood and some days later was asked to return there to talk with a health professional.

Health professional: Rodrigo, have you been feeling anything different lately?

Rodrigo: No, everything is OK.

Health professional: (the Health professional takes the blood exam and looks at it at length). Rodrigo, your blood test shows that you are HIV-positive.

Rodrigo: What?

Health professional: You might have AIDS.

Rodrigo: What's that! I don't get it...

Health professional: Well, it's just that ... your blood test indicates you have the AIDS virus, but we're going to do another exam to see if that's the case. In any case, I'm going to refer you to a psychologist and she'll give you a better idea about the disease. Her room is just over there.

Narrator: After hearing this, Rodrigo simply flipped. He rushed out of the clinic and didn't even want to know about a psychologist, let alone do another exam. He wandered the streets aimlessly. He could hardly hold his tears back, until he finally bumped into André his best friend.

André: Rodrigo, what are you doing here? Geez, you look terrible.

Rodrigo: Something terrible has happened. I'm really bad. I don't know what to do.

André: Come on man! Let's go to a diner and have a soda and you can tell me what's going on. That's what friends are for.

In the bar

Rodrigo: I don't know how to tell you this ... I donated blood the other day and they called me back and told me that I might have AIDS.

André: (taken aback, and pausing before speaking) But are you sure about this?

Rodrigo: The guy told me to do another exam to make sure, but I was out of there in a flash.

André: Gee, but how did it happen? What have you been getting into?

Rodrigo: I don't know, I was walking along wondering where the hell I picked the damn thing up. I'm not a homosexual, I don't do drugs. Why did this happen to me?

Narrator: The two talked a little more and then went their different ways. At night Andre met up with his friends.

Helena: Hi, André! Everything OK? What's up?

André: You won't believe what I heard. I just met Rodrigo and he told me that he has AIDS.

Ângela: What? I never knew he did drugs ... How come?

Alexandre: Wouldn't surprise me if he's been getting it in the ass. Or screwing around with some whore.

Luciana (with eyes wide open, is about to cry): I was with him at Adriana's party.

Helena: Did you kiss?

Luciana: Of course! Oh my God, do you think I'm infected?

Alexandre: I reckon you'd better see a doctor? But, how could anyone go with a guy like that? I always though he was a bit weird ...

André: Cool it! Here he comes.

Rodrigo: Hi!

Everyone: Hi!

Helena: I gotta go and help my Mom.

Ângela: Wait for me, I'm going too.

André: I have to go as well.

Alexandre: I'm off.

Luciana: (staring at Rodrigo) How could you do this to me? I bet you already knew and even so you went with me ...

They go off, leaving Rodrigo alone.

AIDS

The story of AIDS begins at the beginning of the 1980s, when various people in the United State and Europe began to contract a very rare type of skin cancer (*Kaposi's Sarcoma*) or severe pneumonia. What all these people had in common was a debilitated immune system and most of them died shortly afterward. As the majority of the patients were homosexual it was initially believed that it was a disease that only attacked men that had sex with men (which gave rise to countless stories of persecution, discrimination and prejudice) However, new cases began to appear and not only in the homosexual community. Injecting drug users, men and women that had received blood transfusions, particularly hemophiliacs, also began to present the same symptoms.

In 1982, the name Acquired Immunodeficiency Syndrome (AIDS) was given to this syndrome of diseases and, in the following year, French scientists identified the virus and named it HIV, Human Immunodeficiency Virus.

Today, even knowing that this disease can be transmitted through sexual relations without the use of a condom and through contact with contaminated blood, many people still have not realized what is necessary to protect themselves. AIDS can affect any person: men and women; children, adolescents and adults; rich and poor; all races; heterosexuals, homosexuals and bisexuals.

What is it?

AIDS is also an STI but can be transmitted in other ways besides sexual relations, and initially does not present visible symptoms. It requires a blood exam to know if the person is infected or not.

AIDS - what each of these words means

• *Acquired* - that is contracted through a virus transmitted by another person.

• *Immunodeficiency* - the body has a reduced capacity or has lost its capacity to defend itself from diseases and infections.

• *Syndrome* - set of symptoms or signs of a disease.

AIDS is caused by a minute living being, the HIV virus, which attacks the organism's immune system, increasing the possibility of the patient acquiring certain diseases, which can lead to death. These diseases are caused by bacteria, viruses and others parasites normally combated by the body's immune system. When they come into contact with someone who is HIV-positive they become very dangerous, as they take advantage of the person's immunodeficiency condition, producing so-called opportunist diseases: herpes, tuberculosis, pneumonia, candidiases and tumors, among others.

The body's defense system

The blood is the most important defense system of the body. It produces white globules which, like an army, receive missions of identifying, combating and destroying attacking organisms. The lymphocytes are "soldiers" trained to identify each foreign agent that enters the organism and produce a substance, anti-bodies, whose function is to destroy the invader.

In relation to the AIDS virus, unfortunately, this "army" has lost the majority of the battles. After getting into the bloodstream, the HIV enemy becomes practically indestructible. The lymphocyte T4 – precisely the one responsible for coordinating the immunological system – is the main target of the enemy. In overcoming the lymphocytes, HIV transforms them into allies. They start to produce more and more enemy viruses until they are destroyed. The new virus is released to attack new lymphocytes, restarting the whole cycle. The more the lymphocytes are attacked, the lower the capacity of the organism to defend itself, since it has less agents to recognize its aggressors.

HIV/AIDS: how it is transmitted

Sexual relations

The virus is transmitted through vaginal, oral and anal sexual relations, since it is found in the semen and vaginal fluids. The use of condoms is recommended in all sexual relations.

Use of a contaminated syringe

Syringes can transfer the virus from the blood of a possible HIV-infected drug user to other users. For this reason it is recommended that only disposable needles and syringes be used, on that syringes be sterilized.

Blood transfusion

If the donor is infected, his blood will take the virus directly to the receptor. Every blood donor should do a test that detects infection by the AIDS virus. The blood packs used for transfusion must carry a compulsory HIV–TESTED stamp.

Vertical Transmission

This type of infection occurs from mother to child. It can occur in the mother's womb at the time of childbirth or through breastfeeding. Ideally, the couple should have an HIV test when they plan to have children.

The Cure for AIDS

Unfortunately, the cure for AIDS still has not been discovered. What has been discovered so far are medicines capable of prolonging the life, and improving the quality, of persons that have contracted the virus. Nevertheless, advances in this area are visible. Initially, PLWA received only medication that inhibited the multiplication of an enzyme that was essential for HIV to multiply. In the 1990s, the pharmaceutical laboratories began to develop a new class of medicine that neutralized an enzyme fundamental to the maturing of the HIV. Since 1995, many patients have been treated with a combination of drugs, the so-called "cocktail," technically known as "anti-retrovirals", which reduce the quantity of virus in the blood. Even patients in an already advanced stage of the disease begin to recover their immunological system and even return to their normal activities. In Brazil, this medication is being distributed free by the Ministry of Health and other countries are examining this possibility.

New medications are being developed for those people that show resistance to the cocktail combination.

Vaccines also have been tested with the aim of protecting people who do not have the AIDS virus, but so far there has been no proof of their efficiency and, according to specialists, it will still take a few more years to discover an efficient vaccine.

This activity tries to get adolescents to reflect and recognize situations of vulnerability in terms of AIDS.

Activity 2

I am Vulnerable when...

Purpose: To stimulate reflection on the situations in the life of young men that make them vulnerable to contracting STIs or HIV AIDS.

Time: 1 hour

Materials required: Fhases, paper and pencil.

Planning tips/notes: To deal with the vulnerability of adolescent boys or young men it is important to listen to them. It is important to know that besides the lack of information, many young people put themselves in situations of vulnerability because of the pressure they feel in having to correspond to the role that is expected of men and the difficulties they have in dealing with emotions. In the same way, the absence of specific programs for young men increases their vulnerability in relation to STIs and HIV/AIDS.

Procedure

1. Begin the activity by commenting that very often we get into some situations that make us vulnerable because there is some risk involved. For example, if a person does not know that having sexual relations without a condom increased the risk for HIV/AIDS, they are more vulnerable to contracting this disease than someone who has this information.

2. Next, explain that they should form groups of 4 persons and each of them will be given a phrase listing situations in which a young man is more vulnerable.

3. Ask each group to read their phrase, discuss what it means, if they agree or not with the statement and why.

4. When they have finished, each group should choose a representative to read out the phrase and the findings of the group.

LINK

Activity 12: "Vulnerable, who me?", Sexuality and Reproductive Health (Section 1).

Discussion questions

- Do you think that young men are a vulnerable group in relation to HIV/AIDS? Why?
- In what situations do you see this vulnerability?
- In a relationship, what makes us the persons vulnerable to contracting this disease?
- What aspects in our culture makes young men more vulnerable? And women?
- In your region, are there any specific health services for young men? Wich?
- Are there educational programs that deal with the question of HIV/AIDS and substance use? What?

CLOSING

- Discuss what the cultural factors are that make it difficult for men to care for themselves and cause them to avoid situations of vulnerability.
- Emphasize that, besides the situations discussed in the activity, other components that demonstrate vulnerability in relation to STIs, and HIV/AIDS can be analyzed: program and social vulnerability.
- Explain that social vulnerability concerns the political commitment of each country to health and education. After all, to obtain information and incorporate it in your life does not depend only on people, but on factors such as "access to the means of communication, degree of schooling, availability of material resources, power to influence political decisions, possibilities of challenging cultural barriers etc"[1]. Finally, program vulnerability is that which focuses on the existence or not of programs and activities designed to meet the needs of the younger generation, since it is fundamental that effective measures are taken to help young people protect themselves from HIV. The greater the degree and quality of the government´s commitment and of the resources made available for programs in the area of sexuality and reproductive health, the greater the possibility of empowering young men in their search for a healthier and more responsible affective and sexual life.

[1] Ayres, J. R, et ali. Vulnerabilidade do adolescente ao HIV/AIDS. In: *Gravidez na Adolescência*. São Paulo: ASF, 1999.

Resource Sheet[1]

I am vulnerable when I think that nothing is going to happen to me.

I am vulnerable when I do not have anyone I can count on to help me when I need it.

I am vulnerable when I do something for him or her to like me.

I am vulnerable when I do anything to "get laid".

I am vulnerable when I am afraid to show what I feel.

I am vulnerable when I am unable to think for myself.

I am vulnerable when I do not know how to take care of my own sexual health.

I am vulnerable when I do not take responsibility for my own sexual life.

[1] Phrases taken and adapted from **Álbum Seriado Adolescência e Vulnerabilidade**. Projeto Trance esta Rede. São Paulo: GTPOS, 1998.

This activity helps the educator explore the special care that young men should take with their own bodies, promoting preventive health measures, particularly in relation to genital hygiene.

ACTIVITY 3

Me and my Body

Purpose: To promote a discussion on personal hygiene and sexual health.

Materials required: Hydrographic pen, sheets of paper 40 Kg (or sheets of paper stuck together so that the overall size is larger than a human body), old magazines

Recommended time: 1 hour

Planning tips/notes: The facilitator can suggest to the group that they give a name and other characteristics to the drawing of the man's body. If the participants in the group are too embarrassed to draw the genital organs, the facilitator can do so.

Procedure

1. Place on the floor one (or more) sheet(s) of paper, the size of a human body;
2. Ask a volunteer from the group to lie down on the paper for someone else to draw the outline of his body.
3. Ask another volunteer to add the male genitals to the drawing.
4. Next, encourage the group to stick little pieces from the magazine (or rolled into balls) in the places where dirt can accumulate on the body. For example, the facilitator says: "The guy had ice-cream and didn't wash his hands: where will the dirt accumulate?" Then, the participants place the little pieces of paper in the region that got dirty.
5. Encourage the group to do this with the various parts of the body, discussing what the consequences of inadequate hygiene are on the health. The back-up sheet which accompanies this activity can be very useful.
6. Afterward, ask them what alternatives they found to avoid or correct what happened to the young man in question. The group should then remove the bits of paper, part by part, until the body is clean again.

Discussion questions

- What is hygiene?
- What is the importance of hygiene in our life?
- What is the importance of hygiene in our sexual life?
- Besides hygiene, what else is required for taking care of your sexual health?
- Do men and women take care of their body in the same way? Why?
- Can a lack of hygiene increase the possibility of acquiring an STI?

CLOSING

- At the end the facilitator should highlight the importance of body care and specialized sexual health care, taking advantage of what the group themselves have to say during the workshop, mentioning the possible relationships between lack of hygiene and STI.

This activity offers the possibility of reflecting with young men on the possibilities of exercising their sexuality in a safe, creative and pleasurable way.

Activity 4

The Pleasure of Living

Purpose: To reflect on the different ways of exercising sexuality in pleasurable ways and free of the risk of unwanted pregnancies, HIV/AIDS and other STIs.

Materials Required: Large sheets of paper, post-it adhesive tape, assorted colors of felt-tip pens, male condoms, female condoms, dental clams, thimbles, kleen-pack (thin polythene plastic), gloves, plastic bags.

Time: 2 hours and 30 minutes.

Procedure

1st part:

1. Sitting quietly in a circle, each participant is asked to write on a sheet of paper a sensual and erotic fantasy.

2. Depending on the size of the group, sub-groups of 3 or 4 participants should be formed, where the fantasy written by each participant is shared and discussed, according to the following questions:

- Is there direct contact with the fluids/ liquids of the persons involved in the fantasy?
- Can one infect or become infected with any STI or HIV/AIDS through kissing?

3. Each sub-group chooses the most erotic and sensual story, which represents safe sexual intercourse (by using some of the various preventions measures available), protecting themselves from infection from an STI or HIV/AIDS, and shares it with the whole group. In the stories where no prevention was mentioned, it is important that the facilitator points this out before opening up the discussion.

- What attracts your attention in the fantasies?
- Is it less pleasurable when we practice safer sex?
- What differences and coincidences can we see in the stories presented by the sub-groups?

2nd part:

1. Place all the prevention devices, available in the middle of the room (male condoms, female condoms, gloves, etc.) and demonstrate how to use each one correctly.

2. Once this is done, open up a new discussion with the following questions;

- What can we do to make safer sex more erotic?
- Why does the media talk about safe sex?
- Does careful and responsible sexuality reduce our possibilities of pleasure?

Discussion questions

- How do you look after yourself/your partner when exercising your sexuality?
- What are the main health problems faced by adolescents when exercising their sexuality?
- What risks do they face?
- What can we do to lead a life of pleasurable and responsible sexuality, without risk for the persons involved, without violence and without coercion?
- What kind of care related to sexuality is most recommended in your community?
- What self-care practices are most widely used and accepted in your community?

CLOSING

Exercising sexuality is an experience that goes beyond the penis, vagina and penetration. It involves us in a complete, deep and personal way. We must explore new ways of relating to others sensually involving all our senses, and considering new possibilities of pleasure and enjoyment between two persons, without risk of disease, infection or unwanted pregnancy.

The way which young men exercise their sexuality frequently leads them into situations of risk concerning their own health and that of their partner.

This activity shows how HIV/AIDS and other STIs are rapidly transmitted and how we can avoid this.

Activity 5

Signature Hunt

Materials required: Large post-it cards, Pens

Recommended time: 30 minutes

Planning tips/notes: Before distributing the cards, mark three of them with a "C", another three with the message "Do not participate in the activity and do not follow my instructions until we sit down again" and one card with an "H". On the remaining cards write the message "Follow all my instructions", including those marked with a "C" and an "H".

Procedure

1. Hand out a card to each participant. Ask them to keep the instructions on the card they have received secret and obey the instructions contained on their card;

2. Ask them to stand up and choose three people to sign their card (preferably not someone right next to them);

3. When everybody has collected their signatures, ask them to sit down;

4. Ask the person that has the card marked to stand;

5. Ask everyone who has their cards signed by this person, or has signed that person's card, to stand up;

6. Ask everyone who has the signature of these persons to stand up. Continue like this until everyone is standing up, except those who were requested not to participate.;

7. Tell the young men to pretend that the person marked with an "H" is infected with HIV or some STIs and that he had sexual relations without protection with the three persons who signed his card. Remind them that they are pretending and that the participants are not in fact contaminated;

8. Ask the group to imagine that the persons who did not take part in the activity, that is to say, those that received the "do not participate" card, are persons that have not maintained sexual relations;

9. Finish off by asking the group to continue pretending and explain to the participants who have the cards marked with a "C" that they used a condom and, for this reason, run less risk. These young men can also sit down.

10. Discuss the following questions.[1]

Discussion questions

- How did person "H" feel? What was his reaction when he found out he was "infected"?
- What were the feelings of the young men toward person "H"?
- How did those who did not participate in the activity at the start feel? Did this feeling change during the course of the activity? What did the rest of the group feel toward those who did not participate?
- Is it easy or difficult not to participate in an activity where everybody takes part? Why?
- How did those who "used a condom" feel?
- What were the feelings of those that discovered that they might have been infected? How did they feel about having signed the card of someone "infected" by an STI or HIV?
- Person "H" did not know he was infected. How could "H" have known?

[1] This activity was adapted from the activity "In Search of Signatures" contained in the manual *"Adolescência: Administrando o futuro"* produced by Advocates for Youth and SEBRAE, 1992.

This activity promotes reflection on the life of a PLWA.

Activity 6

Party of Differences

Purpose: To promote a reflection on the social life of a PLWA, considering how they are viewed and treated by the people around them.

Materials required: cards, one for each participant, divided in three groups, marked with signs "+" "–" and "?", Adhesive tape

Recommended time: 1 hour

Planning notes/tips: You can take advantage of this activity to start a discussion about the importance of testing, based on the idea of the "HIV question mark". You can choose a "prize" or "punishment", for anyone that tries to see what mark they have on their backs, for example, they have to leave the group and can only take part in the discussion.

Procedure

1. Ask the participants to form a circle.
2. Stick a card on the back of each participant. They are NOT allowed to see the sign they have been given.
3. Then ask them to behave as if they were at a party (chatting, laughing and joking, etc). Explain that each person has been given a sign indicating his condition in relation to HIV, for this reason some are (+), others negative (–) and others with a question mark (?). The (+) have HIV, the (–) do not and the (?) do not know whether they have the virus or not.
4. Explain that everyone can interact using four forms of greeting: handshake, hug, verbal greeting or just using gestures. They should treat the others based on their condition, considering the sign of the others and what they think their own is.
5. After a few minutes of partying, the facilitator asks everyone to say goodbye and to form a circle again, positioning themselves next to those they think they are the same as.
6. Open up the discussion without looking yet at which group they belong to.
7. After that, each person removes their card and, whoever wants to, can comment if their supposition was confirmed or not.
8. Continue the discussion, based on the revelations, exploring particularly how the people that had (–) or (?) on their backs felt.

Discussion questions

- Should persons who are HIV-positive be treated differently? Why? In which way?
- How can we avoid prejudice?
- Should the social life of PLWA be different from that of other people?
- How does it affect work?

Closing

- The facilitator should conclude by highlighting the importance of noticing other aspects of the life of PLWA, beyond disease and sex, considering the technological advances in medicine and the debates on human and civil rights. Prevention is about the virus, not against the person.

This activity serves to promote reflection on the importance of HIV testing and prevention.

Activity 7

Testing and Counseling

Purpose: To reflect on the importance of HIV testing and counseling, considering the motivations and the embarrassments involved.

Materials: 2 cards with the results of the test, one "positive" and the other "negative"

Recommended time: 1 hour and 30 minutes

Planning tips/notes: The facilitator can suggest to the group that they stage a meeting between the two young men that come out of the health center with different results and see what they talk about before and after the result.

Procedure

1. Ask for two volunteers to enact the scene of a young person arriving at the health center to do an HIV test and being attended by one of the staff. The participants themselves should decide what the scene is like, the expression on the boy's face, his behavior and the appearance of the health service official. Explain that it takes some time to get the result of the HIV exam and that this is the boy's first contact with the health center. Stop the scene with a command, e.g., FREEZE!

2. Then ask the group:

A. Concerning the young man: What made him want to do the test? How long did it take him to decide? How will he cope with the result? What does he expect from the health services? How is he feeling? Is he afraid? Confident? Why? Does his family know what he has come to do?

B. Concerning the health professional: Why has he chosen to work there? Does he like what he does? What does he think about a boy who asks to do the HIV test? Is he helpful

when dealing with the public?

3. After posing and discussing the questions, ask two other pairs to enact the same scene, but now, at the time the test result is given. The results, one positive and the other negative, are drawn by lots and handed out to each pair shortly before staging the second scene, without the group knowing which of them is positive or negative.

4. As in the previous scene, prompt the group with questions:

A. Which one is positive/negative and why?

B. How did he receive the news?

C. Who do you think the first person he talks to will be?

D. Why do you think the result of the test was negative/positive?

E. What is he thinking of doing now that he knows he has/does not have the virus?

5. Get the group to discuss the realities of each of the cases.

6. In the final stage, the pairs enact two different scenes representing what the future holds for each of the two young men.

7. Discuss with the group, based on the enacted scenes, "What initiatives should each of them take?" and "What are their expectations for the future?"

Discussion questions

- Why are people afraid of doing the HIV test?
- Do you know where the test can be done safely and anonymously?
- What should STI/AIDS counseling and prevention be like?
- Who should be responsible for the prevention and treatment of STI/AIDS?
- What kind of negotiation should take place between sexual partners when there is a need for STI/AIDS treatment?
- Do PLWA have a right to an active sexual life?
- When someone finds out that he has been infected with HIV, what should he do in relation to his partner?
- What should the life (sexual, family, etc.) of a couple be like, when one of the partners is HIV positive and the other not?

CLOSING

- At the end, the facilitator concludes by making use of what the group themselves have said, particularly during the third stage of the workshop, analyzing the alternatives, in order to demonstrate the importance of testing. You should also highlight the importance of prevention for everyone, whether infected or not.

This activity allows young people to express their views on the pros and cons of using a condom.

Activity 8

Want ... don't want, want .... don't want ...

Purpose: To stage situations that occur in negotiating safer sex, incorporating the arguments on the pros and cons of using a condom.
Reinforce the tools for negotiating safe conditions.

Materials required: Large sheets of paper, Markers, Adhesive tape

Recommended time: 2 hours

Procedure

1. Divide the participants at random in 4 groups, numbering them or giving them different colors.[1]

2. Each group will be given 5 minutes to perform a different task:

Group	Topic of Discussion
M1	Reasons why men **want** to use a condom
M2	Reasons why men **do not want** to use a condom
W1	Reasons why women **want** to use a condom
W2	Reasons why women **do not want** to use a condom

Each group notes down the reasons on a card.

3. Negotiating: not knowing beforehand with whom they are going to negotiate, each group will be asked to discuss the theme they were assigned. The groups assigned with the female reasons will have to personify them.

Thus, the first negotiation takes place:

Group M1 (men who want to use the condom) negotiates with **group W2** (women who do not want to use a condom). Get the groups to negotiate, imagining that sexual intercourse is desired. After negotiating, ask them how they felt and what they have realized.

Following this, ask the other two groups who were observing to present their comments.

The second negotiation now takes place:

Group M2 (men who do not want to use a condom) negotiates with **group W1** (women who want to use a condom).

The discussion is conducted in the same way. In both cases the facilitators write on a sheet of paper the most important arguments, both in favor and against.

[1] This exercise obviously can be used also with mixed groups, which confers more credibility. Likewise, it can be used with single-sex groups of males who have sex with males.

Discussion questions

The whole group is asked to analyze various aspects:

a. In which way is this negotiation similar to what happens in real life?
What are the consequences of unsuccessful negotiation?
It is important to pay special attention to the strongest reasons for NO. The reasons are reviewed, and the group thinks collectively of arguments that might lead to YES. If time allows, a third stage of the negotiation should be conducted, incorporating these new arguments.
b. It is necessary to reflect on the different levels which occur in a negotiation like this. The group is asked "what other aspects of the persons involved are present in a negotiation like this?" The group should realize that not only is rational argument present, but also gender (as a power relationship), communication styles, emotions, attraction, self-esteem and the different experiences the persons have gone through. In the case of women, the fear of losing their partner or low self-esteem might lead them to accept unsafe sex. Among men, the decision of using a condom or not depends, often, on whom they are going to have sex with, whether with their steady partner, a friend or a sex professional.
c. One last question concerns timing: when is the best moment to negotiate condom use? Obviously and above all, if an agreement is not reached, it is better to negotiate this in advance and not just before the sexual act.

LINK

Activity 5:
Types of Communication

Activity 6:
The Seven Points of Self-esteem

Activity 10:
Learning Not to Drink too Much

CLOSING

Negotiating safer sex does not mean winning at all costs, but seeking the best situation for both parties, that is to say, where both parties win. In the field of sexuality, things can be complex because of all the human aspects that intervene. When someone is sure about wanting safer sex and someone else does not accept it, the moment can come when one of the parties (or both) decides not to have sex.

This activity facilitates the discussion of a young man's vulnerability in the face of substance use in relation to possible HIV infection.

Activity 9

What we Know about Substance Use

Purpose: To discuss the connection between STI and HIV/AIDS and substance abuse.

Recommended time: 2 hours

Materials required: paper and pencils; back-up texts 1 2, 3 and 4 , books, newspapers, etc.

Planning tips/notes: The discussion of substance use should be conducted objectively. Look for opportunities for discussion based on scientific facts, but do not restrict yourself to only giving information about the substance, its composition and its effects. Encourage reflection on the relationships between substance use and human rights, citizenship, personal choice, decision making, sexuality and quality of life. Do not label, do not discriminate and do not accuse; these are the fundamental guidelines for prevention. Try to establish confidence with the young people you are working with, so they feel comfortable asking questions, and asking for help and guidance.

Procedure

1. Start the activity by explaining that substance use is one of the most complicated questions to deal with in an educational context. This is because there are various aspects that should be taken into consideration. Very often, people have so much fear of dealing with it that they end up with set phrases, such as "drugs kill you", and go no further.

2. Tell the group that the idea of this exercise is to talk about substance use in the clearest and frankest way possible. Divide the participants in four groups and explain that each of them is going to discuss an aspect related to substance use, and then make a presentation to the others. This may be through a role play, a poster, a TV news program, etc.

3. The first group should discuss and present the reasons that lead young men to use a psycho-active substance. The second should discuss, the most common psycho-active substances and what their effects are. The third, the relationship between substance use and sex and, finally, the fourth, how one can help a male/female friend who is using psycho-active substances. When the groups are divided up, hand out the resource texts and inform them that there are various publications in the room to research and help them in the discussion.

Discussion questions

- Specialists have stated that someone who drinks alcohol becomes more vulnerable to being infected with HIV (the AIDS virus) or another STI. Why do you think this is so?
- Does the same apply to other substances?
- Do friends try to convince young man to drink or use some other psycho-active substance? How?
- How can a young man say to his friends that he does not feel like drinking or using a substance when he is being pressured into doing so?
- If you discover that a male/female friend is a drug user, what would you do?
- What arguments would you use to convince him/her to stop using this substance, or at least reduce the amount, or change it to a less risky substance?

CLOSING

- Explore, in relation to sexuality, the fact that one of the most common questions among young men concerns the effects of substance use on sexual performance. Both sex and substance use are associated with pleasure and freeing a person from repression. For this reason many young men use substances to overcome shyness and increase sexual pleasure.

Explain that the United Nations distinguishes 4 types of substance users:

- *The experimenter* - Limits himself/herself to experimenting one or several substances, for various reasons, such as curiosity, desire for new experiences, peer pressure, publicity, etc. In most cases contact with the substance does not go beyond the initial experiences;

- *The occasional user* - uses one or several substances occasionally if the surroundings are favorable and the substance is available. There is no dependency or rupture of affective, professional and social relations;

- *The habitual user* - makes frequent use of substances. In his relationships, one can already observe signs of rupture. Even so, he still functions socially, though in a precarious way, and running risks of dependence;

- *The dependent or "dysfunctional" user* - lives through substance use and for substance use, almost exclusively. As a consequence, all social ties are broken, which causes isolation and marginalization.

- Explain that there are 3 types of prevention for substance abuse. Primary prevention is that carried out before the first contact with the substance. The second concerns the experimenter and the occasional user. Tertiary prevention concerns people who make habitual use and who are already dependent, and should be referred to institutions that treat these cases.

Resource Sheet - Text1

Looking for the reasons[1]

Sometimes, we ask ourselves: if everyone knows that substance use is harmful, then why do so many people do it?

It seems such a simple question to answer and then we suddenly realize that it is just the opposite.

To start with, it is useful to know that, historically, humanity has always looked for substances that produce some type of alteration in mood, in perceptions, in sensations.

Secondly, it is not possible to determine a single cause. The reasons that lead some people into substance use vary tremendously. Each person has needs, impulses or objectives that influence his choices and make him act in one way or another.

If we were to make a list, according to what the specialists say about what motivates people to use substances, we would find that the reasons are manifold and that our list would still be incomplete:

- curiosity;
- to forget problems, frustrations and dissatisfactions;
- to escape from boredom ;
- to escape from shyness and insecurity;
- a belief that certain drugs increase creativity, sensitivity and sexual potential;
- dissatisfaction with the quality of life;
- poor health;
- looking for pleasure;
- to challenge death, and run risks ;
- the need to experience new and different emotions;
- to be rebellious;
- in search of the supernatural.

If we want to understand and prevent substance abuse, we have to know that it is not possible to generalize the reasons that lead someone to use. Each user has his own reasons.

But even if we know what these reasons are, we still need to analyze other factors: the substance itself, its effects, pleasures and risks; the users themselves with their own life story, experiences, living conditions, relationships and learning; the socio-cultural context, that is to say, the place where the person lives, with its rules, customs; if the person has contact or not with the substances; and what the person thinks about them.

So, why not inform ourselves, clarify doubts and protect ourselves?

[1] Text taken and adapted from Boletim Transa Legal para Comunidade nº 5. São Paulo: ECOS, 1999.

Resource Sheet - Text 2

The Different Kinds of Substances[1]

Psycho-active substances modify the mood, perception and feelings/sensations of the user. They produce changes in behavior that vary according to the type and amount of substance, the characteristics of the person who ingests them, the expectations that one has about their effects and the moment in which they are ingested.

Generally, they are divided according to the effect they produce. The first group is made up of substances which depress the functioning of the brain, leaving the user "switched off", slower and disinterested. These are the so-called depressants of central nervous system activity, which include tranquilizers, alcohol, inhalants (glue) and narcotics (morphine, heroine).

The second group consists of substances that increase brain activity, that is to say, cause wakefulness and mental alertness in the user. These are known as stimulants of central nervous system activity. Among these are caffeine, cocaine, crack, amphetamines and tobacco.

Finally, there is a third group, consisting of substances that act by modifying brain activity. They leave the mind altered and for this reason are called hallucinogenic substances. LSD, ecstasy and marijuana form part of this category, among other substances derived from plants.

[1] Arruda, S. Hoje e Amanhã in *Sexualidade: Prazer em Conhecer*. Rio de Janeiro: Schering/ Fundação Roberto Marinho, 2001.

Resource Sheet - Text 3

Substance Use and Sex: A Risky Mix!

Among the countless myths that surround the question of substance use, one concerns sexuality – the myth that certain substances improve sexual performance. In reality, the effect of substance use varies from person to person and according to a series of factors: biological, (the metabolism of the human body), frequency of use, environment and culture, and psycho-affective aspects. Very often, the positive effects produced by substance use during sexual relations have more to do with what people believe will happen than with their pharmacological properties.

Alcohol for example, contrary to what many people believe, can initially make people feel less intimidated, but as the playwright William Shakespeare once said: "alcohol provokes the desires, but puts an end to the performance." That is to say, it can hinder an erection.

In the same way, marijuana reduces the production of the male hormone testosterone, and can temporarily lead to a reduction in the production of spermatozoa. Moreover, it is more difficult to establish interaction at the time of sexual relations, as the person seems to be more concerned about their own sensations than with their partner's.

Cocaine reduces desire and excitation since users are more interested in using the substance than in having sex. The most serious aspect of all this concerns contamination by HIV, the AIDS virus. According to various surveys, someone under the effects of any substance is very unlikely to be able to use a condom as the capacity of judgement and reflexes are altered. In the same way, someone that is HIV-positive and who makes use of injectable substances can infect others by sharing the same syringe.

[1] Arruda, S. Hoje e Amanhã in *Sexualidade: Prazer em Conhecer*. Rio de Janeiro: Schering/ Fundação Roberto Marinho, 2001.

Resource Sheet - Text 4

I Want so Much to Help...[1]

What can we do to help someone we know that is doing drugs? This is a difficult question, to which there is no easy answer. What we do know is that just talking and talking about it does little to help.

It is important that everyone clearly understands that substance use gives pleasure, and there is no point in pretending otherwise.

If someone needs drugs to obtain pleasure this means, at the very least, that he or she is not having pleasurable, experiences in other situations in life. Hence, the important thing would be for the family, friends, school to offer enjoyable leisure, sport and work options, besides a franker and less repressive dialog.

To help a person engaged in substance use, it is important to avoid undermining the person and judging them. It is important to show that there are many interesting things to do in life, that the pleasure of substance use passes rapidly, while the pleasure that one has in a friendship, in dating, is considerably more enjoyable and lasts much longer. Substance use also fails to resolve problems; on the contrary, when the hangover is gone, the problems continue.

If you can provide this kind of support, this is the first step. But if the person already has a substance dependence, that is, uses the substance everyday and is unable to go without it, it is important to seek the help of competent professionals in this area to effectively support the user in giving up the substance.

[1] Text extracted and adapted from *Boletim Transa Legal para Comunidade* nº 5. São Paulo: ECOS, 1999.

In the table below, based of information supplied by the CEBRID,[1] it is possible to get a clear idea about each of psycho-active substances.

Depressants	Sensations they provoke	Effects they can cause
Tranquilizers	Relieve tension and anxiety, relaxes the muscles and induces sleep.	In high doses they cause a drop in blood pressure; combined with alcohol, they can lead to a state of coma; in pregnancy, they increase the risk of fetal malformation. They generate tolerance[2], requiring an increase in dosage.
Solvents or inhalants (glue, vanish, benzene, liquid paper)	Euphoria, hallucinations and excitation	Nausea, drop in blood pressure; repeated use can destroy neurons and cause lesions in the spleen, kidneys, liver and in peripheral nerves.
Cough syrups and drops with codeine or zipeprol	Pain relief, feeling of well-being, sleepiness, floating sensation	Drop in blood pressure and temperature; risk of coma; convulsions, generates tolerance, requiring an increase in dosage; when withdrawn, dependent users experience cramps and insomnia.
Sedatives	Relieves tension, calm and relaxing sensation	In association with alcohol, cause a drop in blood pressure and breathing rate, which can lead to death. Generate tolerance, requiring an increase in dosage and dependence[3].
Opium, morphine, heroine	Somnolence, pain relief, state of torpor, isolation from reality, sensation of wakeful dreaming, hallucinations	Cause dependence; reduce the rhythm of heartbeat and breathing and can lead to death; collective use of syringes spreads AIDS; difficult withdrawal.
Alcohol	Euphoria, frees speech, feeling of anesthesia	Slight tremors and nausea, vomiting, sweating, headaches, dizziness and cramps, aggressiveness and suicidal tendencies.

Stimulants	Sensations they provoke	Effects they can cause
Amphetamines	Resistance to sleep and tiredness, tachycardia, sensation of being "turned on," full of energy.	Tachycardia and increase in blood pressure; dilatation of the pupil, danger for drivers, high dosage can cause persecution deliria and paranoia.
Cocaine	Sensation of power, of seeing the world more brilliant, euphoria, loss of appetite, sleep and tiredness.	In high doses, causes an increase in temperature, convulsions and severe tachycardia, which can result in cardiac arrest.
Crack	Sensation of power, of seeing the world more brilliant, euphoria, loss of appetite, sleep and tiredness.	In high doses, causes an increase in temperature, convulsions and severe tachycardia, which can result in cardiac arrest. Causes a strong physical dependence and high mortality.
Tobacco (cigarette)	Stimulating, sensation of pleasure	Reduces appetite, can lead to chronic states of anemia. Aggravates diseases such as bronchitis, and can perturb sexual performance. In pregnant women increases the risk of miscarriage. Is associated with 30% of all types of cancer.
Caffeine	Resistance to sleep and tiredness.	Excessive dosage can cause stomach problems and insomnia.

Hallucinogens	Sensations they provoke	Effects they can cause
Marijuana	Calmness, relaxation, desire to laugh	Immediate loss of memory; some persons can have hallucinations; continuous use can affect the lungs and the production (temporary) of spermatozoa; loss of will.
LSD	Hallucinations, perceptive distortions, fusion of feelings (sound seems to acquire forms)	States of anxiety and panic; delirium, convulsions; risk of dependence.
Antichollinergics (plants such as the lily and some medicines)	hallucinations	Bad trips; tachycardia, dilation of the pupils; intestinal constipation and increase in temperature can lead to convulsions .
Ecstasy (MDMA)	Hallucinations, perceptive distortions, fusion of feelings (sound seems to acquire forms); is a stimulant	Bad trips, with states of anxiety and panic, delirium, convulsions, risk of dependency.

[1] CEBRID – Brazilian Center of Information on Psycho-tropic substances. Department of Psycho-biology, Federal University of São Paulo.
[2] Tolerance means that the organism gets accustomed to a certain chemical product and requires an increase in dosage to obtain the same effect.
[3] According to the World Health Organization, every drug produces dependence whether psychological and/or physical. Psychological dependence takes hold when the person is overwhelmed by an uncontrollable desire to use the substance. Physical dependence is chemical and demonstrates the need to restore the equilibrium caused between the substance and the organism. The destabilization of this equilibrium, caused by the abrupt withdrawal of the substance can cause Withdrawal Syndrome.

With this activity, promotes a reflection on the relation between alcohol consumption and other substance use, and risky sexual behavior.

Activity 10

Didn't I tell you so

Purpose: Identify the effects (physical, emotional and behavioral) of alcohol consumption.
Present situations in which alcohol consumption hampers self-care and prevention of HIV/AIDS.

Materials required: Large sheets of paper, Markers, Adhesive tape, Cards

Recommended time: 2 hours

Procedure

1. Ask the group to write on the cards 3 ways of having fun, preferred by the young people they know[1], and then read them out to the group. Note the answers one by one, and calculate the statistics for the group.

2. If the group has not mentioned it, ask them "in which of these activities is alcohol present?"

3. The facilitator asks "why do young people consume alcohol?" and notes down each of the answers. Possible answers might be "to be accepted", "to have fun", "to show who can drink the most", or "not to look bad with their friends", etc., all of which have to do with what is socially expected of a man.

4. After that, ask them about the different effects of alcohol consumption (physical and emotional effects, effects on the mind and behavior), while noting down each of the answers on a large sheet of paper[2].

5. The facilitator might want to add to the different effects of alcohol consumption by employing the following table:

Effects of Alcohol consumption			
Physical	**On the mind**	**On Behavior**	**Emotional**
Nausea and vomiting Loss of balance, numbness in the legs Loss of coordination Reduction of reflexes Bad recollections of personal experiences, Obsession, Dreams	Confusion and difficulty in concentrating. Thought disturbances and loss of memory – unable to remember what one does under the effects of alcohol - Altered judgement	Violent or depressive behavior Difficulty to talk or speak Uninhibited Tearful	Feeling of temporary well-being Relaxation State of exaggerated happiness or sadness, or disgust Sensation of being omnipotent, invincible.

[1] For reflection purposes, situations that they have experienced or observed in persons around them can be taken into account.

[2] It is important that the facilitator explains that the effects are not the same for everyone and in every situation. They vary depending on the: amount of alcohol consumed, speed or length of time of drinking, the size and weight of the person, etc.

6. Divide the participants in two groups and discuss what the consequences of these effects are on their sexuality, that is to say, how they lead to sexually risky behavior, unprotected sexual relations, coercion, etc.

7. Ask each group to organize a role play, where the following situation is staged :

A person who knows about condoms and is motivated to use them but who, under the effects of alcohol has sexual relations without protection, and what the consequences of this are.

Discussion questions

Pose the following to the full group and get their comments.

- What attracted your attention the most?
- Are the role plays staged similar to what happens in real life?
- What is the reaction of young people when someone does not want to consume alcohol?
- What can we do to care for ourselves and support others?
- What effects do other substances have on decision-making and self-care behavior?
- How can we create other forms of fun and social coexistence, where alcohol is not the most important thing?

LINK

Activity 8:
"Talking about alcohol and alcoholism" in the section "Reasons and Emotions"

Activity 8:
"Want... don't want... want... don't want..." in this section.

CLOSING

- A person who practices alcohol abuse runs the risk of suffering sexual abuse, rape, STI and HIV/AIDS contagion, since under the effects of alcohol it is difficult to take adequate precautions, such as using a condom.
- Alcohol facilitates, for some men, the expression of affection and friendship toward other men. It is important to provide an opportunity to express oneself without the need to use alcohol.
- If young men know the symptoms of alcohol intoxication, it will be easier to identify them and have sufficient time to avoid alcohol abuse.
- For young men it is necessary to create other forms of having fun without alcohol being at the center and not to put pressure on those that do not want to consume.
- In the long term, alcohol abuse can give rise to dependence and other problems in the organism and in every aspect of a person's life.

This activity facilitates the discussion on drugs from a wider social perspective, putting it in the context of modern society.

Activity 11

An Ecological Project

Purpose: To promote organization and planning capacity and foster reflection on healthy and pleasurable activities.

Recommended time: Indeterminate

Material required: To be listed after choosing the proposed intervention.

Planning tips/notes: One of the possibilities of working on the prevention of substance abuse is to encourage young men to adopt a quality of life perspective, starting out, for example, with the following questions: what would be healthy for the environment (air, water, etc.); what would be healthy for society (what type of relations, people's participation, social justice, income distribution, etc.); what would be healthy for the body (diet, exercises, self-care, safe sex, consulting a doctor when necessary, etc.). In sum, provide scope for discussion, research and information so that young people can understand and see themselves as a human being that occupies this planet, belongs to this society, and who is a citizen who has rights and responsibilities, limits and possibilities of acting.

Procedure

1. Start a discussion, carrying out a survey with the young men of the public leisure areas that exist in their local neighborhood. It might be a square, a basket ball court, a football field, a playground, etc.

2. Then, discuss what kind of conditions these public areas are in.

3. Having carried out a survey of the areas and their condition, coordinate a debate among the full group of the improvements required, the possibilities and limits that they have for improving these areas, as well as why such limits exist.

4. Propose that together they choose one of these areas and plan a joint action, which

can be something like: a clean-up operation, followed by a campaign to maintain the square; clearing an area which is not being used and planting flowers or saplings; making use of a plot of land to establish a vegetable garden; cleaning and decorating a games room; refurbishing a deactivated room or a store room; recovering a sports court or football field belonging to the school or neighborhood; producing street murals, etc.

5.Encourage and coordinate the organization of the activity by elaborating a project which includes the distribution of tasks, material requirements, necessary time, the need to establish contacts and obtain support from the authorities responsible for the area, etc.

Suggestion for a project model:

a. Justification (Why is the intervention necessary?)

b. Objectives (To what end does the intervention serve?)

c. Human resources (Who can we count on? Who will do what?)

d. Target audience (Who will benefit from this project?)

e. Duration (How long will it take to implement the project?)

f. Location (Where will the project be implemented?)

g. Material resources (What will be required to implement the project? How can these resources be obtained?)

h. Bibliography (What needs to be read or seen to provide assistance in carrying out the project?)

i. Partnerships (Where to find support?)

j. Assessment (How will the success or impact of the project be assessed?)

Discussion questions

- What did you think of this project?
- Was it important for the community? In what way?
- Was it difficult to implement it?
- How did you feel when it was concluded?
- Would you like to carry out other projects like this?
- Do you see any relationship between this project and drug abuse?

CLOSING

- Foster an attitude among the young men of preserving and valuing their health; encourage self-achievement, self-esteem and reinforce the principles of respecting life.
- In their daily existence, encourage the young men to share the places they use, objects and also ideas;
- Try to establish a bridge between ecology, sexuality and the prevention of substance abuse, organizing, for example, excursions so that they can reflect on contact with other people, with nature and discovering themselves.
- Promote activities such as fairs, competitions or sporting events which foster health and healthy behavior;
- Sensitize young men to the needs of people and the community.

This activity enables young men to find out where condoms can be found in their community, either through free distribution or sale.

Activity 12

Where can we find condoms?[1]

Purpose: To learn where condoms can be found, either through free distribution or sale;
To know the opening times of these establishments, the availability and variety of brands, etc.

Materials required: Worksheet, Flip-chart or brown wrapping paper, Hydrographic pen

Recommended time: 1 hour and 30 minutes for the group activity and 1 week for the survey.

Planning tips/notes: The instructions for this activity should be given clearly to the participants, since it will involve two sessions. It works as a homework exercise, in which the young men should find out during the week the places where condoms can be found. Afterward a survey will be carried out of these places in terms of how they operate.

Procedure

1. Explain that the purpose of the activity is to learn where they can find condoms in their community.

2. As a group, brainstorm to find out in what places they can find condoms. They can be places where they are sold or where they are distributed free of charge. Make a note of the places on a large sheet and write at the side whether the place is a point of sale or distributes free of charge.

3. Having placed the names of the places on the sheet, divide the young men into sub-groups. Each sub-group will be responsible for going to one of the places mentioned and carrying out a survey.

4. Hand out a work form (which follows) to each sub-group for them to carry out the survey. This work form should be given according to the place to be visited, whether it is a point of sale or of free distribution. The form will be completed with information about the place visited (name, address, opening times, access to condoms, etc).

5. Read carefully with each sub-group all the questions on the work form and ask them about any possible doubts they might have.

6. By the following session, the adolescents should already have completed the forms. Each sub-group reads the information to the other participants. Then, open up the discussion.

Discussion questions

- What was it like to do the survey? What was easy and what was difficult?
- What places do the young men usually look for condoms? For what reason? (price, opening times, proximity, etc).
  In what places do you find free distribution of condoms? Is access easy? What difficulties are encountered?
- What difficulties do young men have in getting condoms? Where are they easy to find?
- Do the young men know the places they visited?
- Did this task offer anything new in terms of knowing the place where they live?

[1] This activity is taken from Social Marketing Project of Condoms of Instituto PROMUNDO, John Snow of Brazil and SSL International, Rio de Janeiro, Brazil.

Worksheet

(free condom distribution points)

Availability of condoms at _____
(name of place)

Complete the form, using the other side of the page if necessary.

Address of the establishment_____

Observation about the location_____
(note whether it is close or far from the center of the community/street, has any difficulty of access, etc.)

Opening times: **Week days:** from _____ to_____ **Weekends:** from _____ to_____

Time of the visit: _____ **Duration of the visit:** _____ minutes.

1. Is there any sign in the place indicating where the condoms are? (mark the answer with an X)
Yes No
- If there is, what does it say?_____
(note what it says, word for word)

- Time taken to find it? _____ minutes

2. Interaction with employee (or other person responsible) of the establishment. Ask him/her:
How can I get condoms, please?

Employee: Man Woman (circle the correct answer)
Answer: Friendly Unfriendly (circle the correct answer)

Describe the process of getting condoms.

How old do you have to be to be able to get condoms?

What is the monthly limit of condoms per person?

How did the person responsible feel when you asked for condoms?

Why did they feel like that?

3. How did the establishment obtain the condoms? (for example, Ministry of Health, from a company, NGO, etc)

4. Ask the employee/person responsible if the establishment has leaflets or posters about STI and AIDS (If it does, ask for a copy)
Yes No (mark the answer with an X)
Observations:_____
(note if they did not give you a copy and why)

5. Ask the employee/person responsible if the establishment has leaflets or posters about family planning. (if so, ask for a copy)
Yes No (mark the answer with an X)
Observations:_____
(note if they did not give you a copy and why)

6. Describe how the establishment promotes safe sex (for example, if it uses posters, free video, individual promoters, etc.)

Worksheet

(points of sale for condoms)

Availability of condoms at _____
(name of place)

Complete the form, using the other side of the page if necessary.

Address of the establishment_____

Observation about the location_____
(note whether it is close or far from the center of the community/street, has any difficulty of access, etc.)

Opening times: **Week days:** from_____ to_____ **Weekends:** from _____ to_____

Time of the visit: _____ **Duration of the visit:** _____ minutes.

1. Is there any sign in the shop indicating where the condoms are? (mark the answer with an X)
   Yes No
   - If there is, what does it say?_____
   (note what it says, word for word)
   - Time taken to find it? _____ minutes

2. What brand of condom did you find first?
   Is there more than one brand of condom in the shop? (mark the answer with an X)
   Yes No
   Are all the brands only in one place? (mark the answer with an X)
   Yes No
   Observations

_____

_____

3. Interaction with the shop assistence. Ask the shop assistance:
Please can you tell me where the condoms are?
   Shop assistance: Man Woman (circle the correct answer)
   Answer: Friendly Unfriendly (circle the correct answer)
   Observations

_____

_____

Describe the process of getting condoms.

_____

_____

4. Where are the condoms placed? (mark the answer with an X)

☐ In a display case ☐ At the side of the cash register ☐ Behind the cash register
☐ At the side of the display case ☐ Together with men's personal hygiene products ☐ Others _____
(note where they are placed)

5. What brands and prices do they have?
Brand Price Observations (describe color, size, etc)

_____

_____

6. Ask the shop assistant if the establishment has leaflets or posters about STI and AIDS (If it does, ask for a copy)
   Yes No (mark the answer with an X)
   Observations

_____

_____
(note if they did not give you a copy and why)

7. Ask the shop assistant if the establishment has leaflets or posters about family planning. (if so, ask for a copy)
   Yes No (mark the answer with an X)
   Observations

_____

_____
(note if they did not give you a copy and why)

This activity discusses of the use of power and violence in sexual relations and the connection to STIs and HIV/AIDS.

Activity 13

Power and Violence in Sexual Relations: Sam´s Story

Purpose: To reflect on the issue of power and violence in sexual relations and their relationship with STI/AIDS.

Material required: Copy of the Sam´s story for each participant.

Recommended time: 1 hour and 30 minutes.

Planning tips/notes: When we talk of power and violence in sexual relations we usually think of rape, an extreme form of sexual coercion. However, in daily life many hidden forms of exercising power, can occur – which can include language we use in relation to our partner, disrespectful treatment, etc. We know that in intimate relations, where there is an unequal balance of power, negotiation concerning when to have sexual relations, of what type, of whether to use a condom or not, becomes the subject of conflict, sometimes escalating into situations of physical, psychological and even sexual violence, as we describe in the manual "From violence to peaceful coexistence."

For many young men, peer pressure, the feeling of "having to maintain sexual relations in order to vouch for their manhood," often makes them view their sexual partner as a sexual object. Thus, our intention is to promote healthier and more enjoyable sexual relations, where respect for the wishes of the other person and care for one's own health and that of the partner are always present.

Procedure

1. Explain that the purpose of the activity is to talk about the exercise of power and violence in sexual relations.

2. Do some brainstorming with the group concerning the types of violence that can occur in sexual relations.

3. Depending on the number of participants, divide them into 2 or 3 subgroups, handing out the text of Sam´s story to each one, carrying out a directed reading with the participants for 15 to 20 minutes.

4. Return to the full group and open a discussion.

5. After reading the Sam´s story, discuss the following points, encouraging them to reflect on the episode and what other paths Sam could follow:

a) Is this story just fiction or does it have anything to do with reality?

b) What do you think of Sam's behavior in having sex with a drunk girl?

c) Do you think he only did this due to peer pressure?

d) What could be the consequences of Sam's behavior for himself? And for the girl?

e) And if he had not given in to the pressure, how do you think his friends would have treated him?

f) And what about him, how would he have felt?

Discussion questions

- Can what Sam did be classified as violence? Why?
- What consequence do you think this might entail for them?
- Have you ever been in a similar situation to this? What was your reaction?
- How do you view negotiating sexual relations?
- And to use condoms? Can there also be pressure not to use a condom?
- In what situations can this occur? In what situations can this not occur?
- Can women commit acts of violence in sexual relations against a man?
- What type? And how do men generally react?

CLOSING

- Ask the group what they felt about the Sam´s story. Encourage negotiation and respect in sexual relations, where the desire of each person should be respected. If anyone in the group has practiced or suffered violence and disrespect in relation to his sexuality, and expresses this to the group, do not judge or condemn. Try to understand the reasons why such a situation occurred, clarifying the need for respect as the basis for just and equitable relationships.

Resource Sheet

Sam´s Story*

Sam is 18 years old and has a large group of friends and colleagues from school. He is very popular among his colleagues and they love to go out and go partying. The group is always having great parties at Marcinho's house, with lots of music, beer and good looking people. Last weekend there was another party. There were a lot of people there that Sam knew. He was already a bit late and had hardly arrived when Marcinho spoke to him:

– What's up man? Guess who's here? Ju... the dark-haired chick... she's already been with a whole bunch of guys. There's only you that's missing.

– Cut it out man...

– No, I mean it ... talk to the others. Make the most of it, while she's still wasted. Just go for it!

Sam could see that the girl was slumped in an armchair. She must have drunk too much, he thought. And with his friends egging him on, Sam went over to where Ju was.

– Hi babe ...it's Ju... you're all that's missing to make the party really great...

Taking advantage of the girl having drunk too much, Sam took her up to Marcinho's bedroom. The girl was so drunk that she was half-asleep, almost passed out. Even so, his friends urged him on!

Sam ended up having sex with Ju, and not using a contraceptive. A month later he got really scared when one of his friends, who had also had sex with Ju, got an STI.

– Shit, I wonder if I got it too? And what if it´s AIDS? What do I do???

* This story was adapted from a real event, related by a group of young men in Rio de Janeiro.

This activity is a directed fantasy which deals with possible consequences following the discovery that one is HIV-positive.

Activity **14**

I´m HIV-positive: What Now?

Purpose: To reflect on the construction of a life plan for young HIV-positive men, including links that need to be severed and possible challenges in this stage of life.

Material required: A quiet place and creativity.

Recommended time: 2 hours.

Planning tips/notes: Many people imagine that the moment one finds out one is HIV-positive, life is over: professional life, academic, personal, affective, sexual, family, etc. Certainly recognizing that one is HIV-positive has a strong emotional impact, but it does not mean the end of life plans.
The psychological and affective support of friends and family are fundamental in overcoming the initial shock and getting on with life. At the moment, in most parts of the Americas and in other regions too, one finds a series of governmental and non-governmental services for persons living with HIV and AIDS, offering full psychological, legal, clinical and family support in the person's own community. In this respect, we need to appreciate and realize the full potential of each person, offering the necessary support to confront this new stage of life.
This activity seeks to do exactly this, based on a directed fantasy, exploring the potential for facing such a situation, analyzing and highlighting the solutions that appear.
Furthermore, it is necessary to distinguish the person who is HIV-positive from someone who has full-blown AIDS.

Procedure

1. Ask the group to sit down, or if there is enough space, to lie down in a comfortable position and close their eyes. You can also use soft background music.

2. Ask them to breathe slowly and deeply, and try to be as relaxed as possible. Then, speaking slowly, clearly and with long pauses, begin to suggest stages for a "journey", such as:

a. Let us think a little about your daily life.... think about your home ... think about the people that you like ... someone from your family .... some of your friends ... who are they?

b. Think of a great piece of music that you would like to hear...

c. And a game or sport, or some activity

that you would like to practice...

d. And in your daily life, what do you like to do most ... Do you expect to do anything fun today?

e. Now, let's think about a special person, a girlfriend/boyfriend perhaps ... or someone who you are interested in ... trying to get close to...

f. What do you like most about this person? What do you think this person likes most about you?

g. How do you feel when you are with her/him?

h. Now let's think a little about the future... What do you think next year will be like? And in 5 years' time, how do you imagine you will be? What will you be doing? Will you be studying? Working? Dating? Let your imagination flow...

i. Let's come back to the present ... to today ... Let us imagine that you went to the doctor to do a routine test. Are you alone or with someone? What is the place (clinic or health center). Is it empty or busy? What sounds can you hear around you? What does the place smell like? What are the surroundings like?

j. The doctor suggests that you do an HIV test as well. You agree and are now waiting for the result...

k. When you go back, the doctor tells you that you are HIV-positive...

l. What now? What is your life like now? Do you tell the people you are close to? And you partner, how will he/she react? And your family? And your friends? Your colleagues at school? What changes from now on?

3. Allow some time for each person to imagine the sequence of his journey. Remind them that there is not a right or wrong journey, but that each person does the journey according to his experience and his knowledge about life. Allow 15 to 20 minutes for this activity.

4. Ask each person, when they are ready, to return to their original places. Suggest that they begin by wriggling their toes, moving their legs, and if anyone feels like stretching, they can do so. Wait for everyone to come back, ask them to look at their companions and around them and to sit down once again so that they can start to talk about the "journey".

5. Another fantasy possibility is, instead of being HIV-positive, to learn that their boyfriend/girlfriend is HIV-positive and their reaction to this.

6. Discuss the following questions.

Discussion questions

- What was this journey like for each of you?
- How did they feel in one example and in the other?
- Was one easier or more difficult?
- Do you think that life is over when somebody becomes HIV-positive? What possibilities does this person have?
- What changes in the life of someone who is HIV-positive? (at school, in the family, in the community, at work)?
- What feelings are aroused in each person (shame, despair, anger, grief, solidarity, others)?
- And in relation to one's sex life, what changes?

CLOSING

- Ask the group how they feel imagining the possibility of being HIV-positive or of knowing that their girlfriend/boyfriend is HIV-positive. Point out to the group that life continues for someone who is HIV-positive and that nowadays, with the advances in medicine in relation to the treatments offered, there is an increase in life expectancy, and also in the quality of life, for PLWA. If possible, give positive examples of people known in their community or in their country or region.

This activity discusses how the participants lives would be if they were HIV-positive.

Activity 15

Positive life – empowering of PLWA

Purpose: To provide information about resources and perspectives in the life of persons living with HIV in their community, country or region.

Material required: Resource sheets for each participant.

Recommended time: 2 hours.

Planning tips/notes: Nowadays, with advances in medicine and pharmacological resources, besides a greater understanding of AIDS itself, the expectation and quality of life of people with HIV have increased considerably. This means seeing the life of PLWA based on a series of different contexts: people that are dating, that have an active sexual life, that marry, want to have children, work, often suffer prejudice and discrimination on the part of society and require certain special care concerning health treatments and the use of medicine, but above all they require and want respect and dignity in their lives.

There are more and more examples of persons infected for a long time and with an active and productive life (try to find in your community, country or region examples of this), which make us realize that life with AIDS is not "over" but "continues".

Thus, this activity is designed to investigate and, based on the beliefs and values of young men, think about what the positive life of a PLWA is like. But at the same time, we can not avoid pointing to the difficulties that they have to face and also to the question of death itself, a concrete possibility when dealing with this disease. We believe in the positive value of life and in the opportunities for building a more just life, with dignity and solidarity.

Procedure

For the facilitators:

1. Look for information in your community, country or region about PLWA, such as: a PLWA network, a professional who can share his experience with the group of adolescents, or even a film dealing with this question or a person (or more than one, as you thinks fit) that can give a talk about their life, what has changed, etc.

2. These resources can be brought into the group session or in more than one session, as the case may be.

3. In this case, the role of the facilitator is to mediate the discussion between the guest and the group of adolescents, making them feel as comfortable as possible to ask questions, clarify doubts or satisfy their curiosity. If it is a film, elaborate a short list of questions for discussing the film, pointing out the aspects that you consider most important for the setting in which the group finds itself.

4. It is important to set a date in advance so that all the participants show up.

5. It is necessary for the facilitator to do some research into the legislation in the country or region concerning the rights that PLWA have, as well as statistical data about AIDS (number of persons infected, how it was

transmitted, age group, life expectancy, etc) and have this data available to present to the group. It is also necessary for the facilitator to know about the research being carried out at the moment concerning the question of affective and sexual partnerships between HIV-discordant persons (when one person is HIV-positive and the other is not), concerning the question of HIV-positive persons that want to have children (how this is possible for men and women and what implications and risks are involved), and also legal questions related to the citizen's rights that PLWA have.

For the participants:

1. Ask each participant in the group to describe, based on the resource sheet, a typical week in his life. Allow 15 to 20 minutes for this task.
2. Ask each one to write on a second copy of the same Resource Sheet what a typical week in their life would be like, if they had HIV.
3. The facilitator can and should adapt the questions in the Resource Sheet, according to the setting in which he/she is working.
4. Next, start a discussion based on the following questions.

Discussion questions

- What would change in your life?
- Can a young HIV-positive person live a life like any other young person? Why?
- What difficulties does a young HIV-positive man face?
- Can he date, have sex, get married, have children? What changes?
- Does he have to inform his sexual partners?
- Should the AIDS test be compulsory?
- And if a young man suffers some type of discrimination, who can he turn to?
- And in relation to medication? Do you have any information on this?
- Who can he ask for help? Is there any support network for PLWA in your community or region?

CLOSING

- Reflect with the group based on their own experiences. The modifications between the first stage of the Resource Sheet and the second stage are significant for perceiving the values, myths and beliefs built into the relationship of the group of adolescents and the HIV question.

It is necessary for the adolescents to come out of the group session with the widest possible information concerning the possibilities, rights, pressures, prejudices and discrimination that PLWA have and face. We should remember that information is key for reducing prejudice and improving the quality of life for men and women in general.

LINK

With the previous activity and also Activity 1: "Case Study: The Story of Rodrigo" in this section

Resource Sheet

Describe in two or three sentences a typical week in your life, covering the following questions:

1. At home:
a) How many people live together?
b) Do you do any housework?
c) What is the atmosphere like in your home?
d) How do you relate to the people that live in your home?

2. At school:
a) Where do you study?
b) What time?
c) How many hours a day?
d) How do you get on with your colleagues?
e) What do you like most at school?
f) What do you like least at school?

3. Dating:
a) How long have you been going out together?
b) Do you generally see each other every day?
c) Where do you go?
d) What do you do together?
e) What do you like most about her/him?
f) What do you like the least about your relationship?

Resource Sheet

4. At work:
a) What do you do?
b) How many hours a day?
c) What are your working hours?
d) How do you relate with your colleagues?
e) What do you expect from your job?

5. With friends:
a) When do you meet (morning, afternoon, night)?
b) What do you do together?
c) Do you have a favorite place to go to (beach, square, bar, club, street, someone's house)?
d) Do you play any sport together?
e) What do you do to have fun?

6. Leisure:
a) What leisure activities do you have?
b) Do you spend any time alone? How long? What do you generally do in this period?
c) Do you do any activity by yourself? What? How often?


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Field-Testing the Educational Activities

With support from IPPF/WHR and PAHO, the educational activities included here were field-tested with 271 young men ages 15-24 in 6 countries in Latin America and the Caribbean:

- Instituto Peruano de Paternidad Responsible (INPPARES), Lima, Peru
- PROFAMILIA, Bogota, Colombia
- Mexfam, Mexico, DF
- Save the Children-US, Oruro, Bolivia
- Bemfam, Rio Grande do Norte, Ceará e Paraiba, Brazil
- Programa PAPAI, Recife, Brazil (HIV/AIDS activities)
- YouthNow, Kingston, Jamaica

In terms of qualitative results of the field tests, the following issues were cited:

- **First-time in male-only groups.** In several sites, participants mentioned that it was the first time they had ever worked in all-male groups. Most participants praised working in the male-only groups, saying that it forced them to have to talk about emotions, which they said they generally did not do in mixed groups.
- **Increased empathy and attention to caregiving.** In terms of positive outcomes, one young man said after participating in the activities: "…we saw ourselves in the eyes of the others ...". Several participants mentioned that they thought about the positive aspects of caregiving, and questioned why men did not provide more care in the home.
- **Questioning machismo.** One participant said that the activities helped him break the "armour of being a man". Said another young man: "We started recognizing our own machismo. We recognized that all of us were machista."
- **Reflections about fatherhood.** Several groups praised the issue of talking what it meant to be fathers, particularly thinking about what their own fathers had meant to them, something that most said they had never done.
- **Telling their male friends about the groups.** As an indirect result of the groups, several participants said that they told their male friends about the group.
- **Recognizing the cycle of violence.** In one field-test site, participants said in a follow-up focus group discussion that after participating in the activities they had come to see the connection between the violence they had experiences and witnessed and they violence they used. One young man reported having suffered violence from his parents, and having used violence against a younger brother, saying that he now realized the connection between the two.
- **Changed the style of male-to-male interaction.** In one field-test site, the young men said that the activities led them to be able to change how they talked and interacted with each other as young men, moving from competition and threats to honesty and respect.

In terms of recommendations or aspects that needed to be improved, the following were mentioned:

- **The lack of time.** Nearly all the sites mentioned that time was too short for the complexity of the themes. Both young men and facilitators wanted more time.
- **Using the activities with boys only and boys and girls.** Several facilitators noted that the activities could be used just as easily with groups of young women and men together.
- **Adapting the activities to the local context.** In all sites, the facilitators recommended that the activities be adapted to the local context.
- **Wanted more time in male-only groups.** In various sites, interest generated in the themes led the young men to request more groups. In nearly all the field-test site, the young men affirmed that they wanted more time in male-only groups to continue and deepen the discussions about gender, manhood, violence, sexuality and relationships.
- **Requests for additional themes.** In terms of additional themes that they wanted to include, several groups requested more activities related to the the issue of male-female intimate relationships. [Responding to this request, the collaborating organizations

are at work on a new manual on male-female relationships.]

- **Training for facilitators.** The facilitators who carried out the field tests of the education activities did not receive any training in the use of the materials. Instead, all were experienced facilitators who received the draft manuals and applied them. While all recognized that they were able to carry out the activities without special training, all affirmed that training in the use of the manuals was preferable, particularly to help the facilitators themselves reflect about their own values related to men, gender and masculinities. [As a result of this request, the collaborating organizations are providing training workshops in the use of the material, although the material can also be used and acquired without having to participate in these workshops.]
- **Being careful about the "politically correct discourse".** Facilitators in several sites mentioned that at times they perceived that young men were not truly reflecting about the issues in the educational activities, but at times adopted a "politically correct" discourse, that is they repeated to the facilitators what they perceived the facilitators wanted to here. This suggests the need, said the facilitators, of working with young men over an extended period of time, to get past this discourse.
- **Providing more background information via AV presentations.** Several facilitators said that in addition to the activities, it was useful to consider giving basic presentations with information on the various themes – violence, gender, substance use, sexuality, HIV/AIDS – as a complement.

In terms of quantitative outcomes, a simple pre- and post-test instrument was used to attempt to measure changes in attitudes and knowledge after participating in the activities. Because different activities were tested in different settings, and the number of participants in each setting fairly limited, the measured changes must be considered preliminary. Furthermore, because the post-test was applied immediately after participating in the educational activities, we cannot assert long-term attitude change. Nonetheless, we were able to observe changes based on the following questions. Each of these questions was presented with the options: completely agree, more or less agree, disagree, don't know:

a. "A man has to have a lot of girlfriends and have a lot of fun before he creates a family".

In the post-test, there was a significant change in the percentage disagreeing, suggesting at least some questioning of the traditional perception that men must have a lot of sexual experience.

b. "A young father is always irresponsible and never takes on responsibility for his child".

In the post-test, an increased number did not agree, suggesting that they perceived ways in which young fathers could be involved in caregiving and in fact could be more responsible.

c. "The labels and stereotypes that are put on people affect their personal development and inter-personal relations".

In the post-test, more people agreed with this statement, suggesting an understanding an understanding of the consequences of labelling and blaming.

d. "Nothing can be done to prevent violence".

In relation to this question, there was a significant change in the number of men disagreeing. That is, they came to believe that they could do something to reduce violence.

e. "Since men are strong, their vulnerability to HIV/AIDS is low".

In the post-test, an increased number of young men disagreed with this statement, suggesting that they were able to see beyond the "myth" of male strength.

f. "Condoms reduce pleasure and can tear".

In the post-test fewer young men agreed with this statement.

g. "Social networks are beneficial for mental

health, as they assist in developing bonds of affection, care and support".

In the post-test an increased number of young men agreed with this statement, suggesting a possible increase in help-seeking behavior.

h. "If someone offends me, I will use force to defend my honor if necessary".

In the post-test, fewer young men agreed with this statement, suggesting a questioning of male honor.

i. "A man's body is very simple: penis and testicles. It is only necessary to wash it and that's it".

In relation to the HIV/AIDS activities in Section 5 of these materials, 99 young men participated, including those from Recife (Brazil) and Kingston (Jamaica). In general terms, the facilitators affirmed that the participatory nature and content of the activities were well received by the young men who participated. In addition, the facilitators affirmed that it was important to carry out trainings for facilitators in the use of the activities. The young men who participated in the activities said that themes such as prejudice towards people living with HIV/AIDS, as well as the issue of STIs and self-care were relatively new areas of knowledge acquired by the young men and helped them to deconstruct myths related to HIV/AIDS.

Based on these initial field-test results, the collaborating organizations are currently (2002-2004) carrying out a longer-term evaluation impact study to measure and understand the impact of young men participating in the activities over a sustained period of time. This project is being supported by Horizons/Population Council.


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