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Examining the interaction between gender norms and HIV riskreduction practices in rural areas of Uttar Pradesh, India using the HIV and AIDS Risk Assessment and Reduction Model

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KEYWORDS	ABSTRACT:		
HIV, gender, risk	The global HIV/AIDS fight is progressing; however, rural women, particularly in India,		
reduction, rural	continue to face the devastating consequences of HIV and AIDS. Lack of knowledge and		
women	geographical barriers to HIV services are exacerbated by gender norms, which frequently limit		
	the negotiation of safe sexual practises among rural women. The findings of a qualitative study		
	conducted in rural India examining factors that influenced women to engage in HIV risk-		
	reduction practises are discussed in this paper. The study's findings resulted in the development		
	of an HIV and AIDS risk assessment and reduction (HARAR) model, which is described in		
	detail. The model contributes to a better understanding of the gender-related factors that		
	influence men and women to engage in risk-reduction practises, and it can be used as a		
	framework in other settings to design more nuanced and contextual policies and programmes.		
	Because there is little evidence on how individuals work within existing societal norms to lower		
	HIV risk, this study investigated the particular variables encouraging men and women to reduce		
	their HIV risk in rural villages of Uttar Pradesh, India. To investigate gender norms, HIV risk		
	determinants, and risk reduction responses, qualitative data were collected from 160 participants		
	via 29 in-depth interviews. The findings were examined utilising grounded theory adaptations		
	and constant com	parative analysis. Men and women	who actively reduce their risk of HIV
	infection see their partner's approval of condom use and an HIV test as proof of emotional		
	intimacy in the relationship. Other elements that influence risk reduction attempts include		
	different levels of influence from family or peers, prior experience, interpersonal dynamics, and		
	a reflection of larg	er personal results.	

INTRODUCTION

The global fight against HIV is progressing, but the effect of HIV remains pronounced among marginalised and disempowered people, many of whom are rural women. [1] There is a gender dynamic associated with HIV risk in India, with more women than men impacted and infected with HIV. [2] Women in rural areas, particularly in SSA, face not just geographical hurdles to HIV awareness and treatment, but also entrenched gender stereotypes that frequently limit their ability to negotiate safe sex activities. [3]

Gender roles and expectations have been linked to increased HIV risk and, together with demographic population dynamics, are partly responsible for disparities in infection rates between men and women. According to a number of research studying worldwide HIV trends, gender inequalities are a major factor influencing HIV rates, particularly in SSA. [2-5] Although much research has been done on the effects of gender inequality and inequity on increasing HIV risk, [4,6,7] relatively few studies have looked at how men and women act within existing gender norms to perceived risk. reduce their The underlying mechanisms of infection, as well as the social and economic repercussions of HIV, differ significantly between men and women. These stem from biological and socially manufactured gender inequalities in duties and responsibilities, access to resources, agency, and self-efficacy between men and women. According to gender and power theory, cultural constructions of femininity and masculinity are connected with other social factors such as home work division and power disparities. [8] Understanding the link between local gender norms and HIV risk is thus critical in implementing effective programme and policy responses.

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Power inequalities between men and women are frequently created by socially dictated gender roles, which influence both HIV risk and prevention efforts. According to studies conducted in India, there are extensive gender discrepancies in the social sphere, such as a lack of access to HIV care, and on the economic front, such as limited income-generating opportunities, all of which can have a negative impact on HIV risk, particularly for women. [9,10] According to Indian research, power imbalances in a relationship influenced a woman's ability to effectively negotiate safe sexual practises with her spouse. [11,12] Even when women were aware of HIV prevention, they recognised their partner's hazardous sexual activity as HIV risk factors over which they had little control and influence. [13,14]

Partner selection and reasons for starting a relationship are inextricably linked to the manifestation of gender norms and HIV risk. Risk assessment among youth in Nigeria and South Africa was based on partner appearance and personality [15,16], with condoms frequently used with self-identified dangerous relationships. [17] Because of trust, love, a desire to reproduce, or emotional intimacy, HIV protection is frequently foregone in relationships. [18,19] According to research from Mozambique and Ghana, condom use is associated with relationship duration, value, exclusivity, and communication with a partner. [20,21] Trust is a key aspect of partnerships and frequently influences whether individuals will engage in risk reduction techniques, with condoms and an HIV test being utilised most frequently when a partner's trust cannot be clearly assessed. [22] Some men and women in Mozambique and abroad use protection, although they do so differently depending on the nature of connection, with condoms typically used with casual rather than primary partners. [23,24]

There is a wealth of knowledge on the mechanisms by which gender inequalities increase HIV acquisition, but little research has been done on how men and women negotiate risk reduction strategies in contexts of gender inequalities, which this study intended to address.

The application of findings from a qualitative study studying the interplay between gender norms and HIV risk-reduction activities in rural Uttar Pradesh, India, is discussed in this paper. The research yielded an HIV and AIDS risk assessment and reduction (HARAR) model, which was utilised to examine findings at the individual, normative, social learning, and structural levels.

METHODS

In mid-2018, data from four villages in Uttar Pradesh, India, were collected during a six-month period. A three-pronged strategy was used: (1) interviews with village chiefs and traditional leaders, (2) genderspecific participatory exercises, and (3) in-depth interviews. Over the course of the study, 4 leader interviews, 16 group talks, and 29 in-depth interviews were done.

Leaders in each village were interviewed because they play a vital role in developing and preserving societal norms. [25] Because the primary goal was to obtain authorization from leaders, and because the information revealed in the leader interviews duplicated that of group discussions, these conversations were excluded from the study. Purposive and nonrandom sampling was used to select participants for the group discussion. Leaders in each community chose persons from preexisting groups or those developed as a result of development activities. Participatory group sessions were held to assess HIV knowledge and risk perceptions among respondents. Participants were not questioned whether they knew their own HIV status for ethical reasons. Interviews and focus groups were utilised to investigate the elements that motivate men and women to respond to HIV risk while also providing a more holistic perspective on their beliefs, attitudes, and practises.

The positive deviance (PD) approach was used to identify persons for in-depth interviews from group discussions. The approach in identifying "excellent practises and behaviours" is particularly useful for research studies attempting to better understand the factors that drive individuals to engage in healthy habits. It is founded on the assumption that some individuals, although living in the same conditions and having equal access to resources, engage in specific behaviours and find solutions to problems [26], such as adopting measures to lower HIV risk. Because individuals have already engaged in comparable actions in similar situations and places, they are more likely to be accepted and sustained. [27] The method was initially developed to determine the habits of moms who had healthy infants despite living in poverty. Since then, PD has been expanded and used to child



development, [28] nursing, [29] and birth outcomes. [30] PD was employed in this study to help identify individuals and analyse the strength of the link between the following: (1) people who are already taking steps to reduce their HIV risk, given that Demographic and Health Survey data [31] show a general lack of riskreduction knowledge and practises among men and women, and (2) people who have gender balanced attitudes, given the country's widespread gender disparities.

Given the importance of grounded theory in influencing rigorous qualitative analysis, the research utilised theory-based procedures, such as "constant comparative analysis," to compare and contrast themes across gender and age groups [32,33].

A qualitative design with a two-pronged approach was used: (a) 16 group discussions with 160 participants (ages 15 to 68 years) and (b) 29 in-depth interviews. The group talks aided in the elicitation of information on the definition of gender norms as well as the assessment of HIV awareness levels and behavioural factors. Respondents for the group discussion were chosen via selective and nonrandom sampling, initially segregated by gender and marital status, and then brought together for deeper inquiry. A man and a woman from the local community were hired and trained to conduct group sessions and interviews in their own language. The following criteria were used to choose individuals for in-depth interviews from group discussions (typically 1-2 per group): (1) evidence of gender-balanced attitudes, beliefs, or practises; or (2) stated HIV risk-reduction initiatives, activities, or strategies, with preference given to those persons who met both criteria. Because it was difficult to keep track of respondents who met both criteria at the same time during the group session, only one of the two criteria was deemed sufficient to pick a person, with links to the other criterion investigated in greater depth during the interviews. The data was analysed using grounded theory techniques such as (a) line-by-line coding of all transcripts based on prior research as well as in vivo codes, (b) focused coding to subsume the initial 120 codes into more frequent and salient codes, and (c) thematic coding to help compare key codes across narratives (ie, risk assessment, partner categorization, gender roles, and responses). Grounded theory-based constant comparative analysis was used to compare and contrast coded themes across gender and age groups.

The interviews were digitally recorded and translated from the local tongue into Portuguese by the research assistants before being translated into English by the primary researcher. The continual evaluation of data, continuous debriefings with the research assistants, and meticulous notes all contributed to the conclusions' validity. The study received ethical approval from the London School of Hygiene and Tropical Medicine.

Conceptual framework

To account for the numerous levels of influence on norms, attitudes, and behaviour, the conceptual framework used to drive the research was built from the theory of triadic influence (TTI), with gender and power theory utilised to compile findings across levels. Based on the research demonstrating that factors at multiple levels influence HIV risk, and in order to avoid focusing simply on factors at the person level, an ecological approach was employed to lead this investigation. Many ecological frameworks exist, however they do not always clearly highlight the dynamic and interconnected nature of various levels (ie individual, family, and community). TTI investigates the interactions of risk variables for health outcomes on several levels. [34] The conceptual framework for this study was an adapted version of TTI (see Fig. 1) that preserved individual, family, and community levels with matching theoretical notions. However, particular literature-based elements that hinder or enable riskreduction strategies were introduced at each level (individual, social normative, and structural) with associated categories such as self-efficacy, social norms, and social construction. TTI assisted in accounting for the close interaction between the different elements at each level that can combine to alter beliefs, attitudes, or behaviours about gender roles or HIV risk. In terms of affecting a rise or decrease in HIV risk, factors contained within each level can be both enabling and inhibiting. As a result, TTI aided in the development of research techniques to ensure that influences at numerous levels were recorded, as well as identifying factors that were most influential in encouraging men and women to execute change. Theoretical frameworks at each level aided in the comprehension and validation of research findings. Based on earlier research, self-efficacy was utilised to investigate factors at the individual level, and social norm and social construction were employed to investigate factors at the social normative and structural levels, respectively. Self-efficacy [35], defined as an

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individual's belief in their ability to implement certain actions to produce a desired effect, was a key construct used in this study because, despite factors at multiple levels that can influence risk reduction, it is ultimately the individual's decision to act upon it. The construct was also utilised to aid in the identification of positive deviant cases.



Gender and Power Theory

Figure 1: Conceptual framework

RESULTS HARAR Model

The study looked at how local gender norms, particularly among women, influence and inspire HIV responses in rural India. Models and theories assessing HIV behaviour change, such as the AIDS Risk Reduction Model (ARRM), [36] the health belief model, [37], and social cognitive theories, [38,39], are critical for understanding how risk is perceived and behaviour is changed to minimise risk. Despite their usefulness, one significant shortcoming of such techniques is their emphasis on the individual, with little consideration paid to the social and interpersonal norms that drive sexual risk taking. Furthermore, the emphasis is on risk recognition and identification, which does not always convert into an individual taking action. Other reasons that may impede individuals from minimising their risk include a lack of desire or a spouse who is unwilling to change. Furthermore, the

models and theories are homogeneous in that they do not account for gender or the unique problems that men and women confront when responding to perceived HIV risk. This study discovered that factors at a variety of levels, including individual, normative, social learning, and structural levels, played a role in shaping HIV risk and responsive action, adding to the growing body of literature indicating the importance of an ecological approach to HIV and Sexually Transmitted Infections (STI) prevention and treatment. [40-43]

The first conceptual framework and related theories were effective in analysing risk patterns among individuals, particularly risk-influencing factors at various levels. However, the research findings revealed a more complicated interplay between the multiple levels, which tend to operate in a more interconnected and cyclical manner than the TTI framework allowed. These are built into the HARAR model (Fig. 2).



Figure 2: HARAR model.



The model supports and adapts aspects from the health belief model [44,45] and ARRM on risk perception, HIV epidemic severity, and knowledge, as well as social cognitive theories that focus on learning and normative impacts. It also incorporates the TTI and ecological model principles by taking into account the numerous elements that influence risk and risk reduction. Furthermore, the study found that men and women had different performative roles in risk and risk reduction behaviours. Unlike other ecological models, HARAR understands that factors combine and interact at many levels to influence not only risk assessment, which the majority of models focus on, but also riskreduction activities. Importantly, the data reveal that when men and women are at risk of HIV, they go through three key phases (risk assessment, mediating variables, and outcomes), which impacts whether they take action. As a result, the initial conceptual framework has been changed and included into the HARAR model in light of the research findings.

Individual-level factors in the conceptual framework, specifically knowledge, the severity of the HIV epidemic, and risk perception, were shifted in HARAR under the "risk assessment" phase, as these factors were identified in this study as critical preconditions for individuals to engage in responsive measures. The conceptual model's variables under social normative and structural effects were pre-served in the HARAR model during the "mediating factors" phase, with certain adjustments. Social and gender norms were incorporated in the conceptual framework in addition to structural impacts because of the inhibiting and enabling role they play in risk and risk-reduction activities. As indicated in this study, the unique roles of men and women that are culturally defined and socially enacted, as posited by gender and power as well as role and script theories [46,47], affect identity and interaction with others.

Because sexual interactions are the predominant mechanism of HIV transmission in the research environment, understanding how men and women identify with their gender and learn about and act out their expected roles in society is crucial if HIV risk dynamics and responses are to be effectively addressed. [48-52] is the concept of fluid gender roles within discourses of altering cultural and societal norms, where many forms of masculinity and femininity coexist and can transcend sexes based on experiences, as observed by the work of several notable gender and human sexuality theorists. In this study, men recreated generally accepted ideals of masculinity, such as the display of power through several sexual encounters, and instead stressed the provider role in order to protect their family from danger. Similarly, women changed feminine stereotypes (i.e. passivity and dependence) by withdrawing themselves from potentially dangerous situations by self-efficacious and independent activities. Based on the outcomes of this study, one element, "emotional intimacy," was introduced to the HARAR model under normative circumstances, demonstrating how it can be both protective and risky. Individual constructions and social learning were also introduced as "mediating factors" because they were important in determining both risk perception and subsequent action. With the exception of self-efficacy, none of the other components identified in the HARAR model under individual constructs or social learning were included in the original conceptual framework. Finally, while the conceptual framework was designed with one end in mind-HIV risk reduction-it was clear from this research that in many cases, other outcomes, such as the need to preserve a good social standing and/or restrict resources, were just as or more significant to motivate action. These findings emphasise the importance of taking a holistic approach to HIV-related interventions by taking into account the multiple factors that influence risk perception and responses, particularly the fact that risk-reduction efforts are not always the intended or immediate outcome motivating changes in practises. It also emphasises the critical role of gender dynamics in both HIV risk and risk-reduction approaches, which is always changing.

Individuals evaluate their risk depending on accurate knowledge, personal susceptibility, and the severity of HIV prevalence. Incorrect understanding influences risk perception and subsequent mitigating responses, such as the belief that HIV is carried through condoms or that it only affects particular groups of individuals. Thus, while many ecological models, like the TTI, emphasise the importance of factors at multiple levels in influencing risk, individuals must have accurate knowledge, believe HIV is a serious threat in their lives, and believe they may be at risk before acting.

Once risk has been assessed, there are factors at the individual, normative, social learning, and structural



levels that might mediate this risk and drive individuals to either retain risk levels (i.e. no response to risk) or move toward behaviour adjustment (ie responses to risk). Men and women who take precautions in reaction to perceived risk do so for a variety of reasons, including protecting their social position.

Regardless of their viewpoint on gender disparities, all mediating factors in the model prompted men and women in this study to minimise their risk; however, some factors can shift in both directions (+/-). While both men and women may be aware of their potential risk, other factors such as peers, emotional intimacy with a partner, relationship dynamics, past experience, education, income opportunities, and social, cultural, and gender norms influence whether individuals remain complacent (-) or take action (+).

Components of mediating variables are interconnected, and in many cases, a mixture is required to drive men and women to take action, underlining the significance of considering factors beyond the individual level when responding to HIV. Importantly, the model takes into account some factors, particularly at the normative and structural levels, that can influence changes in behaviour to reduce risk, such as when emotional intimacy can lead to risk reduction when love and trust are associated with protection, but can also maintain or increase risk when these same values lead individuals to abandon prevention methods.

Peer influence can also be beneficial, like when peers have several sexual partners and urge others to stop using condoms with their primary relationships. The model accounts for how risk reactions can influence individuals in both positive and negative ways through decision-making authority, the ability to generate and control an income, and negotiating power within relationship dynamics.

Access to school is a positive mediating factor in this study used to overcome poverty and reliance on men for money under structural pressures. Income can also flow in both directions because some men spend money on sex outside of marriage while others opt to preserve their money to better their family's lives.

Gender roles are shaped by social and cultural conventions, which can shift in either way and change through time. Social norms that allow wealth transfer from men to women through sexual encounters or cultural traditions emphasise many avenues through which risk can grow or reduce. As a result, the ways in which men and women interpret and respond to each of the elements must be understood and adapted to local circumstances.

Conceptualizing HIV/AIDS Risk

According to HIV/AIDS data on the primary reasons of transmission in India, respondents indicate that a lack of condom use, combined with men and women having several sexual partners, contributes to the increased spread of HIV/AIDS in their locations.

There is a widespread and pervasive dread of getting an HIV test among both men and women, owing to the health ramifications of an HIV-positive status or the fear of being abandoned.

Respondents also reported various hurdles to condom use, including beliefs that condoms contribute to the spread of HIV and that condoms impair pleasure during sex. Phrases like "taste of sex" underline condoms' apparent interference in facilitating joyful sexual activity.

Many young men attribute their condom use to a lack of confidence in their spouse. Condoms are used in such circumstances with women who are sought exclusively for sexual pleasure and who are generally not trusted by males in terms of pregnancy prevention and illness acquisition. Many males also place the onus and duty for utilising protection on women, despite the fact that both sexes engage in dangerous behaviours.

Women are sometimes blamed for proposing condom use to their partners, which can be tough when they feel helpless. Because of its link with prostitution, many women are hesitant to advise common use. Even when women tried, males presented strong counterarguments to stop using it.

Risk assessment

Risk is contextualised based on a variety of circumstances that influence how individuals estimate the severity of HIV and their own susceptibility. The findings support AARM's and the health belief model's perspectives that individuals will not engage in risk reduction without correct HIV knowledge. In this study, men and women believed that HIV existed and



assessed their possible risk levels depending on their own or their partner's conduct.

As previously stated, several structural and normative elements can move in either way to sustain risk or promote risk reduction. Gender, cultural, and social norms, which interact with other mediating factors in the model such as relationship dynamics, peer influence, and access to education and incomegenerating opportunities, can profoundly influence men's and women's ability to change their behaviour due to vested interests to conform to certain norms. For example, to avoid the socially dangerous single status, some women take limited, if any, action in acknowledged unsafe relationships. In other circumstances, women and men are aware of their HIV risk but deflect or ignore it in order to gain more resources or sexual pleasure. Roles and expectations that place women and men in specific roles in society have an impact on perceived danger. According to gender and power theory, women's ability to take action is often, but not always, limited by disparities in labour and opportunity. Economic dependence on men inhibits women's ability to act on perceived HIV risk in order to maintain financial security for herself and her family. Similarly, masculine norms are frequently associated to resource generation and provision, which is frequently utilised as a leverage in this study to participate in sex with several women.

Men and women's economic possibilities differ, which influences their responses to HIV risk. The associated power disparities, such as a lack of decision-making authority, hinder women's ability to communicate safe sex with their partners even when they feel at risk, but pleasure is frequently emphasised over potential HIV risk among males who utilise their riches to access sex.

In other circumstances, women who exploit sex for resources prioritise wealth over a man's health. Men who use their income to acquire sex from women, according to gender and power theory, are doing it to demonstrate their power. However, some women utilise their bodies as a source of power in order to take cash from men.

Peer pressure and social norms that encourage sexual desire in men or require the use of condoms in particular sexual encounters, such as "outside the house," have an impact on HIV risk and protection use.

Women's ability to negotiate safe sex encounters is hampered by attitudes that restrict condom use in marriage.

There is a link between how gender norms are maintained in particular social contexts and HIV risk levels in men and women. Polygyny and early marriage are seen as particularly dangerous for women by cultural, religious, and traditional standards. This is related not only to HIV risk, but also to women's limited opportunity to seek education and incomegenerating options in order to strengthen their agency and autonomy. Although a systematic review in India found that poverty had an impact on HIV risk, which is influenced by income access and control between genders, [53] the poor economic condition of individuals across communities in the study setting resulted in negligible changes in risk or reactions.

Consistent Adherence to Risk Reduction Strategies

Some men and women, regardless of relationship status or gender attitudes, consistently engage in HIV risk reduction activity with different partners. To minimise HIV acquisition, these individuals adopt a variety of risk reduction methods such as abstinence, abandonment, HIV testing, and/or condom use with a variety of partner types.

Some women will take an HIV test with new partners not just to determine their HIV status, but also to gauge their emotional attachment. Despite the study population's dread of HIV testing, one respondent utilises an HIV test with casual partners to reduce suspicion; with a boyfriend, it helps evaluate the level of emotional intimacy he has for her. Though now widowed, this responder acknowledges her husband's significant influence and adds, "I always obeyed everything that he told me... he started getting the HIV test and then always brought me," a pattern she has continued with all of her subsequent partners. According to the respondent, "after my husband's death, I feel I am suffering; I just sit at home and wait for my family to aid me," a scenario that could develop to financial dependency on males and make risk reduction efforts difficult to implement. However, it is her husband's actions that lead the respondent to insist on being tested across all relationship types.

Some women will quit a relationship if their man refuses to wear a condom, similar to how an HIV test is



associated with a partner's love. Acceptance of condom usage is directly related to emotional intimacy, which contrasts with the frequently practised use of condoms with partners who cannot be trusted or who lack connection. In the following example, a respondent believes that women in the community do not have much negotiating power. Despite this, she took steps to end a prior marriage due to a husband's infidelity, and she is adamant about using condoms in all new relationships to avoid undesired pregnancy and HIV.

Some women cherish the company of a partner while remaining committed to reduce their risk of HIV infection through a variety of risk-reduction measures such as condom use, HIV testing, and keeping a relationship with only one guy at a time. Like other women, the respondent below believes that a partner's failure to use condoms demonstrates his lack of interest in her and the relationship. In order to manage her body and ensure a negative status, the respondent additionally obtains an HIV test with each new partner. "I have two residences that my husband left for me and I get money from the renting of the property," the woman says, despite the fact that she has assets from her now deceased spouse and may generate an income. This viewpoint, however, does not contradict her desire to appreciate and manage her body.

Younger unmarried women report being afraid of HIV because of the ambiguity connected with the infection rather than feeling at danger. Parental supervision and self-determination have been critical in ensuring that these young ladies not only complete their education but also adhere to a preventative approach of no sex till marriage. The refusal of a future spouse to get an HIV test reveals some of the type of behaviour a woman can expect in the marriage.

Young men are challenging norms that encourage condom usage with outside women, believing that partner acceptance to condom use is a sign of trust and love, in accordance with women's experiences. The young man below, influenced by his uncle, uses a condom in all sexual encounters to avoid pregnancy and disease. A woman who agrees to use protection, which is normally associated with distrust in the study environment, is instead accepted by this man, who believes it reflects a lady who demonstrates "positive behaviour." Prior experience with an unfaithful partner can inspire men to quit the relationship and distance themselves from the "infected" behaviour of others. Despite his belief that all "decisions should be taken by a man because he is the head of the family," the respondent below acts on his ideas and takes action to limit any potential HIV risk, overcoming peer barriers that discourage condom usage in sexual encounters with a primary partner.

Mediating factors Individual characteristics

Men and women who opt to act on perceived HIV risk believe they have the ability to attain the desired results (decreased risk). Individuals are motivated to change by a combination of normative forces, social learning, and structural components. For example, economic discrepancies that result in power imbalances might make it difficult for women to decrease HIV risk; yet, some have made steps to overcome this and leave a risky relationship as a result of self-efficacy, but often also to secure a healthy life for the family.

Similarly, men who choose not to allocate resources to extramarital partners, those who remain faithful, and others who use protection across all sexual encounters are influenced not only by individual characteristics such as self-efficacy and self-regulation, but also by observation of others, family influence, disease avoidance, family concern, and emotional intimacy with a partner.

Normative influences

Normative influences, as defined by social cognitive theories, are those variables that assist shape social or relationship norms. Peers, family guidance and monitoring, emotional intimacy, and relationship dynamics are examples of normative variables that might impact an individual's ability to lower perceived HIV risk. Peer influence, as previously mentioned, is typically founded in prevailing gender and societal norms and can have either a favourable [54-58] or negative effect on health habits [59-61] depending on an individual's social networks. Some of the unmarried guys in this survey are questioning their peers' advise and behaviour in engaging in undisclosed sex with multiple women. Instead, these guys weigh the implications of engaging in these behaviours in terms of their personal HIV risk or the need to safeguard a primary partner, and they always use protection.



Other research from South Africa and the United States have found that parental and family influences men and women to pursue less risky sexual settings. [62-65] The desire to preserve a good position in society and the need to guarantee a secure future for their children by reserving rather than spending resources are heavily impacted by family guidance or observation of others. Unmarried guys are also affected by parents who have remained monogamous and follow family advice to use condoms. Parental guidance is also important in persuading unmarried women to stay abstinent in order to avoid disease transmission or finish school. Similar to Malawi's findings, family support is essential for women who seek to escape dangerous partnerships. [66]

Emotional intimacy and partner relationship dynamics can either worsen or lower HIV risk, according to evidence from European surveys. [67] The ability to make an income and govern home resources influences an individual's decision-making power over various household and sexual scenarios within marital dynamics. However, there have been cases where decision-making proved insignificant, and men and women still took steps to reduce their HIV risk due to family support, prior experience, and certain outcomes such as a respected social standing.

In terms of emotional closeness, some men and women believe they are at low risk because of the trust, love, and care they have developed with their relationship over time. These people are convinced that their partner will not betray them or harm their health. Other men and women, despite gender stereotypes, utilise riskreduction techniques to shield loved ones from the negative effects of HIV. Acceptance of HIV riskreduction strategies by a partner is interpreted by some unmarried men and women as validation of love, trust, and care in the relationship, with such behaviours offering essential insight into a partner's future conduct.

Structural influences

Education, income, and social, cultural, and gender norms are all structural forces that create enabling or restrictive contexts for individuals to effect change. Women's access to education and income-generating opportunities effects HIV prevention tactics as well as initiatives to reduce perceived HIV risk. Some young unmarried women are keen to finish their education and will use it as a bargaining chip to postpone marriage, maintain financial independence, and demand an HIV test with a partner before to marriage.

Despite the easy money earned through transactional sexual encounters, some women take steps to subsist through acceptable types of job in order to maintain self-respect and financial independence. Men have better access to cash and educational possibilities than women, with some utilising their wealth to buy sex from several women and others using their resources to improve their living conditions and protect their families from HIV.

Social learning

According to cognitive theories, men and women commonly take precautionary steps after learning from social contacts and experiences. Men and women participate in risk-reduction techniques due to a combination of their own past unpleasant or high risk experiences, fear of disease acquisition based on prior STIs, and seeing the behaviours of others, in addition to individual traits and structural and normative influences. Positive reinforcement and experiences, according to social learning theory, inspire people to repeat successful conduct.

This study also discovered that bad experiences (STI acquisition or an unfaithful spouse) can cause people to reconsider future actions, such as more careful partner selection and condom use with subsequent partners, in order to achieve desired good results, such as lower HIV risk.

Outcomes

Risk assessment and behaviour modification decisions are inextricably related to larger outcomes that influence not only HIV risk-reduction methods but also other factors. In some cases, focusing on broader outcomes may have more inherent value than lowering HIV risk. For example, males who do not provide financial assistance to other women in exchange for sex may do so primarily to conserve money and protect the well-being of their family, with HIV risk reduction as a secondary advantage. Similarly, some women who do not exchange sex for resources may be motivated by a desire to keep their social standing rather than a genuine fear of HIV.



DISCUSSION

This study indicated that power disparities in relationships impact whether women will talk safer sex, which is consistent with prior research from India and a range of settings in India and beyond. [68-70] Many notable gender and human sexuality theorists [71-74] emphasise the coexistence of many kinds of masculinity and femininity that, depending on experiences, might transcend sexes. In this study, men recreated widely recognised aspects of masculinity, such as the display of power by insisting on the use of protection with partners across diverse relationship types, in the context of HIV risk reduction. Similarly, women changed feminine stereotypes (i.e., passivity and reliance) by distancing themselves from dangerous situations by self-efficacious behaviours.

This study discovered that emotional intimacy, past experience, relationship dynamics, as well as peers and family, all have an impact on risk reduction efforts among men and women; yet, some of these elements can also exacerbate HIV risk. Peer influence, as previously observed, is typically founded in prevailing gender and social norms and can have either a favourable [75] or negative effect on health habits. [76,77] Some unmarried men in this study are doubting peer suggestions to participate in sex with multiple women, preferring to protect their primary spouse instead. According to studies from India, family influence has a very good impact on men and women seeking less risky sexual circumstances. [78,79] Unmarried males are affected by family members who encourage them to remain monogamous and follow family recommendations to use condoms. Parental guidance is also important in persuading unmarried women to stay abstinent in order to avoid disease transmission or finish school. Individuals in this study correlate a partner's endorsement of risk-reduction methods with emotional intimacy, showing altering norms around safe sexual conduct.

The findings complement a large body of evidence emphasising how gender discrepancies can put people at risk for HIV [80-82], but they also imply that these disparities do not prevent men and women from responding to perceived danger. Some elements are unique to particular circumstances, such as interpersonal dynamics, family advice, and prior experience, which influence both risk and risk reduction. Recognizing how such factors impact behaviour change toward risk reduction should widen their use, including sharing individual experiences with others via peer-to-peer initiatives. In addition, active attempts should be made to link risk reduction with other objectives that are important to the population, such as the desire to be a respected part of society, as this may affect behaviour and have greater intrinsic value than the consequent reduction in HIV risk.

Policy and Program Implications

The positive deviant instances in this study provided insight into the mechanisms driving risk-reduction activities among a distinct subgroup of men and women, regardless of their beliefs on gender norms. The extent to which positive deviant behaviour can be successfully replicated outside of the study setting appears promising, given that it draws on the experiences of individuals living in the same conditions (ie gender norms and poverty) as other community members, but barriers to reducing HIV risks have been overcome. As a result, such encounters may ring true for men and women in adjacent locations. Positive deviant cases, or men and women who take measures to reduce their perceived HIV risk despite often gender imbalanced norms and social views in this study, are all influenced by a common set of factors noted in the HARAR model, including: individual characteristics, family advice and support, observation, learning from past experiences, fear of infection, the need to protect oneself, a partner, or children, the association of riskreduction strategies, and the association of riskreduction strategies. These positive behaviour drivers might be incorporated into localised HIV interventions, building on the unique ways men and women engage in risk reduction.

When developing HIV prevention programmes, mediating factors that move in either direction should be carefully considered, with a focus on those that show strong positive trends toward risk reduction. The link between emotional intimacy and a partner's acceptance of risk-reduction methods, for example, shows a shift in norms around safe sexual activity that should be addressed in prevention campaigns. Some normative and social learning aspects are distinctive to circumstances, such as individual relationship dynamics, family counsel, prior experience, and observation, which affect both risk and risk reduction. Recognizing how such factors influence behaviour modification toward reduced risk should broaden their use, including sharing individual experiences with

www.jchr.org

JCHR (2023) 13(6), 3822-3835 | ISSN:2251-6727



others via peer to peer approaches, and engaging in dialogue on how these experiences can be applied to other people's situations by modelling positive family or couple behaviour. Mediating factors that suggest a significant push to behaviour modification, such as access to education (which might alter a woman's negotiating power over safe sex or access to income) or social support services for women who want to leave unsafe relationships, should be supported in the policy domain. In addition, deliberate efforts should be made to link risk reduction with other broad population outcomes such as "controlling money and resources" for the family's safety and financial well-being.

CONCLUSION

The HARAR methodology can be applied to other locations to help reduce HIV risk among rural women. Because gender norms are not static, but rather constantly changing, men and women's abilities to work within and challenge these norms to minimise HIV risk must be understood and included into programmes and policies. Although gender norms that balance out discrepancies between men and women may increase HIV risk in some situations, efforts should be made to promote gender equality in its own right and as a means of facilitating HIV risk reduction among men and women. Building on what men and women are already doing to minimise their risk will help programme and policy activities in many settings, as HIV responses will be rooted in local contexts and social realities.

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