INTRODUCTION

1 sida
2 sexualidad
3- Genero

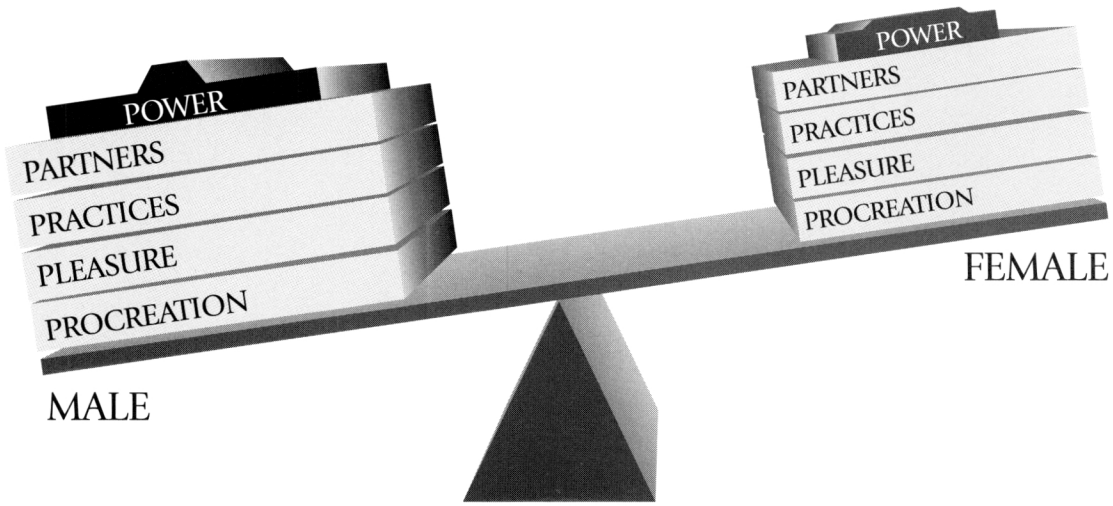
Since the emergence of the HIV/AIDS pandemic, important strides have been made in understanding the nature, scope, and impact of the disease on individuals, households, and communities worldwide. One of the most critical developments has been the recognition of the roles that sexuality and gender play in influencing the spread of the disease. While strides have been made in understanding how gender and sexuality affect women and men's vulnerability to HIV/AIDS, less is known about how to design and implement interventions that take into account these important behavioral determinants. To move forward, the complex concepts of sexuality and gender must first be deconstructed and defined, and only then can they be incorporated into prevention interventions.

What is Sexuality and Gender?

Sexuality encompasses an individual's feelings, desires, beliefs, and behaviors in light of socially accepted attitudes and norms governing sexual interactions with members of the same or opposite sex (Dixon-Mueller 1993). Understanding sexuality requires an exploration of the social networks in which people live both the sexual and non-sexual aspects of their lives (Gagnon and Parker 1995). Gender refers to the social construction of roles, responsibilities, and obligations associated with being a woman or a man. Gender roles and responsibilities vary over time and by class, caste, religion, ethnicity, and age (de Bruyn et al. 1995). While there are noticeable differences in what women and men are expected to do from one culture to the next, what is consistent across cultures is that there is a distinct difference between women's and men's spheres of functioning and their access to productive resources, such as income, land, credit, education, and decision-making authority (Sivard 1995; Mehra, Drost-Maasry, and Rahman 1995; Mehra 1995). Women and men's sexual lives, and hence their vulnerability to HIV/AIDS, are profoundly influenced by gender (Rao Gupta and Weiss 1993; de Bruyn et al. 1995; Elias and Heise 1995).

Studies conducted as part of the Women and AIDS Research Program of the International Center for Research on Women (ICRW) have made important contributions to the growing body of literature on gender, sexuality, and

The Role of Power in Sexual Decision-Making



HIV prevention. Funded by the U.S. Agency for International Development (USAID), the first phase of the program, from 1990 to 1993, supported 17 studies in 13 countries in Latin America and the Caribbean, Africa, and Asia and the Pacific.[1] The overall aim of the first set of studies was to learn more about the socioeconomic and cultural constraints that women face in adopting the behavioral recommendations that form the core of HIV prevention interventions. These recommendations are: abstain from sex, reduce the number of partners, use condoms consistently and correctly, and seek treatment for STDs. The program was also undertaken to examine the sexual lives of a wide range of women and men (different ages, socioeconomic backgrounds, and life circumstances) rather than only sex workers, who were the population most studied at the time.

The research provided information about five key elements of sexuality—what people do sexually (practices), with whom (partners), and the underlying determinants of pleasure, procreation, and power. In addition to increasing our understanding about these 5 Ps of sexuality, the findings revealed critical gender differences in the experience of each of these elements. Across the studies, findings showed that the power imbalance found in the economic and social spheres of life—with men having greater access to productive resources than women (Sivard 1995; Mehra, Drost-Maasry, and Rahman 1995; Mehra 1995)—are also reflected in heterosexual relationships. It was found that women have less control than men over the initiation of sex and the nature and conditions of each sexual encounter. The findings highlighted the critical role that power dynamics play in determining women's and men's sexual interactions, including whose pleasure and desire to bear children is given priority, who is able to adopt protective behaviors, and, ultimately, who is at risk of sexually transmitted diseases (STDs) and HIV/AIDS (see figure above).

[1] For a description of the studies, see Weiss, Whelan, and Rao Gupta 1996 or contact ICRW to receive a packet of reports-in-brief that summarize the findings from the 17 studies.

To date, HIV prevention programs have focused on some of these elements of sexuality, but without much attention to gender and power. For example, prevention programs promote condom use and a reduction in the number of sexual partners. Some programs focus on pleasure by eroticizing the condom or extolling sexual fulfillment through non-penetrative sex. While such messages are important, they do little to change the fundamental element of sexuality which lies at the root of women's vulnerability -- their limited power in sexual decision-making. The ICRW Phase I studies made clear that in order for prevention programs for adolescent and adult women to be successful, the gender power dynamics that underlie sexual relations must be addressed. The studies showed that women's lack of access to critical resources—such as information, skills, technologies, services, social support, and income—increases their vulnerability to HIV. Therefore, by increasing women's access to these resources, their power within the relationship could be enhanced and, hence, their ability to protect themselves from HIV/AIDS.

In 1993, Phase II of the Women and AIDS Research Program[2] was begun, with the goal of designing and testing interventions that incorporated a gender perspective. This second phase of the program supported seven research teams to build on their research conducted during Phase I, plus three new initiatives. These ten studies were conducted in eight countries and are described in the table on pages 16-17.

While the studies differed in their target audience and methods, an underlying common principle of the interventions was to provide resources to women that would enhance their power within the family, household, and community. These resources included information, skills, services, barrier methods, and peer support. Access to these resources was accomplished through HIV prevention activities in schools, workplace settings, community organizations, and STD and family planning services. The specific objectives of the interventions were to:

- increase awareness and knowledge about reproductive anatomy, HIV/AIDS, and STDs, and how gender roles influence sexual risk;
- improve partner, peer, and family communication about sexuality and HIV/AIDS;
- increase the use of barrier methods; and
- modify social norms to support women's role in sexual communication and decision-making.

An important methodological feature of the interventions was the use of small groups to increase knowledge and awareness among both women and men, to develop skills, and foster support for gender equity in sexual relations. The importance of group interactions as an intervention strategy for women emerged from the Phase I studies. During focus groups and group interviews, researchers noted that women were relieved that they could talk to their peers about their sexual relationships and the consequences of communicating with their partners about reducing their risk of HIV/AIDS. Women also noted that they derived strength from sharing their experiences with other women and as a

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[2] USAID's offices of Health and Nutrition, and Women in Development provided ICRW with additional funds to support research teams to use the findings generated from Phase I.

result felt less isolated. Such opportunities enable women to see that they are not alone with regard to their fears and worries, and permit them to try out new behaviors in a non-threatening environment (Rao Gupta and Weiss 1993). Other research has shown that small groups provide a context for not only increasing knowledge and improving skills, but for the construction of social norms that influence individual attitudes and behavior (DiClemente and Wingwood 1995; Golub 1998).

In Phase II, the small group interventions engaged participants in discussions of gender-related attitudes, values, and norms governing relationships, communication, and sexual behavior. The small groups also provided a forum to develop skills for sexual risk reduction, including analysis of risky behaviors and situations, decision-making, communication, and condom use. Opportunities to develop communication skills included group discussions with same-sex and opposite-sex peers about HIV-related topics. These discussions provided the context for sharing of ideas, attitudes, and beliefs; for expressing and considering different perspectives on sexual issues; and for negotiating agreement or consensus on controversial topics.

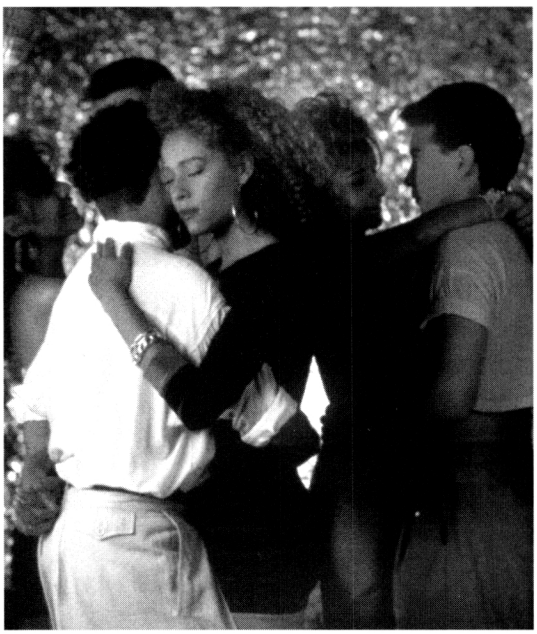

Photo Courtesy of Johns Hopkins University Population Communication Services, and PROFAMILIA.

While there has been some research on the role of groups in positively influencing knowledge, attitudes, and behavior associated with HIV prevention among women in the United States (Kelly et al. 1994; Weeks et al. 1995; Wingwood and DiClemente 1996; Kelley et al. 1997), there has been little research in developing countries that examines the outcomes of group-based interventions that reflect a gender perspective. This report describes the findings from the Phase II studies with a particular emphasis on how the group-based interventions addressed gender and sexuality. While the studies' findings, in most cases, cannot be generalized to the larger population, collectively they provide important information about how to design interventions that meet women's needs.

The first section of this paper presents findings from the formative research that guided the content of the interventions. The second section focuses on the challenges in evaluating group-based interventions and presents research findings pertaining to the acceptability of the interventions and the outcomes on participants. The third section discusses lessons learned for ensuring effective group process. The final section summarizes the major findings and discusses the implications of the research for strengthening and scaling-up interventions that reflect a gender and sexuality approach to HIV prevention.

Key Findings from the Formative Research

As part of each study, formative research was conducted to explore the gender-related barriers that influence HIV risk and the adoption of risk-reduction behaviors. Researchers used primarily qualitative methods to learn more about knowledge, attitudes, norms, and behaviors common among the target audiences. This information was in turn used to develop intervention content and methodology.

Described in this section are the key findings that emerged from the formative research conducted as part of Phases I and II and the intervention content and activities that were developed based on the findings.

Women Lack Knowledge About Sexual and Reproductive Health

The research showed that women and men lack basic information about reproductive anatomy, STDs, and the relationship between sexual practices and risk. For women, this lack of information is promulgated by social norms which dictate that "good women" should not know about such topics. In order to change this perception, the interventions provided women with information on a broad range of topics and emphasized the importance of information-seeking behavior to women's health and well-being. In Thailand, for example, materials that explained the functioning of women's sexual and reproductive organs, emotional and biological signs of puberty, signs and symptoms of STDs and reproductive tract infections (RTIs), and contraception were developed for use by peer educators with factory workers. The peer educators reported that this resource filled an important gap in knowledge among their peers (Cash et al. 1997). In South Africa, as part of a group intervention with STD patients, participants were shown a visual model of a woman's reproductive anatomy. Females as well as males expressed amazement when shown the model. They stated that the information helped them understand why condoms would not "get lost up inside." Seeing a visual representation of the female anatomy reassured the women and men about the safety of male and female condoms (Hadden 1997).

As a result of family, social, and peer influences, sexual experience is seen as a desired goal for boys and linked to their developing concept of masculinity.

Ethnographic research conducted in Senegal revealed that walking barefoot on the urine of someone who has an STD, encountering a "bad wind," and being the victim of a curse were commonly believed to be causes of STDs. As part of the intervention, members of two traditional women's associations—the Dimba and Laobé—were taught to recognize the signs and symptoms of an STD and the link between transmission of STDs and sexual relations. Correct information about STD transmission and STD symptoms was communicated by the Dimba and Laobé during community rituals and small group discussions. Qualitative data collected from participants reached by the Dimba and Laobé suggest that the intervention had an effect on women's knowledge of STDs and health-seeking behavior. For example, the wife of a neighborhood chief said:

> *Before I thought lower abdominal pain was normal for women of reproductive age. But now with the discussions and ceremonies initiated by the Dimba, I am aware that this pain could be an STD and could make me more at risk of getting AIDS. This is why I go to the clinic, as do many of my friends (Niang et al. 1997).*

Traditional Notions of Virginity Contribute to Sexual Risk

Findings from the formative research with youth revealed important gender differences in societal norms governing premarital sexual activity and the importance of virginity before marriage. In countries such as Brazil, Zimbabwe, and Sri Lanka, a high value is placed on maintaining a girl's virginity prior to marriage. But in addition to reflecting a physiological condition, a girl's virginity is associated with being passive and ignorant about sexual matters. In societies that promote a culture of silence, girls are reluctant to seek information for fear they will be suspected of being sexually active. At the same time, adults are not forthcoming about sexual information for fear that this will lead to sexual activity. Girls face tremendous social pressure to maintain an image of virginity and innocence regardless of the true extent of their knowledge or sexual experience. They are, therefore, reluctant to take precautions against pregnancy, STDs, and HIV because this would imply an active sexual life. Boys encounter fewer restrictions regarding their own sexual behavior. As a result of family social, and peer influences, sexual experience is seen as a desired goal for boys and linked to their developing concept of masculinity. Starting sexual activity during adolescence is a socially acceptable facet of masculinity but with potentially high health consequences, such as HIV/AIDS and other STDs (Weiss, Whelan, and Rao Gupta 1996).

All of the studies with youth recognized the importance of addressing gender-related attitudes and norms regarding virginity and premarital sex, and did so in different ways. In Sri Lanka, peer educators facilitated a discussion with their peer groups about the social versus biological meanings of virginity, and critically analyzed the relationship between specific sexual behaviors—e.g. kissing, interfemoral sex (rubbing the penis between the partners' thighs), oral sex, or vaginal intercourse—and social and health consequences such as loss of virginity, HIV/AIDS, and pregnancy (Silva et al. 1997). In Zimbabwe, secondary school students were asked to clarify their values regarding premarital sex and to explore how the concept of virginity differed for males and females (Woelk, Tromp, and Mataure 1997).

In the Recife, Brazil study, focus group discussions and in-depth interviews conducted with adolescent females, their mothers, and boyfriends revealed that an adolescent girl's sense of self-esteem, her relationship with her mother, her image in the community, and her expectations for the future are strongly influenced by the cultural norm that young women should remain virgins until marriage. Girls themselves are torn between behaving as good daughters, on the one hand, and their own sexual desires and need for autonomy, on the other. The young male informants also valued virginity among females because they associated girls who marry as virgins as being more submissive to their husbands. "The virgin girl, she is more captive; she goes by her man," according to one Brazilian male. In addition, formative research revealed that female and male adolescents view anal sex as a way for girls to preserve their virginity and believe that a woman will not contract HIV through anal sex. Although the prevalence of anal sex could not be assessed from the focus group and in-depth interview data, some boys revealed a preference for anal sex, associating it with greater satisfaction: "If a woman doesn't practice anal sex with me, I get angry...because vaginal sex for me, today, we only find it loose, loose, loose" (Vasconcelos et al. 1997).

The booklet ("The Story of Maria") developed by the peer educators in Recife, Brazil, for use with their peer groups included a chapter that explored the various pressures exerted on a girl--by the family and community to maintain her virginity, by her boyfriend to have sex, and by her own desires for autonomy. The goal of this chapter was to help young women make an informed decision about becoming sexually active outside of marriage, and to question traditional gender norms and ideas about virginity and its relationship to sexual risk. According to one female participant in the peer education program:

> *The chapter that I thought was the most interesting was the one about the girl and the unfaithfulness of men, because it was true that the man went out and had sex before he got married because the girl was a virgin...I think this is wrong, it's disrespectful...A woman has her needs, men say they have them too but a woman manages to wait, and why can't they?*

The booklet also addressed the risks of anal sex. Findings from the group interviews held with participants at the end of the program confirmed the relevance of including this topic. For example, when asked what was the most important thing they learned, one peer education participant replied: "I didn't know that a person could get AIDS from anal sex, too because lots of girls have anal sex so they won't get pregnant or lose their virginity." The fact that the risks of anal sex were raised spontaneously is important not only because it indicates new knowledge, but also a willingness to discuss a topic generally considered taboo (Vasconcelos et al. 1997).

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Social Norms Limit Communication About Sex

Another important theme that emerged from the formative research and guided intervention design was that of communication. Several studies revealed that social norms are not supportive of communication about sexual topics by women, particularly those who are unmarried. Among adolescent male factory workers in Thailand, for ex-

ample, a girl's social presentation of politeness, inexperience, innocence, and lack of assertiveness were valued qualities. According to one boy, "In order for there to be a serious relationship, a girl must be neat, housewife-like, clean, and not talkative." Both males and females felt that a girl who makes a request for condom use would be perceived as "bad," "unclean," "promiscuous," or "easy." During the peer leader training, the female peer leaders said that a variety of fears (of a boy's anger, being looked down on, being perceived as having had sex before, losing the relationship, or of being gossiped about) prevent girls from communicating about HIV/AIDS, sex, and prevention behaviors. The male peer leaders said that boys also feared communicating about sex, but for different reasons. Boys were worried primarily about committing themselves to a relationship. They also said they were afraid to talk about their sexual history because if girls knew, they would not have sex with them. In addition, boys noted that "when you have sex there is no talk, just immediate emotion." Both girls and boys also felt that alcohol inhibits safe sex behavior: "It makes us feel brave and shameless" (Cash et al. 1997).

[Boys] said they were afraid to talk about their sexual history because if girls knew, they would not have sex with them.

The research team in Thailand used these findings to create comics and storybooks that included male and female characters whose attitudes and behaviors reflected prevailing norms about communication, sex, and HIV prevention. During training of the peer educators and the small groups they facilitated, participants discussed and debated these portrayals. Among the female and male factory workers reached by the program, these discussions increased understanding of how traditional notions of male and female behavior contribute to a lack of communication between partners and to HIV risk. The discussions also contributed to increased peer and partner communication about HIV/AIDS and risk-reduction strategies (Cash et al. 1997).

As in Thailand, young women in Recife, Brazil, reported that there is little serious communication with their boyfriends about sex. They noted that they learn how to touch and kiss, and perform other sexual practices from their boyfriends. Some girls pointed out that there is a great deal of resistance on the part of boys to serious discussions about HIV, STDs, and related sexual issues. As one girl noted: "There are some that talk like this: 'You want to learn about sex? We'll explain it to you. Let's go over there and we'll show you how it is done.'" The booklet used in the peer groups, "The Story of Maria," modeled boyfriend-girlfriend communication as well as mother-daughter communication, and the group-based discussion sessions focused on overcoming barriers for girls to talk about sex with their partners, peers, and families. Qualitative data collected from participants at the end of the program revealed that communication with mothers, and to some extent with partners, had improved (Vasconcelos et al. 1997).

Communication was also found to be problematic among adults. Formative research showed that social norms were not supportive of adult women communicating with their partners about sexual pleasure, condom use, and fidelity. The women wanted increased communication with their partners and to be better informed about sexual health. In Senegal, as part of large group public ceremonies and small group discussions, the Dimba, a traditional

women's association that focuses on fertility, emphasized the importance of communication by women -- to "let women speak" and "listen to women" (Niang et al. 1997). In São Paolo, a pamphlet entitled "Ousadia! Prazer de Vivir" (Courage! Pleasure for Living) was developed for use with small groups of women. The pamphlet poses questions for discussion about sexual communication in the context of relationships, gender roles, and women's rights. Findings showed that for a small number of women, participation in the women-only groups led to increased communication with their partners about what gives them pleasure and about condom use (Bonciani and Rodrigues de Morais 1997).

In the South Africa study, partner communication was an important theme in the four discussion sessions (the first three single-sex and the fourth, mixed-sex) with small groups of male and female STD patients. For example, the themes of the single-sex sessions were: "How do I ask my partner to use protection?" and "How can my partner and I protect ourselves and still have a baby if we want one?" Despite the cultural barriers to communication, women liked roleplaying how to ask their partners to accept using a male or female condom. Findings from the evaluation showed that the use of barrier methods (i.e. male condom, female condom, and spermicide) did increase significantly among the women who participated in the four-session intervention as compared to women in the control group who received a single talk about HIV/AIDS and STDs (Hadden 1997).

Fear of Violence Acts as a Barrier to HIV Prevention for Women

The formative research revealed that one of the barriers women face in suggesting condom use is fear of a violent reaction from their partners. Female STD patients participating in focus groups and in-depth inter-

Members of the Dimba, a traditional women's association in Senegal

The session also included roleplays in which men took the role of women and talked about how it felt to be beaten up for requesting condoms.

views in the South Africa study noted that they were generally able to initiate discussions on HIV/AIDS but not on condom use. According to one informant, "Zulu women do not tell their sexual partners what to do." Another stated "If I just mention the word condom he will hit me." Within a steady relationship the suggestion of condom use implies promiscuity. Female informants noted that women whose fidelity was doubted feared being assaulted and even abandoned. Male STD patients who were interviewed considered "steady partners" to be women who were "well-behaved." By this they meant a woman who did not sleep around, who obeyed her male sexual partner, who did not question his sexual behavior, and who took care of him (Hadden 1997).

The South Africa project addressed gender-based violence in the context of condom negotiation by asking male and female STD clients who participated in the last of four group sessions to first share their personal experiences related to the issue. Women expressed their pain and anger about situations in which they were physically abused after asking their partners to use a male condom. The men somberly recalled their own experiences in which they had beaten up or verbally abused a sexual partner who asked them to use a condom. Lively discussion from both women and men followed their sharing of personal experiences. The session also included roleplays in which men took the role of women and talked to their partners about how it felt to be beaten up for requesting condoms. Group facilitators reported that the sessions were very successful in engaging participants in discussion and that the men took their roles very seriously. One facilitator noted: "The men showed feeling; they were not laughing at the women" (Hadden 1997).

In sum, the studies highlighted the importance of conducting formative research to identify gender-related barriers to HIV prevention such as lack of information about sexual health, lack of understanding about the consequences of sexual practices, the presence of social norms that limit sexual communication and information-seeking behavior, and the threat of sexual coercion and violence. The studies also demonstrated the importance and feasibility of transforming these findings into intervention content and activities that incorporate a gender perspective.

Evaluating Intervention Outcomes

The studies faced numerous challenges common to small-scale research and intervention initiatives in assessing outcomes on participants, such as improved knowledge, attitudes, skills, and behaviors. These challenges included funding and time limitations, difficulty in collecting follow-up data on participants, and field realities that interfered with planned data collection and intervention implementation. Despite these various challenges, the research teams gained important insights into evaluating group-based interventions.

Methodological Lessons Learned

The original aim of the Mexico study was to compare different interventions for increasing and improving communication about sexuality and STD/HIV prevention between parents and their adolescent children. The different interventions for parents included a video and an instructional course that included the showing of the video. It was envisioned that these parental interventions would be randomly assigned to third-year classes of secondary schools. Despite initial interest, it was difficult to recruit parents to both see the video and to attend the course. Moreover, although both parents were invited, only a few fathers viewed the video and none attended the course. Nonetheless, even though the groups were self-selected, the study obtained important information about parents' motivations for participation and the extent to which their participation had a positive impact on communication as perceived by their sons and daughters (Givaudan, Pick, and Proctor 1997).

This study, as well as others, illustrated the importance of using multiple methods of data collection, including qualitative methods, to allow for the corroboration and further elucidation of findings. To assess the outcomes of the peer education intervention in Thailand, the researchers administered a questionnaire to unmarried factory workers to assess changes from pre- to post-intervention and conducted in-depth, unstructured interviews with couples, where one or both partners had participated in the intervention. For the pre-post instrument, unmarried factory workers listened to pre-recorded conversations between a couple or groups of adolescents and were asked to identify whether the attitudes and behaviors portrayed in the conversations were problematic in terms of sexual risk and why. To help them

understand the scenario, respondents were also given the text of the dialogue. The questionnaire aimed to measure cognitive changes in respondents' ability to identify risky situations and to explain what youth should and should not do to reduce the risk of HIV/AIDS. In contrast, the in-depth, unstructured interview format allowed for a more complete picture of the situational and contextual factors that impact on beliefs and behaviors. The interviews elicited respondents' own experiences with regard to partner communication and risk-reduction behavior and the challenges and contradictions between knowledge and practice the respondents face. For example, one young woman acknowledged that she had sex with her boyfriend "but we never use a condom because I am confident that he is free from AIDS." While the in-depth interview showed that she was not using condoms even though she recognized their role in HIV prevention, it did reveal that she asked her partner if he had sex with sex workers. He in turn replied that he had seen many people die of AIDS in his village and that while he went drinking with his friends he didn't go to prostitutes. These data indicate that the woman attempted to protect herself by communicating with her partner, although she did not opt for negotiating condom use, a more protective strategy (Cash et al. 1997).

Similarly, the qualitative data collected as part of the Salvador, Brazil study with family planning clients provided important insights into the context of condom use of women who participated in the clinic-based discussion group. When asked whether they used condoms in general, 30 out of 47 (64 percent) women interviewed said they did. Upon further questioning, it was revealed that about half of the women said they used condoms at every sexual encounter. For the other half, condom use was inconsistent—these women said they used condoms when they were fertile, when their partner agreed, when they felt their partner had been unfaithful, when undergoing medical treatment for a vaginal infection (including an STD), when they felt like it, or when they had extramarital sex. One example of this inconsistent use was a 31-year-old, in-union woman who said that she used condoms for HIV prevention but also noted, "I haven't been using the condom because it is causing a little irritation on my vagina" (Badiani, de Mello e Souza, and Becker 1997).

For many of the studies, documentation of the content of group sessions and the responses of participants was an important methodological tool for assessing program acceptability, individual experiences, and changes in group norms and attitudes. It also indicated whether the intervention was being implemented as planned, which had important implications for the interpretation of outcome data. In the Sri Lanka study, monitoring the discussion content over time revealed increased support among young men regarding the appropriateness of sexual communication between partners and the value of mixed-sex sessions for promoting negotiation and consensus-building among males and females (Silva et al. 1997). Documentation and analysis of group sessions in the South Africa study provided insights about women's successes and failures with getting their partners to use either the male or female condom between the group sessions and how their experiences with negotiating barrier methods changed over time (Hadden 1997).

Intervention Outcomes

This section focuses on the findings that pertain to some of the intervention outcomes measured by the studies. These include the acceptability of the intervention, session attendance, communication about sex and HIV/AIDS, condom use, and perceptions of male/female relationships.

Acceptability of Discussing Gender and Sexuality

While the studies varied in the way they addressed gender, sexuality, and HIV/AIDS, research results generally support the acceptability of discussing these topics in different contexts such as schools, clinics, workplace settings, and the community. The Zimbabwe study, for example, showed that teachers and students responded well to discussing the dilemmas faced by young people growing up in an era of HIV/AIDS. Data from a self-administered questionnaire and face-to-face interviews with teachers showed that they were pleased with their new role in helping students explore their feelings and values about relationships and sexuality through the use of non-didactic methods—methods that are rarely found in school-based family life education programs. Observation of classroom sessions revealed that approximately three-fourths of the teachers who had undergone training were successfully using participatory methods in the classroom to engage their students in discussions about HIV/AIDS, relationships, and sexuality. The majority of students who participated in group interviews were also supportive of how AIDS education was being addressed in the classroom and were pleased with the way their teachers facilitated the classroom discussions instead of using a lecture format (Woelk, Tromp, and Mataure 1997).

In the Salvador, Brazil study, the vast majority of clients waiting for reproductive health services agreed to participate in the hour-long group discussion and the proportion of participants who attended two or more times increased from 12 percent in 1995 to 22 percent in 1996. Observation data showed that the counselor was very skilled in eliciting discussion from clients about gender and sexuality through the use of the booklets and other participatory techniques and that there was a high level of participation in many of the groups observed. She also managed to include a substantial amount of information while helping clients to feel comfortable sharing their personal experiences and feelings related to sexuality, relationships, HIV/AIDS, and STDs. Data from exit interviews and in-depth interviews conducted two months after the clinic visit revealed that clients appreciated the discussion group and that, for many, the group is what they liked most about the clinic. They noted that it was a chance for them to reflect on their relationships and their sexuality, and to see that they have much in common with other women. Among the things they considered most important about the group was talking and learning more about HIV/AIDS, condoms, STDs, family planning, and women's rights (Badiani, de Mello e Souza, and Becker 1997).

In Senegal, community residents who participated in group discussions organized by the Dimba and Laobé were pleased with the quality of the information they received and welcomed the opportunity to speak about their own health problems and sexuality with others. According to one woman who had participated in a mixed-sex discussion group organized by the Dimba: "It is the first time

that we have been given a chance to speak in such detail about our sexual problems with the men, even though we interact with them every day. These sessions made it possible for us to better know them and for them to better know us" (Niang et al. 1997).

"It is the first time that we have been given a chance to speak in such detail about our sexual problems with the men, even though we interact with them every day."

While there was wide satisfaction with the various interventions among those who participated, actual attendance in multiple group sessions varied across the studies. In the São Paolo, Brazil study, the process of forming and maintaining the groups of adolescent and adult women to talk about sexuality and HIV prevention proved to be more difficult than anticipated. For all five groups of women, attendance decreased with each session. The researchers who conducted the study and also facilitated the three-session group intervention concluded that because the epidemic is still very distant in the lives of the low-income women targeted for this intervention, spending time to discuss HIV prevention, even in the context of sexuality, was not a high priority. Economic issues, neighborhood violence, and drug use among their children were more immediate concerns in their lives. The project was most successful, however, in engaging women who already were part of organized groups (Bonciani and Rodrigues de Morais 1997).

In contrast, participant attendance in the peer education intervention in Recife, Brazil, was more consistent; nearly 80 percent of the 145 young women (mean age of 15 years) recruited participated in all of the ten group sessions. Factors that may explain the high retention in this study include training adolescents to be educators of their peers, having two peer educators work together to facilitate each group, recruiting the peer educators' friends into the program, and working with the peer educators to develop a structured curriculum ("The Story of Maria") that dealt with issues relevant to the lives of the young women targeted (Vasconcelos et al. 1997).

Two of the studies—South Africa and Sri Lanka—found gender differences with regard to participation in multiple-session group-based interventions. While attendance by STD patients in each of the four sessions held at the STD clinic was generally good in the South Africa study, session attendance was somewhat higher among females than among males. For the 51 women enrolled in the study, attendance at each of the three single-sex sessions ranged from 34 to 42. For the 50 men enrolled, attendance ranged from 24 to 32. For the fourth mixed-sex session, 38 women attended as compared to 26 men (Hadden 1997). Similarly, the Sri Lanka study reported retention of males was less than females. The male peer educators initially recruited 27 unmarried males for each of two male groups but retained only 10 and 17. The female peer educators recruited members in smaller numbers -- ranging from five to nine for the six female groups -- and retained almost all of them. This is particularly noteworthy because several female participants indicated parental concern about their involvement in the program. Explanation of the program to the youth and their families by the community public health worker and her presence at all program activities may explain why no young, unmarried woman was prohibited by her parents from participating. The lower rate of retention for males was attributed to poor motivation and scheduling conflicts with sports activities. While almost all of the females

attended at least six sessions, only half of the males attended at least six sessions (Silva et al. 1997). While both the Sri Lanka and South Africa studies reported that males and females expressed satisfaction with their respective intervention, the data suggest there are more competing priorities for males than for females in these two contexts.

While the number of studies is too small to generalize, the findings raise concerns about time and opportunity costs as well as interest in attending a multi-session group intervention by adolescent and adult males as well as by adult females.

Communication about Sex and HIV/AIDS

Across the studies, the findings showed that the interventions had a positive impact on partner communication among the group educators/facilitators as well as those they reached. For example, the Senegal researchers reported that the training of the Laobé to incorporate HIV/AIDS prevention messages into their community-wide ceremonies and small group discussions had a positive effect on communication with their partners. According to one Laobé woman:

> *Some time after the training, my husband returned from a trip and during the erotic play that I had learned from the other Laobé, I looked at his penis. I realized that there was a small pimple on it. I did not say anything to him and I continued to excite him until he came without penetrating me. After that I led him into a discussion of his extramarital affairs, STDs, the need for him to seek care, and told him that in the meantime he needed to use a condom (Niang et al. 1997).*

Other studies also reported increased partner communication among women who do not have as much social license to speak about sex as the Laobé. In the Salvador, Brazil study more than half of the women interviewed two months after their participation in the clinic-based discussion group reported talking with their partner about the themes raised in the group. Women reported that the group made it easier for them to communicate with their partners, as well as others, about sexuality and reproductive health issues. Some women stated that being better informed fostered communication. Others, particularly shy women, highlighted that the modeling and roleplaying conducted during the group made them more at ease in broaching the issues. Although the study did not collect pre-intervention data, some women attributed more consistent use of condoms, giving their partners condoms, or telling their partners to use condoms during extramarital sexual encounters to their participation in the women's discussion group. In addition to evidence of increased communication with partners, the discussion group had a positive impact on provider-client communication as perceived by the providers. Medical staff reported that compared to women who had not participated in the discussion group, those who did tended to present specific concerns or questions, be more active in the provider-client relationship, and be better informed (Badiani, de Mello e Souza, and Becker 1997).

Women reported that the group made it easier for them to communicate with their partners, as well as others, about sexuality and reproductive health issues.

In the Thailand study of unmarried factory workers, a comparison of pre- and post-intervention data revealed improvements in the female adolescents' ability to explain why it is important to communicate about HIV/AIDS and safer sex, and to suggest ways to

Summary Description of Studies Supported by Phase II of the Women and AIDS Research Program

	Country	Study	Report Authors and Institutional Affiliation	Study Objectives
AFRICA	**Kenya**	Assessing the Outcome of a Workshop on Women and HIV/AIDS for District Level Policy-Makers in Kenya	R. Nduati, J. Makokha, and R. Kamau Network of AIDS Researchers of Eastern and Southern Africa (NARESA)	▸ Increase workshop participants' knowledge and awareness about gender-related factors that influence HIV risk ▸ Examine extent to which research findings and best practices presented at workshop were integrated into district-level HIV/AIDS activities
	South Africa	An HIV/AIDS Prevention Intervention with Female and Male STD Patients in a Peri-Urban Settlement in KwaZulu/Natal, South Africa	B. Hadden Columbia University University of Natal	▸ Collect qualitative data on sexual attitudes and behaviors from female and male STD clinic patients ▸ Develop and test a four-session, small group intervention—including STD treatment and distribution of barrier methods—to reduce sexual risk behavior
	Senegal	An Evaluation of HIV Prevention Interventions Utilizing Traditional Women's Associations in Senegal	C. Niang, H. Benga, A. Diagne Camara, A. Ndiaye, R. Nguer, and Y. Thiam Université Cheikh Anta Diop	▸ Integrate STD/HIV education and condom distribution into traditional community interactions of the Dimba and Laobé ▸ Determine acceptability of activities by the community ▸ Assess changes in knowledge, communication, and sexual and health-seeking behavior
	Zimbabwe	Training Teachers to Lead Discussion Groups on HIV/AIDS Prevention with Adolescents in Zimbabwe	G. Woelk, M. Tromp, and P. Mataure Department of Community Medicine, University of Zimbabwe	▸ Improve adolescents' knowledge, attitudes, skills, and behavior associated with HIV prevention ▸ Train teachers to use participatory methods to explore relationships, sexuality, and HIV/AIDS with students ▸ Assess intervention outcomes on students and teachers
ASIA & THE PACIFIC	**Sri Lanka**	Youth and Sexual Risk in Sri Lanka	K.T. Silva, S.L. Schensul, J.J. Schensul, B. Nastasi, M.W.A de Silva, C. Sivayoganathan, P. Ratnayake, P. Wedsinghe, J. Lewis, M. Eisenberg, and H. Aponso Center for Intersectoral Community Health Studies, University of Peradeniya; Center for International Community Health Studies, University of Connecticut; Institute for Community Research.	▸ Assess attitudes, beliefs, and knowledge of unmarried youth with regard to sexuality and HIV/AIDS ▸ Describe youths' sexual behaviors ▸ Utilize data to design, implement. and evaluate pilot intervention for community youth
	Thailand	AIDS Prevention through Peer Education for Northern Thai Single Migratory Factory Workers	K. Cash, J. Sanguansermsri, W. Busayawong, and P. Chuamanochan Department of Pharmacy, Chiang Mai University	▸ Expand peer education program for factory youth ▸ Compare effectiveness of peer education in single-sex versus mixed-sex groups on young women's understanding of sexual risk and on partner communication
LATIN AMERICA & THE CARIBBEAN	**Brazil**	Sexuality and AIDS Prevention among Adolescents in Recife, Brazil	A. Vasconcelos, V. Garcia, M.C. Mendonça, M. Pacheco, M. das Graças Braga Pires, C. Tassitano, and C. Garcia Centro da Criança e do Adolescente (Casa de Passagem)	▸ Understand adolescents' conceptions of virginity, marriage, fidelity, self-esteem, and autonomy ▸ Identify obstacles to condom use, and mother-daughter and partner communication. ▸ Design a participatory peer educator training program for female adolescents ▸ Document and analyze program outcomes
	Brazil	Sharing Experiences: Empowering and Educating Low-Income Women on HIV Prevention in São Paolo, Brazil	R. Rodrigues de Morais, R.D.F. Bonciani, and W. Vilela Coletivo Feminista Sexualidade e Saúde	▸ Assess the efficacy of a pamphlet to stimulate discussion on gender roles and relationships, sexuality, and HIV/AIDS prevention among women ▸ Assess whether three-session group intervention improved women's knowledge, attitudes, and patterns of communication
	Brazil	Sexual Health and STD/HIV Prevention: A Qualitative Evaluation of Integrating Clinical and Educational Interventions in Salvador Clinic	R. Badiani, C de Mello e Souza, and J. Becker Sociedade Civil Bem-estar Familiar No Brasil (BEMFAM), Universidade Federal do Rio de Janeiro, IPPF/WHR	▸ Identify providers' and clients' attitudes toward service integration and the women's discussion group ▸ Determine clients' perceptions of the impact of the discussion group on their knowledge, attitudes, communication patterns, and self-care behavior
	Mexico	Strengthening Parent/Child Communication: an AIDS Prevention Strategy for Adolescents in Mexico City	M. Givaudan, S. Pick, and L. Proctor Instituto Mexicano de Investigación de Familia y Poblacion (IMIFAP)	▸ Develop video for parents and adolescents and course for parents to promote communication about sexuality and STD/HIV prevention ▸ Compare different levels of treatment for increasing and improving communication between parents and adolescent sons and daughters

Description of the Intervention	Methodology
Three District Health Management Teams (DHMTs) and three NGOs participated in a 4-day workshop. Information on HIV/AIDS, STDs, and gender was presented and existing programs with a gender focus were discussed. Participants developed one-year workplans for the initiation of gender-sensitive HIV/AIDS activities.	In-depth interviews conducted with 16 participants nine months after the workshop, to determine their perceptions of the usefulness of the workshop and the extent to which the workplan activities were initiated.
Four weekly 90- minute, small-group sessions (first three were single-sex, fourth co-ed). Sessions emphasized modeling, role playing, and problem solving. Control group received a single, information-only session. Intervention and control groups also received access to barrier methods and STD treatment.	50 men and 51 women enrolled in both the intervention and control groups. Participants interviewed at baseline and at post-intervention four weeks later. A process evaluation conducted throughout the implementation of the intervention. 47 women and 36 men in the intervention group and 34 women and men in the control group interviewed post-intervention.
Training the Dimba and Laobé on STD/HIV prevention, developing prevention messages and incorporating them into community-wide ceremonies, conducting small group discussions with community residents, and promoting and distributing condoms. Intervention conducted with the Dimba in Kolda and with the Laobé in Kaolack.	Interviews conducted with the Dimba and Laobé, and with community residents who attended the ceremonies and group discussions. A questionnaire administered to a random sample of adults living in intervention and control neighborhoods in each city, before and after project activities were carried out. Sample size: 200 women and 200 men in Kolda and 100 women and 100 men in Kaolack.
Seven workshops conducted in which 95 teachers from 43 schools participated. Teachers also provided with resource materials. Two follow-up workshops conducted to share experiences in the classroom and community.	Classroom observation, interviews with teachers and headmasters, and a self-administered questionnaire sent to teachers. Form 3 students from eight project and eight control schools completed a self-administered questionnaire at the beginning of the school year and seven months later. Discussion groups also conducted with 100 students from ten project schools.
Female and male peer educators conducted ten sessions—nine in same-sex groups and the tenth in mixed-sex groups—with unmarried, community youth.	39 females and 27 males completed questionnaires before and after group sessions. Post-intervention group interviews with peer educators and participants. Systematic documentation of group sessions also conducted.
Female and male peer educators trained to conduct educational activities with single-sex and mixed-sex groups of unmarried factory workers. Peer-led activities carried out over a three-month period.	120 females completed pre-intervention and 97 post-intervention interviews. In-depth interviews conducted with 12 couples to explore changes in partner communication and adoption of risk-reduction strategies. Peer leaders also interviewed about their experiences.
Teams of two peer educators, aged 13 to 19, recruited 145 adolescent females to participate in a series of 9 weekly group sessions to discuss "The Story of Maria," a curriculum the peer educators helped to develop.	Weekly process evaluation conducted with peer educators. Focus groups conducted with peer educators and a subset of participants post-intervention. Questionnaire administered to participants to assess their opinions of the program and the skills of the peer educators.
Three sessions held weekly with each of five groups of adolescent or adult women. A pamphlet, "Courage! Pleasure for Living" used to guide sessions and stimulate discussion. Women offered condoms at each intervention session.	42 participants interviewed pre-intervention and 19 interviewed two months post-intervention. Discussion topics and level of participation documented for each session.
Staff trained to improve their knowledge, skills, comfort level, and confidence in discussing sexuality and STD/HIV prevention with clients. A women's discussion group implemented for clients waiting for reproductive health services. Condoms offered to participants.	Data collected from client records and service statistics. In-depth, semi-structured interviews conducted with clinic staff (9). Brief exit interviews (29) and in-depth interviews (47) conducted with women's discussion group participants. Observation of discussion groups and client/provider interactions also conducted.
Group 1: Students received sexual and family life education course (SFLE) and saw video promoting parent/child communication. Parents invited to attend 9- session course and see video. Group 2: Students received SFLE course and saw video; parents invited to see video. Group 3: Students received SFLE and video; parents received no intervention during research period. Group 4: Students and parents received no intervention during research period.	Data collected via structured interview from students and parents prior to and 3 months after intervention. Self-administered questionnaire also given to parents to examine their opinions of the course and/or video.

raise these topics with male partners. For example, the pre-intervention interview revealed that half the respondents had no idea how girls could communicate with boys about STD and HIV/AIDS prevention. At follow-up, almost all of the respondents offered suggestions on how to improve partner communication. Before the intervention only 20 percent agreed that it was appropriate for a girl to ask a boy about his past sexual experiences, and only half of these could explain why it was important. After the intervention, more than three-fourths felt it was appropriate and all could offer reasons in support of their opinion.

"After the education, I can talk [to my partner] about AIDS without reluctance."

Data from in-depth interviews with 12 Thai couples (in which one or both partners had participated in the peer education intervention) provided important information about whether participants had applied their increased awareness about the importance of communication to their behavior. Although the sample was small, all participants reported that communication with their partners about safer sex and HIV/AIDS had improved. According to one girl who had participated in the program but whose partner had not: "At the beginning we were shy to talk about sexual relations. We thought if we get married we will be talking about it. After the education, I can talk about AIDS without reluctance." Some young women talked to their partners about not going to brothels, asked them to use condoms if they did, or to be faithful, and they reported that their partners were receptive to their requests. HIV testing was also discussed and was seriously considered by male and female respondents, particularly to be done prior to marriage. According to one male whose partner had participated in the peer education intervention: "She talks to me about AIDS frequently. I will get a blood test when we decide to marry" (Cash et al. 1997).

Findings from the Recife, Brazil study revealed that communication improved on many fronts for the adolescent females involved in the peer education program. Both the peer educators and their peers reported that the intervention increased their awareness of the importance of communicating with their partners about sex and also enhanced their confidence and self-esteem to do so. Some also pointed out that such communication was not possible before their participation in the program. According to one participant:

> *Before, my communication with him was like this: whatever he wanted, I did...Sometimes it even made me feel nauseous, but I did it because I liked him. Today this has changed; when I don't want to it ends there. Sometimes he gets angry with me, and I don't even want to know. It's not because I don't like him, I'm not trying to blackmail him, it's that I learned a lot from the girls from Casa de Passagem.*

Another noted:

> *...So I started to explain to him, to converse, to talk about the first time he had sex. And he said, "I think that the day we are going to have sex, I bet that the first time, you are going to ask for a condom." I said, "Of course I'm going to ask for a condom. I know this, you have had sex with various [women] and I have to be more careful."*

Addressing mother-daughter communication about sex in several chapters of the booklet, "The Story of Maria", facilitated dialogue

between the young women and their mothers. According to one female peer educator: "Things are better. When I give my opinion, she goes by what I'm saying. Now my mother values me when before she didn't." Peer participants in the program reported similar improvements:

> *After I joined the group, I changed a lot, because I didn't talk to my mother, or to my sisters or my father. My parents would say "You are a naughty girl!" After I got the booklet [The Story of Maria] I read it aloud so my mother could listen, and my father said, "This is true, it's good that you are learning this. Your mother and I are from the old times, and we don't have anything to teach you. Now you are going to teach your sisters, the whole family.*

In addition to evidence of increased communication about HIV/AIDS and sexuality, the Recife study revealed a positive change in community norms around young women's role as communicators and educators about sexual topics. At the beginning of the program, the peer educators reported that they were taunted by people in the community and called the "Little Sex Professors." At the conclusion of the program, a ceremony in which over 400 community members attended was held to recognize the valuable contributions of the peer educators and their peers to their communities. Given the conservative norms that predominate in these communities and the taboos prohibiting young, unmarried women from talking about sex, this level of support was a significant accomplishment of the program (Vasconcelos et al. 1997).

Condom Use

An important research question that a number of studies addressed is whether promotion and distribution of male condoms to women as part of a group-based intervention is effective, given the many barriers women face in negotiating condom use. What is clear from the findings is that it is possible to increase condom use among women by providing a non-stigmatizing source of condoms, peer support, and opportunities to share and practice communication strategies. In the Senegal study in which members of two traditional women's associations – the Dimba and the Laobé -- distributed condoms and promoted them as part of community rituals and small group discussions, female clients reported great satisfaction and a lack of stigmatization associated with getting condoms from these groups. For example, one woman who bought condoms from a Dimba member noted that medical personnel and pharmacists viewed clients as prostitutes when they requested condoms, thus women were reluctant to ask for them. Findings from the quantitative data showed that there was a significantly greater increase in the number of women in the intervention neighborhoods where the Dimba were active, as compared to women in the control neighborhoods, who reported using a condom. What is noteworthy about the intervention is that the promotion of condoms did not contradict the goals of each group – namely fertility for the Dimba and enhancement of sexual pleasure for the Laobé. The Laobé added the condom to its array of erotic products that they sell in the marketplace. The Laobé promoted the idea that the condom made the partner's

erection harder which contributes to increased sexual pleasure for both partners (Niang et al. 1997).

Findings from the Salvador, Brazil study showed that condom education and distribution was also beneficial for women, albeit not for all intervention participants. Of the 47 women interviewed in-depth at least two months after their participation in the discussion group, more than 90 percent opted to receive condoms from the clinic.[3] When asked what they did with the condoms, more than a fourth said they used all the condoms they received and another fourth reported that they were being kept for future use. Most of the remaining women said they either gave them to a partner, without specifying whether they were used with that partner, or gave them away to others. Some women reported that the group intervention influenced them to either use the condom for the first time or more consistently. According to a single, 28-year-old woman: "I wasn't using the condom and for some time now I have been using it because I'm not going to trust my boyfriend, although I think he is trustworthy." A 31-year-old woman not only convinced her partner to use condoms but to talk with the clinic's physician and counselor, and to participate in the discussion group which welcomed the participation of men. Some women also attributed giving their partners condoms and telling their partner to use condoms during extramarital sexual encounters to their participation in the discussion group. An interesting finding of the study was that while condoms were prescribed as part of STD treatment[4] and promoted for STD and HIV prevention, they were not vigorously recommended for contraception outside of the women's discussion group. The condom's advantages were not mentioned in any of the family planning consultations observed as part of the study. In several consultations the client was satisfied with the condom but her partner was resistant. On these occasions staff did not discuss ways of reducing barriers to condom use (as they did with the IUD and the pill) such as negotiation strategies, bringing her partner to the clinic to discuss contraception, trying a different brand, or using a lubricant. The researchers concluded that the women's discussion group combined with condom distribution contributes to an increase in protected sex episodes, but that, if condoms are to be used more consistently, condom promotion messages need to be consistent and staff members need to help clients problem-solve barriers to condom use as they do for other family planning methods (Badiani, de Mello e Souza, and Becker 1997).

A 31-year-old woman not only convinced her partner to use condoms but to talk with the clinic's physician and counselor, and to participate in the discussion group.

The South Africa study also demonstrated the value of distribution of condoms to women, combined with education, skills-building, and peer support. Baseline data showed that reported condom use among female STD patients in the intervention and control groups was very low. At post-intervention none of the women in the control group reported consistent male condom use compared to 17 percent of the women in the intervention group. The difference for occasional condom use was more marked between the two groups: whereas 57 percent of the women participating in the group intervention reported occasional condom use, only 12 percent of women in the control group said they occasionally used condoms (Hadden 1997).

[3] After participation in the women's group intervention, clients are offered five condoms. Clients may come back on a monthly basis to receive 10 free condoms.

[4] The clinic where the study was conducted offered STD diagnosis and treatment.

In addition to receiving male condoms, the female STD patients enrolled in the intervention and control groups received female condoms and the Patentex Oval -- a low-dose nonoxynol-9 (75 mg) vaginal, foaming, contraceptive suppository.[5] Baseline use of the three methods combined was low in both the intervention and control groups. At post-intervention, the difference in use of any protection method by women in the four-session group intervention compared with women in the control group was statistically significant (P<.0001). Data from this study revealed that women not only increasingly got their partners to use the male condom but were also using the new protection methods as additional tools. Of the 27 women from the intervention group who reported use of the male condom by post-intervention, nine reported that they had used the female condom and 12 had used the Patentex Oval as well. The question has been raised about whether the introduction of a new HIV protection method will result in migration from male condom use towards the new method. Among women in the group intervention, only one woman who initially reported use of the male condom by her partner migrated toward using the female condom and the Oval at post-intervention. However, the issue of migration away from male condom use may not be a significant issue where condom use in general is low, which was the case with the women enrolled in this study (Hadden 1997).

In contrast to the findings with adult women, there was no evidence of increased condom use among adolescent women reached by the interventions. There are several reasons for this. First, many adolescent participants were not sexually active. Second, it is likely that there was underreporting of sexual activity by young women. Third, condom promotion and distribution to youth varied by setting. In the Zimbabwe school-based study, condoms were mentioned as a preventive option during the teacher training. However, the project did not develop any participatory activities for youth that promoted condoms, and, in keeping with the policy of the Ministry of Education in Zimbabwe, condoms were not distributed in the schools. There was no evidence from the qualitative data that condoms were being used more often. However, an unexplained finding from the pre-post questionnaire was that a significantly greater number of females in the intervention schools reported having seen a condom post-intervention compared with females in the control schools (Woelk, Tromp, and Mataure 1997).

In the Thailand study, condoms were distributed to the peer educators for educational purposes and occasionally to group members. Unlike in many countries, condoms are widely available in Thailand. The peer education program for factory workers emphasized correct condom use and worked to destigmatize communication about condoms and their procurement for unmarried females. Despite the programmatic emphasis, findings from in-depth interviews with 12 couples revealed that condoms were not being used within the relationship. Respondents cited other risk-reduction strategies, such as telling their partners to use condoms when going to brothels or abstaining from sex because the spirits would not approve (Cash et al. 1997). This study only

[5] Given the research debate regarding the use of spermicides in STD and HIV prevention, the Oval was presented to the women in the study as the last alternative in a hierarchy of protection methods that included first, the male condom, and second, the female condom. Use of the hierarchical approach and distribution of the Patentex Oval was in line with current policy in South Africa at the time of the study.

explored communication and condom use with committed partners. More research is needed to determine whether the intervention was effective in influencing communication and condom use in casual relationships.

While condoms were not distributed to youth in the Mexico study, the video that was developed for use with parents and adolescents included one vignette that depicted a mother instructing her daughter in condom use. As part of the study the video was shown to students in schools and to parents, with the aim of fostering parent/child communication about sexuality and HIV/AIDS. Interestingly, the mothers and fathers agreed that the situations presented in the video were realistic and that it was helpful for learning how to communicate effectively with their sons and daughters. Almost all of the mothers were supportive of the video's depiction of frank communication between mothers and daughters, including a demonstration of how to put on a condom. One mother said: "It is very important that our children know about protection methods." Another replied: "It was a very important decision [that the mother made] and it was good for the girl." The mothers also commented about the advantages of talking about sexuality with their daughters: "She must know about everything that can happen these days and protect herself from diseases" and "It is important because, if she doesn't know, how is she going to ask her partner to use one [a condom]." None of the ten fathers who saw the video responded negatively about the scene. Only one mother said she thought the daughter was not old enough for such a discussion (Givaudan, Pick, and Proctor 1997).

Almost all of the mothers were supportive of the video's depiction of frank communication between mothers and daughters, including a demonstration of how to put on a condom.

Perceptions of Gender Roles and Relationships

The studies reported several positive outcomes of the interventions with regard to how participants view gender roles and relationships with regard to sexuality, but clearly a number of challenges remain. In Recife, Brazil, the ability and right to say no to unwanted sex and sex without a condom was reported by both the female peer educators and their peers as a result of the intervention. For example, when asked what she learned from the program, one peer educator noted:

> *I learned about AIDS, about sexuality, gender, and what I liked most was learning about the rights of women, that women have rights, to say no when…in relation to their boyfriend…one can say no when someone touches them. Now I have all this information. I am stronger. I know what I want in life now.*

The peer educators and their peers also talked about how attitudes about gender roles (e.g., "this is the way it is supposed to be – the man controls the woman") affected their sexual behavior and how that had changed. According to one program participant, "I didn't say no to him – he wanted to, I liked him, so I had sex without a condom. Not now."

The program also contributed to a greater understanding of the need to become involved in community mobilization efforts to challenge wider social inequalities and problems. For example, the peer educators participated in a community-wide demonstration to protest the rape of a young woman in the community. They also produced a play that addressed racism, gender differences in

education, and women's low social status. The play was performed widely in the community. Yet the research team recognized that to build on the success of the intervention they needed to expand their work with the community, including the development of programs for males (Vasconcelos et al. 1997).

In Zimbabwe, data from end-of-project group interviews with students showed that males and females gained a new understanding about sex and relationships. Many said that they know now that "boys and girls can be friends without love and/or sexual involvement." Both sexes said they no longer laugh at the girls who stain their dresses while menstruating because they understand that menstruation is a natural process. Some girls said they could now mix freely with boys without worrying that others would assume that they were having sex with them. This suggests that the classroom discussion sessions fostered a new level of respect and communication between females and males. This is important in a culture in which girls cannot verbalize their feelings and opinions about sex for fear of being perceived as sexually active (Woelk, Tromp, and Mataure 1997).

Despite this achievement, the findings indicate that a large gap remains between male and female students in Zimbabwe on a number of issues such as whether sex is necessary for the continuation of a relationship and what girls mean when they say "no" with regard to sex. In group interviews, girls noted that only when their "no" is firm, consistent, serious, and accompanied by a good reason (e.g. fear of AIDS or disruption of their schooling due to pregnancy), will boys believe them. Yet even with a firm "no" they recognized that males would be persistent in their demands for sex, which may include physical force.[6] When males were asked whether they believed a girl when she denied wanting to have sex, the majority indicated that they did not believe the girl. Boys noted: "They never say yes." "If she loves you, she'll do anything you want." "Why would she agree to go to the bush if she doesn't want sex?" The researchers concluded that mixed-sex classroom discussion sessions need to be initiated at younger ages before attitudes about sex are well-entrenched (Woelk, Tromp, and Mataure 1997).[7]

The Senegal researchers also noted the challenge in modifying men's attitudes towards women's role in sexual decision-making. Although the public ceremonies and small group discussions conducted by the Dimba and the Laobé emphasized the importance of communication and giving women a voice in deciding the conditions under which sex takes place, the men who participated in one small group blamed women for HIV/AIDS. They also believed that their wives did not have the right to resist sex nor demand the use of the condom. However, they did acknowledge that such behavior would be more acceptable from female partners other than their wives. The researchers concluded that changing gender norms requires a concerted effort to engage men in ongoing discussions about gender roles and relations and to increase women's social status in the home and community. Nevertheless, the intervention laid the groundwork by training respected female community leaders to begin the process of public discussions of gender and its relationship to HIV/AIDS (Niang et al. 1997).

Changing gender norms requires a concerted effort to engage men in ongoing discussions about gender roles and relations and to increase women's social status in the home and community.

[6] Girls are justified in their fear of physical force as 25 percent of males from the intervention schools and 18.5 percent of males from the control schools reported that they had forced a girl to have sex.

[7] The evaluation of this intervention focused on Form 3 pupils who ranged in age from 15-20 years.

Fostering Effective Group Process: Lessons Learned

Across the studies, both facilitators and participants responded favorably to the use of small group interventions as an effective mechanism to address sexuality, gender roles, relationships, and communication. Certain elements, however, must exist for group interventions to effectively engage participants in listening and discussion which can lead to changes in attitudes, perceptions, beliefs, and behaviors. This section will discuss the findings from the studies in light of these elements, namely training and support of facilitators, use of participatory methods, and group composition.

Facilitator Training and Support

The researchers identified a number of important elements for facilitator training and follow-up that help to ensure optimal facilitator performance. First, training workshops need to provide facilitators with opportunities for experiential learning (i.e., participation in activities designed for the target audience such as roleplays). Experiential learning helps facilitators develop skills such as how to engage participants in discussion, build consensus, and solve problems.

Second, training workshops need to provide feedback to participants related to their development of skills as facilitators and educators. In the Thailand project, for example, each peer leader was videotaped leading a group discussion. After the taping, the other trainees critiqued the peer leader's performance based on a checklist of competencies (Cash et al. 1997).

Third, the training workshops need to help facilitators/educators become comfortable addressing sexual issues by exploring and discussing their own perceptions and attitudes. In Zimbabwe, having teachers discuss their feelings and fears about HIV/AIDS and their own and adolescents' sexuality was a key component of the teacher workshops (Woelk, Tromp, and Mataure 1997). This was also an important part of the training for clinic staff in Salvador, Brazil. Specifically the training focused on becoming comfortable with sexual terminology; challenging biases regarding sexual practices, sexual partners, and condoms; sharing their own experiences learning about sex and its influence on their sexual development; and constructing definitions of sexual and reproductive health (Becker and Leitman 1997). As a result of their training, staff reported increased confidence and comfort in discussing sexuality with their clients (Badiani, de Mello e Souza, and Becker 1997).

Fourth, follow-up consultation with group facilitators/educators needs to be ongoing. In Sri Lanka, project staff were available on-site during each session to provide immediate consultation when needed. In addition, half of the training sessions were interspersed through the duration of the intervention to provide ongoing training (Silva et al. 1997). In Recife, Brazil, the female peer educators participated in weekly meetings to discuss their experiences using "The Story of Maria." Part of each session addressed family problems and conflicts the girls experienced in the community as a result of their participation in the project. The project team worked to validate them and their work in order to ensure their continued participation. The importance of this approach was reflected by the fact that only one of the 21 peer educators selected for training dropped out of the program (Vasconcelos et al. 1997).

Participatory Methods

The studies provided insights regarding the usefulness and acceptance of different methods and approaches for ensuring participation. Teachers in the Zimbabwe project reported that picture codes (i.e. showing a picture and asking questions about what the picture represents), role play, drama, and discussing questions submitted anonymously were most effective for engaging students in discussion. Roleplay was noted by teachers as especially effective for promoting student learning and teacher understanding of youth perspectives. Students reported that they liked small-group work (with reporting back to the whole class), drama, roleplay, and discussing anonymous questions. The use of anonymous questions provides an important strategy for permitting students to raise and discuss uncomfortable or taboo issues without embarrassment. Students also reported that brainstorming, particularly the opportunity to contribute ideas without concern for correctness, was much appreciated (Woelk, Tromp, and Mataure 1997).

Roleplay was reported to be a particularly successful strategy in the South Africa study for engaging male and female STD patients in discussion of sensitive topics such as negotiating condom use, sexual coercion, and violence, and for understanding the perspectives of the opposite sex. The use of stories and "Dear Thandi" letters was also found to foster discussion about HIV/AIDS and sex-related issues. "Dear Thandi" is an advice column that runs in popular magazines in which the letter writer asks for help in dealing with emotional and relationship problems. Interestingly, both the male and female participants preferred to discuss the roleplays, stories, or Dear Thandi letters and share personal experiences as a group (ten participants) rather than break-up into pairs or triads. The larger group may have been more comfortable for participants as this was more in keeping with the oral tradition of storytelling within African culture (Hadden 1997).

The Sri Lanka study found that asking participants to complete an individual activity prior to group discussion facilitated participation by all members of the group. For example, at the beginning of one session, the peer educators had each group member complete a checklist indicating which of a list of behaviors represented sex and whether it was risky using a broad definition of sexual risk. Following the completion of the individual checklists, group members discussed each behavior to arrive at consensus on

Roleplay was noted by teachers as especially effective for promoting student learning and teacher understanding of youth perspectives.

definitions of sex and sexual risk. The individual activity helped group members contribute to the overall discussion. The use of a numbered checklist in this activity also was critical to promoting discussion of taboo topics. Group members could refer to the explicit sexual behaviors by number rather than by name, thus reducing embarrassment (Silva et al. 1997).

The Thailand researchers found that prior familiarity was critical for the successful functioning of the mixed-sex groups.

Reticence by participants to discuss sexual issues was a concern of other research teams as well. This reticence was viewed as a reflection, particularly for females, of sanctions against open discussion of sex and the possibility of social stigma based on perceptions of promiscuity. Special efforts were made to minimize participants' (especially females') apprehension about discussing sex. In São Paulo, Brazil, for example, the project team found that none of the 42 women who participated in any of the five groups that met three times each had ever discussed HIV/AIDS before, let alone in the context of sexuality and gender. At the first session, the women gave each other facials using homemade ingredients in an attempt to relax them and make them feel positive about themselves. At this session, group members also developed basic principals for group work that included the right of everyone to speak, to not interrupt or judge what someone is saying, and to be respectful of each others' intimate experiences (Bonciani and Rodrigues de Morais 1997).

Peer educator training in Thailand

Group Composition

One of the unique contributions of the studies was the opportunity to explore the use of male-only, female-only, and mixed-sex discussion groups in cultures where discussion of sexual issues, even among same-sex peers, is often taboo. A number of the studies demonstrated that mixed-sex discussion groups can be conducted effectively and that participants can become comfortable engaging in such discussions. It was also found that mixed-sex groups encourage debate and sharing of ideas and allow participants to learn from and take the perspective of the other sex. For example, the majority of Zimbabwe secondary school students who participated in group interviews to assess their classroom experiences believed that mixed-sex discussions were good for sharing opinions. A common response was "there are things that boys should know about girls and vice versa" (Woelk, Tromp, and Mataure 1997). Observation of the discussion group for clients of the Salvador, Brazil, reproductive health clinic revealed that when men were present (either as clients or as the partners of female clients) the level of interaction was greater, particularly about differences in male-female perspectives and roles (Badiani, de Mello e Souza, and Becker 1997).

While there was wide acceptance of mixed-sex formats, the studies revealed that certain elements were key in order for them to work effectively. The Thailand researchers found

that prior familiarity was critical for the successful functioning of the mixed-sex groups. Mixed-sex groups worked best when members worked in the same factory and knew each other, and when the male and female co-facilitators were friends and could work together cooperatively; otherwise, males tended to dominate the group. A significant barrier to the mixed-sex groups in this setting was that most factories are single-sex and, therefore, the males and females in most of the mixed-sex groups came from different factories. This lack of familiarity contributed to the lack of completion of the peer education program in two of the six mixed-sex groups. Group members were reluctant to discuss sex-related topics and seemed to be more interested in socializing than participating in program activities. The researchers concluded that it may be too socially prohibitive for young, unmarried women and men who don't know each other to speak openly about sexual matters (Cash et al. 1997).

The opportunity to first gain information and experience in discussing sexual issues with same-sex peers may have been critical to the success of the mixed-sex discussion session in Sri Lanka and South Africa. In both studies, males and females first met separately a number of times (three for the STD patients in South Africa and nine for the youth in Sri Lanka) prior to the mixed-sex session. The findings from both studies suggest that the single-sex groups helped both adolescent and adult women, who were initially embarrassed to discuss sexual matters, develop their public "voice" – their ability to speak in front of others (Silva et al. 1997; Hadden 1997). In other work conducted in Sri Lanka by members of the research team, young men and women who were put in mixed-sex groups to discuss sexual issues without prior opportunities to do so separately varied widely in their participation (Nastasi 1997). In contrast, those who first participated in the single-sex sessions in this study eagerly engaged in discussion in the mixed-sex group (Silva et al. 1997).

Allowing time to develop rapport among group members was reported to be a critical factor in the Zimbabwe school-based study, thereby highlighting the importance of a multi-session group intervention. Both teachers and students reported that girls became less reticent to discuss sex as the sessions progressed (Woelk, Tromp, and Mataure 1997). In the Sri Lanka study, female members were initially uncomfortable discussing sexual topics even within same-sex groups. By the end of the program, both peer educators and participants engaged freely in discussion in the mixed-sex groups. The young women eagerly challenged the young men on issues related to sexual risk (e.g., norms about virginity, importance of communication by women, and negotiation of sexual practices with partners). In post-intervention feedback, the participants and peer educators indicated an interest in more opportunities to engage in mixed-sex discussions and felt that they should have occurred earlier in the program. The impression of the project staff was that these discussions would not have been successful early in the process (Silva et al. 1997).

Single-sex groups helped both adolescent and adult women, who were initially embarrassed to discuss sexual matters, develop their public "voice."

BRIDGING THE GAP:
ADDRESSING GENDER AND
SEXUALITY IN HIV PREVENTION

Conclusions

Findings from the studies conducted as part of the Women and AIDS Research Program illustrated the critical roles that gender and sexuality play in influencing men and women's sexual interactions, their ability to practice safe behaviors, and their risk of HIV/AIDS. The studies also contributed to our understanding of how to operationalize complex concepts like gender, sexuality, and power to guide the development of HIV prevention interventions. They also highlighted the importance of increasing women's access to critical resources such as information and education, skills, technologies and services, and social support in order to reduce their vulnerability to HIV/AIDS.

While the interventions varied by target audience, when examining the studies as a whole a number of key topics emerged that should be addressed by future interventions for both females and males. These topics are sexual practices and risk, masculinity and femininity, virginity, communication, and sexual coercion and violence. A distinguishing characteristic of these topics is their emphasis on the psycho-social and relational aspects of sexual interactions.

A common feature of the interventions was the use of small groups that, in effect, challenged the culture of silence surrounding the discussion of sexuality and gender in many cultures, particularly when initiated by women. The studies showed that participatory, small group interventions can be implemented in different contexts such as STD and family planning clinics, schools, workplace settings, community and NGO facilities, and public spaces. The group-based interventions were found to foster critical analysis, collaborative learning, problem-solving, and peer support. The interventions also allowed for the development of communication skills through interactions with same-sex and opposite-sex peers. This kind of analysis, dialogue, and skill development is what contributes to changes in social norms and distinguishes group-based interventions from one-on-one educational interactions.

The studies provided important data about the structure, functioning, and outcomes of single-sex and mixed-sex group sessions. Findings from Zimbabwe, Sri Lanka, Thai-

land, and South Africa showed that mixed-sex groups were well accepted by both adults and adolescents and contributed to improved communication and understanding about sex and relationships. But, as suggested by the Thailand study, prior familiarity can help to ensure the successful implementation of peer-led group activities among unmarried youth. Moreover, as demonstrated by the findings from South Africa and Sri Lanka, participation by adolescent and adult women in same-sex groups first, to gain knowledge and confidence to discuss sex prior to interacting with males in mixed-sex sessions, may be warranted.

Nothwithstanding the importance for women of interacting in groups with men, the findings also demonstrated the value of female-only discussion groups. For example, service providers in the Salvador, Brazil study noted improved communication in clients who had participated in the discussion group prior to receiving services. Improved communication with partners and family members about sex and HIV prevention was also reported by intervention participants in that study as well as the studies conducted with unmarried young women in Thailand and Recife, Brazil. Such findings are noteworthy given the extent to which social norms inhibit communication about sex in a variety of contexts: between parents and children, service providers and clients, and males and females during initial intimacy and within stable relationships.

The interventions discussed in this report were small-scale, pilot efforts that, nevertheless, have made an important contribution to our understanding of how to increase women's autonomy and decision-making with regard to sexual relationships and, thereby, reduce their vulnerability to HIV/AIDS. Building upon the key elements identified through these research studies poses the following challenges for program managers, policymakers, and researchers:

■ Ensuring Adequate Training and Support of Facilitators

Across the studies, the value of facilitator training, supervision, and support was demonstrated. An important component of scaling-up, therefore, is to allow sufficient time and resources for effective training. When dealing with gender and sexuality, facilitators must be made comfortable discussing intimate topics and behaviors, and prejudices and stereotypes must be broken down. Skills should also be developed in participatory methodology to replace didactic approaches that are standard practice in the formal educational systems of most countries.

■ Engaging Participants in Multiple Group Sessions

To deal adequately with the complex and entrenched issues of gender and sexuality, a multi-session intervention clearly has advantages over a single-session group interaction. But the studies revealed there are challenges in recruiting and retaining participants, particularly males, in multiple sessions, even with the provision of incentives, such as snacks and transportation expenses. More research is needed to understand why participants drop out and to identify new approaches for attracting and retaining participants that can be utilized by institutions and organizations that have limited resources.

If time and opportunity costs of participants cannot be minimized to allow for attendance at multiple group sessions, a one-session group intervention, while limited, does offer certain benefits. Findings from the study conducted in Salvador, Brazil, revealed that some women credited their participation in a single-clinic discussion group with an increase in knowledge and awareness, a willingness to try condoms again or for the first time, improved communication with their partner about sex, and returning to the clinic to receive free condoms. Another important finding was that the health providers reported that the women who attended the group session were more active in the client-provider interaction, tended to present more specific concerns or questions, and were better informed than women who did not participate. Single-session discussion forums can be easily incorporated into many settings. For example, the time that clients wait in health care settings offers a valuable opportunity. More research is needed to identify ways of maximizing such opportunities for the implementation of group-based approaches to HIV prevention that reach females, males, and couples.

■ Fostering Group Action and Community Mobilization

The Recife, Brazil and the Senegal studies highlighted the value of group-based interventions for fostering group action on HIV prevention in the wider community. For example, the group of Brazilian peer educators developed a play on HIV/AIDS that reached both youth and adults. The peer groups also participated in a public demonstration organized by Casa de Passagem, the NGO that carried out the study, to protest the rape of a young woman. In Senegal, the intervention focused on equipping groups of Dimba and Laobé to be a public voice for HIV prevention and women's role in sexual decision-making during community rituals. Building solidarity within the group so that the group itself works together to bring about social change through community mobilization and advocacy is not easy. More efforts are needed to develop and evaluate interventions that aim to organize group participants—both males and females—to educate the larger community and challenge norms about gender roles that increase women and men's vulnerability to HIV/AIDS.

■ Increasing Women's Access to a Wide Range of Resources

The studies discussed in this paper have shown that group-based interventions can result in increased knowledge, skills, and social support among women—important components of power. But such interventions must occur within a context of increased access to not only reproductive health services and barrier methods, but to economic resources such as employment, credit, and vocational training. Improving women's access to economic resources is critical to their being able to negotiate protective behavior and to leave a relationship that places them at risk of HIV/AIDS. More work is needed to identify ways to link group-based interventions that focus on HIV prevention to the provision of reproductive health services and technologies, and to programs that enhance women's economic and social status.

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