4. Case Studies of Gender-based Responses to Combating HIV/AIDS

Introduction

Programmes that promote HIV prevention by addressing gender equality, as well as the social and economic factors that put people at increased risk for infection, are more likely to succeed in changing behaviour, as can be seen from the case studies described below. The AIDS Vancouver and the Positive Women's Network (Canada), for example, provides an alternative research perspective which questioned the traditional focus on women's behaviours, such as sex workers' use of condoms or women's risk-taking behaviours in drug use. Instead, it addressed the reality of marginalised, excluded or 'forgotten' high-risk populations. Gender and culture were both addressed as determinants of health.

Gender-based research such as this, and other examples listed on the Canadian Women's Health Network website (see Chapter 5), demonstrate clearly the importance of listening to women's voices and addressing their lived realities in informing HIV/AIDS prevention campaigns. Applied HIV/AIDS research, conducted locally by researchers in co-operation with local communities, has considerable potential to influence national policy and promote action on the social factors that affect women's and men's health and wellbeing over their lifespan. This increases the likelihood of being able to target strategic interventions to high-risk populations, including sex workers.

One of the case studies focuses on this area – female prostitutes and HIV prevention programmes in Canada. Other studies address a number of different issues. From Africa comes a case study on marketing the female condom in Zimbabwe. This suggests that female condoms are providing new and additional protection from STIs/HIV to some study participants, though more research is needed. A case study of HIV counselling and testing among pregnant women in Canada offers best practices in this area, while involving men in preventing gender violence and HIV transmission is the focus of an international case study of a programme called Stepping Stones. This uses peer groups to help people translate information about prevention into behavioural change. Another innovative programme, called the School Without Walls, comes from Southern Africa and involves the transfer of local knowledge for HIV programming. The need to mobilise the community for effective control and prevention is also emphasised by a case study on sexual and reproductive health integration in Bangladesh. The final case study, from Canada, looks at gender differences in sexual health promotion among adolescents.

These case studies illustrate how a gender-based perspective on HIV/AIDS research, policy and programme will:

- respect women's and men's different perspectives and experiences;
- weave together research, policy and action in a meaningful way;
- hear the voices of women and men not typically heard in health research or health systems;
- explore strategies that build on the needs identified by HIV-positive men and women;
- address factors that influence the respective values and behaviours of women and men, particularly those residing in low income, economically marginalised, high-risk and hard to reach populations; and
- influence national public opinion through research and action that is targeted to specific policy audiences at the local, state/provincial and/or federal jurisdictions.

Case Study: Participatory Research with Marginalised Communities (Canada)

This project has played a big part in lifting my self-esteem, in getting me out there and getting a job and accepting a position in the help-

ing field … It's boosted my confidence and made me feel comfortable expressing how I really feel.

Research participant

Women's individual behaviour is often cited as the cause for their HIV infection or illness progression, for example, sex workers' use of condoms or risk-taking behaviour in drug use. HIV prevention strategies often target behaviour without exploring the larger factors that shape and inform it. In 1998, AIDS Vancouver and the Positive Women's Network initiated a research project that looked at women's risks from HIV infection and illness progression, using two main principles as a guide:

- Social and political factors form barriers to women's health, and should be explicitly explored along with potential strategies to overcome these barriers.
- The community's norms of whose voice gets heard and who is the 'expert' should be challenged.

Social and political factors form barriers to women's health, and should be explicitly explored along with potential strategies to overcome these barriers

Research focusing on behaviours assumes that individuals have enough power in their society to be able to change their behaviour and that they have choices. While this may be true for some individuals in some groups, social conditions reduce the options to a very narrow range for many people in marginalised groups. This is reflected in HIV statistics. It is the people at the bottom of the social and political hierarchy in their society who are most at risk from HIV/AIDS. For a woman living on welfare in a dangerous area, using valium or heroin or alcohol to cope, her risks are determined not by the right personal selection of a healthy option but instead by a socially-determined lack of options.

There are numerous social and political barriers that prevent women from taking care of their health. This fact was clearly understood and articulated by participants in the research. In looking at social barriers to health, the project hoped to re-orient the focus of research, examining the socio-

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economic conditions rather than women's behaviours and targeting social change in order to lessen the barriers to women's health.

The community's norms of whose voice gets heard and who is the 'expert' should be challenged

Several AIDS studies and consultations in Vancouver in recent years asked service providers about the risks and solutions for marginalised communities and asked members of marginalised communities only about their behaviours or lifestyle, not their ideas or suggestions for change. Many researchers used community members for their research, then took the information out for their own interpretation and profit but did not leave information or skills behind for the community. The project wanted to work with groups who had been researched a great deal but who had not been involved in creating knowledge in a meaningful way.

By sharing with women the tools and the means to do research, it was hoped that marginalised communities would have an opportunity to explore their definitions of the problems and their solutions, and use the information to take the kind of action they wanted to see happen. It was also hoped that their research and advocacy efforts might influence health policy and collaborative work with sympathetic policy-makers and health workers. If women from marginalised communities could use their research results as a tool to access decision-making bodies, perhaps they could then find allies in these decision-making bodies that would result in shared power and social change.

Phase One

The purpose of Phase One was problem identification. It used focus groups to gather information and, more importantly, to generate community interest and support. The project co-ordinator collaborated with other agencies to work with six different groups of women: Spanish-speaking immigrants and refugees; women with serious mental illness; First Nations and aboriginal women; HIV-positive women; current and former substance users; and lesbian/bisexual women. Each group looked at how specific social factors impact on their risk for HIV infection and illness progression, including:

- income;
- power in intimate relationships (meaning friends, partners, family);
- relationship with health care providers and health institutions.

The study . . . found significant barriers to personal health and safety due to poverty.

Income

The study, like many others, found significant barriers to personal health and safety due to poverty. However, women talked not just about the lack of access to food and housing but also about the discrimination they experienced because of their poverty as a barrier to their health. The prevailing attitude that the poor must have done something wrong and deserve to suffer intensifies for many of them the guilt they already feel, so they do not ask for services that are rightfully theirs. This class discrimination erects additional barriers for those already living in poverty and further limits their health options.

Policy-makers must begin to see and understand that the standard of living maintained by welfare levels in Canada creates health risks not only due to material deprivations but also due to the shame of being poor in a wealthy land. Constructing affordable housing and providing extra money for good quality food are two examples of material benefits, but equally important is the shift required in how the 'non-poor' view those living in poverty.

Power in intimate relationships

Like numerous other studies, the research found that past and current experiences of abuse were linked to increased risk of HIV infection. Women also linked their experiences of abuse to ongoing poor health and shortened life spans. For example, an AIDS-defining illness might not be the most significant health risk for an HIV-positive woman in these communities. Instead, it might be a violent partner who assaults her; a long-standing drug addiction as a means to cope with memories of childhood abuse; or an inability to leave her home to seek medical treatment for weeks or months after a rape. Health

Some women were taking their free prescription medications and selling them on the street in order to earn enough money to buy herbal or other alternative medicines.

risks of this type can form a web of barriers that makes it unlikely the woman would live long enough to develop an AIDS-defining illness.

Despite the innovative work done by some groups in Canada to document and take action on these issues, there is still need to raise the public's awareness. Policy-makers and public health educators have a potentially important role to play in helping to investigate and publicise the links between relationship abuse and HIV. Also, provision of adequate, long-term resources to women leaving abusive relationships (especially in rural areas) needs to be more actively linked to HIV prevention and support strategies.

Relationship with healthcare providers and health institutions

While there were stories of healthcare providers whose sincere caring had made a life-saving difference for women, there were also stories of appalling discrimination and the life-threatening consequences of inferior treatment. These point to the long-standing need to develop policy initiatives which will encourage ongoing training for health care providers regarding structures of power, privilege and oppression, in order to reduce discrimination against marginalised groups. Up-to-date HIV information also needs to be provided for non-specialist doctors so they are more comfortable with providing care and support to HIV-positive people.

Another barrier identified by women across all six focus groups was the lack of support from the mainstream medical establishment for access to alternative medicine and complementary therapies. HIV-positive women saw the pharmaceutical industry as controlling the treatment and research agenda of the 'AIDS establishment'. Some women were taking their free prescription medications and selling them on the street in order to earn enough money to buy herbal or other alternative medicines. Women and men will continue to use alternative and complementary therapies with or without their doctor's support or knowledge. It is therefore strongly suggested that the mainstream medical profession be encouraged to work with alternative and complementary healthcare professionals, integrating such research and information into their practice, and that the Canadian public healthcare system be amended to include the provision of alternative healthcare services and medicines.

Phase Two

After Phase One was completed, the project co-ordinator had established enough trust with women in the focus group communities to begin the second phase. This involved the training and support of peer researchers in order to further identify community needs and preferred strategies for change. A community-based educator was hired to work with the peer researchers using simple, accessible participatory methods. These focused not only on research skills but also on fostering bonding, communication and sharing between peer researchers, contributing to their empowerment as a group. After receiving training in one-to-one interviews and focus group facilitation, peer researchers took the information from Phase One back to other women in their self-identified home communities. They asked women what changes they wanted to see happen in order to reduce barriers to their health, as identified in the previous phase.

Through this process, combined with ongoing support and skills building, women gained a sense of ownership of the research. The project became theirs, not just the property of AIDS Vancouver and the Positive Women's Network. This was the first step in the transition from *community-based* research to *community-owned* research, and the stage at which staff began to learn more deeply about the meaning of changing the balance of power.

Recommendations

Sharing power must be encouraged at multiple levels of a project, whether research, prevention campaigns or whatever the level of involvement is with the community. The following suggestions seek to encourage power-sharing with communities, and can be implemented at local and national levels.

Networking: It is important to utilise links with other community agencies in order to share information and resources, share the work-load and involve the greatest possible number of community members. In this way, the project and its results do not become the 'property' of one agency. This can be a challenge when agencies have different agendas and perhaps also compete for funding. However, by involving other agencies in meaningful ways, sharing of power is role-modelled at the community agency level. Including a mix of people (for example from the community, local government, health professions, agency staff) will also challenge different pieces of the project, ensuring mutual education and increased potential for project integrity.

Involving members of the community: If a community is to increase its voice and power, then people must have a place in decision-making. However, the trap of 'tokenism' can arise due to differing levels of power. In Phase One, the project had only two seats reserved for community members on the advisory board; the other six were agency staff and health professionals. This had the effect of making the two HIV-positive women sometimes feel intimidated and silenced. There must be awareness of and sensitivity to these power dynamics, as well as a commitment to seek and develop innovative methods to solicit community involvement beyond the usual advisory boards and 'special committees'.

Working within the community: In order to facilitate the above, outreach services and sharing of resources are both important. Service providers need to get out of their offices and take their services to where women spend their time – the community centre, the church, the street – rather than expecting women to be able to come to their agencies. Outreach workers are crucial to a programme's link with a community, facilitating the community's communication of its needs. Communities also need resources in order to facilitate the communication of their needs and vision. Peer education and skills training, combined with encouragement to develop strong political analysis, give marginalised groups the tools to participate fully in the processes of learning about their needs and opportunities, and then take the action required to address them.

Changing the balance of power: Increased awareness and education can be shared among all members of the community.

This is the very essence of changing the balance of power. Working toward community empowerment, and challenging political and social systems, means changing the very nature of the current system. Hence, it can be helpful to remember to:

- *Invest in the long-term:* In-depth work with a community takes time and commitment. Prepare for this from the outset, putting in the supports and resources necessary to sustain staff and community members. If work is done too quickly (for example to meet a funder's short-term project goal), this can leave the community in worse shape than before the project started.
- *Prepare for conflict:* Conflict will naturally arise when different groups are brought together. Skilled facilitation is required to work through conflict, not around it.
- *Ask whose needs are being met:* The agency's priority may not be the community's priority. When community members are asked to define their priorities, they may want to act on needs other than those identified by funders, agencies or academic institutions. Empowerment means letting the marginalised communities take the lead and giving them the skills and resources to do so.

Truly representative community consultation and mobilisation is a slow and complex process.

Conclusion

Truly representative community consultation and mobilisation is a slow and complex process. It is important to take the time to develop community voices and listen for what is being said (not just what the researchers want to hear). Because of this, the sense of ownership and empowerment felt by all members of the team, and the depth and diversity of the information gathered, has created a very rich research project. It is hoped that by targeting barriers in social and political systems and supporting community empowerment, the project is contributing to a process of change that will continue long after the research is finished, and will sustain real change in the health and dignity of marginalised communities.

Source: Tolson and Kellington, 2001

Case Study: HIV Prevention Programmes and Female Prostitutes (Canada)

Introduction

During the earliest days of the HIV epidemic, female prostitutes were seen as 'vectors of transmission'. Many believed that prostitutes would be the mechanism through which HIV would spread from the gay community to the heterosexual community. There were calls to quarantine female sex workers, or to license prostitutes and to have the license tied to being free of sexually transmitted infections (STIs) including HIV. At the same time, there was also opposition to such demands, particularly from the gay community and prostitutes' rights organisations who strongly disagreed with the portrayal of female prostitutes as the problem.[1]

The almost exclusive focus on female prostitutes as the 'cause' of the spread of HIV represented a fundamentally flawed assumption about the nature of the relationship between female prostitute and client within the North American context. Indeed, the assumption that multiple high-risk sexual services were being provided without the use of condoms was not borne out by research. As research in the past 15 years has consistently indicated, most female prostitutes within North America (as well as parts of Europe and Australia) typically use condoms with clients, and rates of HIV are relatively low among non-injection drug using prostitutes (Hancock, 1998; Jackson et al., 1992; Seidlin et al., 1988). In fact, most North American prostitutes are now characterised as 'safer sex professionals' because of their role in ensuring the use of condoms when providing a sexual service.

Incorrect assumptions about the nature of the female prostitute-client relationship continue to exist, however. Many HIV-related policies and programmes are based on the notion that the female prostitute is, and should be, the one responsible for safer sex. The prostitute is viewed as selling a commodity – sexual services – which are purchased 'freely' on the market, and because she is selling the service she is respon-

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[1] 'Prostitutes' here refers specifically to women who exchange sex for money or in kind and does not include women in the sex trade industry who exclusively provide other services such as phone talk sex.

sible for the health and safety of the client (Davidson, 1998; Jackson and Hood, in press). As such, most HIV prevention efforts target female prostitutes with HIV education, providing access to condoms and often other medical services. However, this focus fails to take a critical look at the nature of the sex trade industry, the relations that maintain the industry and women's dependence on the sale of sexual services. It also ignores the class, race and gender inequities that play a fundamental role in women's entrance into prostitution and their vulnerability to HIV.

Within much of North America there is a double standard in terms of female prostitution . . .

Female prostitution and the double standard

Within much of North America there is a double standard in terms of female prostitution or women who work in the sex trade industry. On the one hand, there is a dominant moral disdain for the selling of one's body to multiple customers. This disdain is represented in the criminalisation of activities related to the woman's role in prostitution (Davidson, 1998). Women who engage in the sale of sexual services are arrested for soliciting and constantly have to guard against police arrest, especially if they are street prostitutes – the most visible form of prostitution. On the other hand, the clients (or 'Johns') of female prostitutes typically do not undergo constant police scrutiny. Although in some centres there are instances where clients have been arrested and sentenced to 'John' school that is intended to deter them from frequenting prostitutes, it is typically the woman prostitute who is stigmatised and punished, not her male clients. This means that more often than not it is the woman who suffers the economic consequences related to arrest, thus contributing to the economic hardships that have led many women into prostitution in the first place.

Female prostitutes are also often blamed for the violence perpetuated by clients, and frequently there is a weak, if any, response by the police and other authorities to such violence. At the same time, there is state support for some prostitution-related activities (which are often male-owned and operated), such as escort services and body-rub parlours. Typically, these businesses are provided with licenses to operate, and those

A double standard also underlines many HIV prevention programmes and policies in Canada.

involved in such activities profit from the women's work of selling sexual services, yet it is the women who take the greatest risks in terms of violence perpetuated by clients (Alexander, 1998; Jackson and Hood, in press). Some women who work as street prostitutes are forced – either overtly or covertly – to provide much of their earnings to 'pimps', while many women who work as 'escorts' are also required to provide a large percentage of their earnings to the owners of these establishments.

HIV-prevention programmes/policies and the double standard

A double standard also underlines many HIV prevention programmes and policies in Canada. Prevention programmes do not typically target male clients even though these men may be as 'sexually active' as female prostitutes, visiting multiple women for both paid and unpaid sexual services. This double standard is especially problematic given that research indicates that when condoms are not utilised during the prostitute-client relationship, it is frequently because of the clients' resistance to condom use. Such resistance can take many different forms, from subtle coercion to more overt forms of violence. Regardless of the form, however, this represents a risk of HIV for female prostitutes.

Women also report being raped by clients, which once again points to the serious inequities between prostitute and client. It is also a situation that makes it impossible for the women to be 'safer sex professionals'. Many within the legal profession, as well as much of the public, believe that female prostitutes who are raped are 'asking for it' because of their work. This reveals a serious misunderstanding concerning rape, which is forced sexual relations against one's will and takes place because of gross power inequities in gender relations. Given this lack of understanding, and the stigma that many female prostitutes face when they attempt to report a rape, many rapes of female prostitutes are unreported and many women endure this violence and the long-term consequences of the violence without needed supports and services.

Clients also utilise economic incentives in an attempt to ensure sexual services without the use of condoms – incentives that some women find difficult to resist because of their desperate economic need. In some instances this need is related to an alcohol or drug addiction, found to be quite prevalent among female prostitutes. Tremendous barriers confront women with addictions seeking treatment. These include the waiting times for accessing programmes, the lack of economic and social support for children when the women are in treatment, and the poor attitudes of some counsellors who are not sensitive to the women's situation and their work as prostitutes. The prevailing attitude is that drug use is a legal issue rather than a medical problem and this has been a major stumbling block to the establishment of needed treatments and treatment centres, as well as to many women seeking treatment. Many pregnant women and women with children are afraid to admit drug use and to seek help owing to the 'well-founded belief' that they will lose their babies (Whynot, 1998).

. . . although it is widely believed that HIV-infected female prostitutes should not be working, calls to have HIV-infected men who frequent prostitutes barred from doing so are not heard.

Just as women have traditionally been responsible for birth control and the unintended pregnancies resulting from birth control failures, female prostitutes are typically viewed as responsible for keeping the trade safe from STIs, including HIV. In many instances women take on this role because of the importance of maintaining their own health and wellbeing (not only so that they remain healthy but also so that they can continue to care for and financially support their families). However, there are contexts when condoms are not used, as noted above, and at times condoms break. In such instances the women, not the clients, are typically blamed and stigmatised for the consequences. Furthermore, although it is widely believed that HIV-infected female prostitutes should not be working, calls to have HIV-infected men who frequent prostitutes barred from doing so are not heard.

HIV prevention programmes/policies and the private sphere

To date, in Canada, most HIV prevention programmes have focused almost exclusively on ensuring condom use within prostitutes' working lives with male clients. Relatively little attention has been given to women's private lives and their

Most HIV-prevention programmes are not organised to address the general health and wellbeing of female prostitutes.

risks of HIV infection within this sphere of their lives when having sexual relations with men. However, many have noted that female prostitutes' greatest risk may be when having sexual relations with private partners (for example, a spouse or a boyfriend) who is an injection drug user because of the fact that typically condoms are not used outside of the work setting.

For many prostitutes condoms are associated with work and there is often a resistance to using them when having sexual relations with someone other than a client. Some women have noted that a condom interferes with the closeness of a private relationship exactly because of the use of condoms with clients. Condoms with clients represent both a physical and psychological barrier and this means that there is little interest in using them when one wants to be emotionally close to one's partner.

At the same time, when prostitutes do feel they would like to use condoms with a boyfriend or spouse because they believe that they are at high risk of HIV or other STIs, they are sometimes fearful of even broaching the topic for fear of negative repercussions. Some women have reported that their male partner would be terribly offended if the issue of condom use was raised because it would represent the client-prostitute relationship rather than an intimate relationship. This points to the fact that safer sex is not safe if it has the potential to challenge a relationship with a significant partner who might become violent.

Conclusion

Since the 1980s, many HIV-focused policies and programmes have been developed that were aimed at prostitutes. Numerous and varied educational programmes now exist in many centres, and prostitutes are frequently provided with free condoms, access to counselling services and so forth. However, such efforts are fundamentally aimed at ensuring that prostitutes remain free from HIV (as well as other STIs), in order to ensure that clients are safe from STIs and can pursue their leisure experiences without fear of HIV. Most HIV-prevention programmes are not organised to address the general health and wellbeing of female prostitutes. The women are viewed primarily as 'workers' rather than as women who enter the sex trade industry often because of economic need that is a product of systemic inequalities based on class, gender and race. For a large number of women who work in the sex trade industry, their vulnerability to HIV is rooted in the fact that they are economically disadvantaged and their poverty is directly related to gender, racial, ethnic and other inequalities.

Many women enter the sex trade industry because of poor employment opportunities and lack of work skills. In many instances, women who work in prostitution have experienced a history of child abuse – physical, sexual and/or emotional – that has led them to leave home at an early age. They thus lost the chance to complete their education with family support. Attempts to continue their education are extremely difficult and more often than not thwarted because of the economic costs of education and maintaining themselves financially. A number of women living on social assistance are unable to provide for themselves and/or their children. This makes the sex trade industry an attractive option both because it allows them to augment their income and because it provides work opportunities in a situation where they do not possess the education and skills to otherwise obtain a decent wage.

Clearly, programmes and policies are needed to tackle the underlying issues that are often precursors to women entering the sex trade industry and that keep them tied to this work even when it is dangerous and risky to their health. The socio-economic conditions that make women vulnerable to HIV – lack of power within male-female relationships, economic dependency, drug and alcohol addictions – need to be addressed. Women require access to educational and work opportunities and affordable housing and childcare. Policies are needed to ensure economic security for women and their children, as well as access to non-judgmental counselling and legal and medical services, regardless of their work. Women who find themselves working in the sex trade industry require the same level of protection as other women, and should not have to endure emotional abuse from professionals by being labelled as 'deviant', 'immoral', or 'unfit mothers'. These labels and the stigma associated with them only work to make women feel inferior, and fearful of obtaining needed services that might reduce their vulnerability to HIV.

For a large number of women who work in the sex trade industry, their vulnerability to HIV is rooted in the fact that they are economically disadvantaged and their poverty is directly related to gender, racial, ethnic and other inequalities.

It is also important that women who work or have worked in the sex trade industry take part in the development of policies and programmes to address the inequities women face. Providing them with a voice in the planning of programmes and development of policies will help to ensure the implementation of social changes that will directly benefit these women. It will also help to empower the women, most of whom have lived much of their lives outside the realm of programme development and policy decision-making.

Source: Jackson, 2001

Case Study: Marketing the Female Condom (Zimbabwe)

The female condom is a relatively new product that prevents pregnancy and sexually transmitted infections (STIs). The World Health Organization (WHO) estimates a 5 per cent annual accidental pregnancy rate associated with perfect use of the female condom, compared to 3 per cent with the male condom. A study on contraceptive efficacy suggests that perfect use of the female condom also reduces the annual risk of becoming infected with HIV by more than 90 per cent among women who have intercourse twice weekly with an infected male. This is similar to the level of protection offered by the male condom.

The female condom may also prove to be an HIV protection option over which women have more control. Many women may be unable or unwilling to negotiate male condom use with their sexual partners because of prevailing gender-related inequalities, norms and roles that exist in many societies.

In 1996, based on the positive findings of acceptability trials and as a result of advocacy efforts by the Women and AIDS Support Network, the Zimbabwe National AIDS Co-ordination Programme (NACP) of the Ministry of Health and Child Welfare invited Population Services International (PSI) to initiate a five-year female condom social marketing programme in Zimbabwe. The programme was launched in 1997.

To avoid the stigma associated with STI/HIV prevention, the female condom is marketed as a family planning product, a ‘contraceptive sheath’ under the brand name Care™. The product's original marketing slogans included "The care contraceptive sheath is for caring couples" and "For women and men who care". The female condom was initially sold through selected pharmacies and clinics at a heavily subsidised retail price of US$0.24 for a box of two. Distribution has since expanded to other urban outlets, including large supermarkets and convenience stores.

Research

As experience with the female condom in Zimbabwe and other countries increases, a number of research questions has arisen about its use and its potential for STI/HIV reduction. Answers to these questions (for example, who uses the female condom, with whom and why?) have important implications for reproductive health programmes. Currently, the female condom is a relatively expensive product, priced at approximately ten times the cost of a male condom. From a programme and policy standpoint, the decision to introduce this product in a given country on a wide scale implies significant financial costs. The introduction of heavily subsidised and relatively inexpensive female condoms in Zimbabwe through a social marketing programme has provided large numbers of urban women with easy access to this product. So the situation in Zimbabwe allowed the Horizons Project and PSI to address critical research questions with a fairly large number of respondents about female condom use under real life conditions.

The study used a combination of quantitative and qualitative methods. An intercept survey was conducted with women and men exiting urban sales outlets that carry both Protector Plus™ male condoms and Care™ female condoms. In total, 493 female condom users, 633 male condom users and 624 non-users were included in the study. Male and female users of the female condom also participated in in-depth interviews and focus groups.

Results

Who uses the female condom?

Users are generally in their mid- to late-twenties and, compared to male condom users and non-users of either method, have higher levels of education and access to household resources. Among women, more users of the female condom are unmarried and are primary breadwinners in their households compared to users of male condoms and non-users. The vast majority of men and women had used the male condom at least once before trying the female condom. More than half of male users, but only 17 per cent of female users, reported having more than one sexual partner within the last year. Use of the female condom is higher within the context of marriage or regular partnerships rather than casual or commercial partnerships.

Reasons for female condom use

Novelty or experimentation and pregnancy prevention were primary reasons for the initial use of the female condom. However, a third of men and 21 per cent of women reported STI/HIV prevention as a motivator for trying it.

Perceptions of, and problems with, the female condom

Users perceived the female condom to be effective and reliable both as an STI/HIV prevention method and a contraceptive method. But 30 per cent of men and 57 per cent of women reported some difficulty with use, such as problems with insertion, discomfort during sex and excess lubrication.

Negotiation of the female condom

Both male and female users concurred that women, more than men, initiate dialogue about using the female condom, decide on its use and procure the product. However, a considerable percentage of both male and female users reported that both partners jointly decided to use it. Focus group and in-depth interview data revealed that while some women, particularly married women, were interested in using the female condom for disease prevention, they were not comfortable discussing this openly with their partner. Some 13 per cent of women reported using the female condom without their partners' knowledge. While this suggests that for some women the female condom can be totally under their control, in the vast majority of cases it requires communication with and co-operation from a woman's partner.

Nearly a fourth of women and 15 per cent of men said that one of their partners opposed female condom use. While most said they used a male condom instead, about half the married women whose partner opposed using the female condom had unprotected sex.

Consistency of female condom use

Overall, about 15 per cent of women and men reported always using the female condom. Consistent use was reported much less frequently with spouses than with regular partners outside marriage. Among those who had used both the female and male condom, approximately 80 per cent of men said they intended to use both methods in future. A greater proportion of women said they would use the female condom again (68 per cent) rather than the male condom (54 per cent). Married women were less likely than single women to report continued use of either barrier method.

Increased STI/HIV protection among some female condom users

Twenty-seven per cent of married women had never used a male condom before they used the female condom, and 20 per cent of consistent female condom users reported that they were not consistent male condom users before trying the female condom.

Continued male condom use among female condom users

Of inconsistent female condom users who have used the male condom, 93.8 per cent reported continued use of the male condom. Female condom users often alternated the use of male and female condoms. Women reported using female condoms when their husbands came home late at night or when they suspected infidelity. Also, some men reported using female condoms with their wives and regular partners while continuing to use male condoms with casual partners and sex workers.

Policy implications

The female condom has been used within marriage or a regular partnership and among consistent users, primarily as a family planning method which reflects the aims of the social marketing campaign. Single women and married men with outside

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partners seem to benefit most from its introduction. These are important groups to reach in a country such as Zimbabwe, which has a high prevalence of HIV in the general population.

An important issue for programme planners is ensuring access to the female condom for people from all economic and educational strata. If significantly greater percentages of people with higher socio-economic status or more formal education continue to use the product at higher rates, then the price of the condom may be too high. It is also possible that special support services may be needed to facilitate access, negotiation or correct use of the female condom among people with lower levels of resources and education.

Married women have particular needs that have to be addressed in future campaigns and educational programmes. Many married women perceive themselves to be at risk of HIV infection but do not use any barrier method. Among female condom users, married women are more likely than single women to encounter partner resistance to the female condom and less likely to report future use.

Face-to-face contact – with partners, friends, relatives or health professionals – was found to be important for motivating female condom use. Training both peer educators as well as clinicians and pharmacists to provide women and men with information and support services about the product may be an effective means of increasing correct and continued use. Also, female condom programming must assist users, in particular women, to be prepared for negotiation and agreement of use with partners. They must be equipped with the necessary skills and tools.

Data from this study suggests that female condoms are providing new and additional protection from STIs/HIV to some study participants. More research is needed to more accurately assess the female condom's contribution to increasing the incidence of protected sex among women and men in Zimbabwe.

Source: Kerrigan et al., 2000

Case Study: HIV Counselling and Testing among Pregnant Women: Best Practices (Canada)

Introduction

In Canada, women of childbearing age (15–44 years) accounted for approximately 79 per cent of the total AIDS cases among adult women reported to the Laboratory Centre for Disease Control, Health Canada, to the end of 1999 (Health Canada, 2000d). Of the 196 paediatric AIDS cases reported by that date, the majority (78 per cent) were attributed to parent-to-child transmission (PTCT) (Health Canada, 2000e). PTCT can occur in the mother's uterus prior to birth, during birth at the time of labour and delivery, and following birth through breastfeeding. Other factors that can increase the risk of transmission include maternal viral load, mode of delivery, timing of delivery after rupture of membranes and length of time breastfeeding.

Parent-to-child transmission [of HIV] *can occur in the mother's uterus prior to birth, during birth at the time of labour and delivery, and following birth through breastfeeding.*

Despite these facts, offering voluntary counselling and testing (VCT)[2] to pregnant women for HIV was not a public health policy objective to prevent the perinatal spread of HIV prior to 1994. Before this, HIV testing among pregnant women was provided either at the request of the pregnant women or on the judgement of their doctors. However, the results were then published of a randomised clinical trial of antiretroviral medication provided to mothers during the second or third trimester, during labour and delivery, and to their newborns for six weeks. These showed a two-thirds reduction in PTCT and caused the role of HIV testing in pregnancy to be rethought. (Connor E.M., Sperling R.S., Gelber R. et al., 1994). Further Canadian studies have shown antiretroviral therapy to be effective in reducing PTCT rates even lower than the eight per cent achieved in the trial (Forbes, J., Burdge, D.R., Money, D., 1997; Lapointe, 1998).

Although increased attention has been focused on the issue of the prevention of PTCT, most studies in the area have been quantitative in nature (i.e., they have been mainly concerned with looking at the numbers of pregnant women undergoing HIV testing). Little work has been done to investigate pregnant women's experiences with antenatal HIV testing from a qualitative perspective.

The present study was formulated to explain some of the gaps in our current knowledge regarding HIV VCT among pregnant women in Canada. More specifically, it aimed to pro-

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[2] While this article uses the UNAIDS terminology of VCT, it is clear that HIV counselling and testing of women in this study was not always perceived as voluntary.

vide timely information from pregnant women to inform a federal position on an effective antenatal HIV counselling and testing policy for Canadian women. The goal was to document pregnant women's experiences of HIV testing in pregnancy and, based on these experiences, their perceptions of best practices regarding HIV counselling and testing.

Additionally, this national study allows for a comparison of the application and acceptability of current prenatal HIV testing policies in three provinces: Alberta, Ontario and Nova Scotia. In Canada, HIV testing programmes are the responsibility of provincial and territorial governments. There are no national recommendations or national policy guidelines in this area and, as a result, there are a range of different policies. The provinces were selected for this study because they had different approaches. In Alberta, the provincial policy offers an opt-out option, which essentially allows for all pregnant women to be routinely tested as part of the prenatal screening programme unless they specifically decline this. In Ontario, all pregnant women and women contemplating pregnancy are offered the opportunity for HIV counselling and testing. And in Nova Scotia, the provincial guidelines have recently changed from a policy suggesting HIV counselling and testing at the discretion of the physician to one suggesting that HIV counselling and testing should be offered to all pregnant women.

Methods

A total of 105 pregnant women, 35 from each province, was interviewed regarding their antenatal HIV counselling and testing experiences. The stratified sample of women in each case included Aboriginal women, women from HIV-endemic countries, visible minority women, women who would be considered to be at high risk for HIV infection, women considered to be at low risk and women who inject drugs. With the woman's consent, each interview was audio-taped and then transcribed and analysed to determine the types of issues women experience in relation to HIV counselling and testing during their pregnancy. The interview followed a guided conversational format, which allowed the pregnant women to elaborate on a number of key, interrelated issues. These included whether HIV testing had been offered, how it was offered and what were the women's assessments of best practices for HIV counselling and testing grounded in their own experiences.

Results

. . . the established Canadian principles of voluntary HIV counselling and testing are not always maintained by programmes that offer to test women during pregnancy.

Preliminary findings show clear evidence that the established Canadian principles of voluntary HIV counselling and testing are not always maintained by programmes that offer to test women during pregnancy. While the majority of the women interviewed did accept testing when it was offered, many reported that they did not experience the offer to test as voluntary and did not feel that they had given their specific informed consent to be tested. Many women interviewed also reported that they had not been given adequate information to assess the risks and benefits of HIV and testing for themselves or for their unborn child.

In Alberta, where all pregnant women are routinely tested for HIV as part of the prenatal screening programme or other pregnancy-related tests (with the option to opt out), only 2.4 per cent of pregnant women declined testing during the second year of the programme. None of the women interviewed for this study had declined testing. However, many of the women either had no prior knowledge that they would be tested for HIV or were not informed about the test. If they were informed about the test, they were not presented with the option of declining. Nevertheless, all the women indicated that they were pleased that their doctor had included the HIV test among the prenatal tests that were ordered and would have agreed to the test if they had been given the option. They also added that they wanted to know about the testing even though it was routine. Furthermore, many of the women who participated in the study had had previous HIV testing and although they believed that they were still HIV negative they agreed to have the test since it was routine.

In Nova Scotia, where it is recommended that testing should be offered to all pregnant women, there were very few refusals of the test among study participants. This may reflect the fact that some women being testing for HIV either do not know it or do not feel comfortable asking their physician why the test is being offered to them. In addition, women who perceived themselves to be knowledgeable about HIV risk tended to decline testing when it was offered since they felt they knew their risks better than their physicians. Variability was found in the offer of testing by social class or ethnicity. For example, rural Aboriginal women were more likely to have been tested than were white women. Also, very few women interviewed in Nova Scotia felt that they had been given adequate pre- and post-test counselling or information regarding the use of the test results. Several women commented that they had wanted to do whatever their physician suggested regarding prenatal blood tests, believing that they were doing what was best for the baby. Some women also commented that they did not feel comfortable questioning or refusing the recommendations of their physicians to take the test for fear of possibly receiving sub-standard health care at subsequent appointments.

In Ontario, where all pregnant women and women contemplating pregnancy are offered the opportunity for HIV counselling and testing, some women have refused the offer of the test. Reasons for refusal centre on a previous history of accessing HIV testing outside pregnancy or their concerns regarding the use of the test results. Some women declined testing, as in Nova Scotia, based on their own assessment of their behavioural susceptibility to HIV infection, often confirmed by previous negative results; others declined simply because they were regularly tested either as blood donors or as part of their annual physical examination.

Discussion

Grounded in their own personal experiences, the women interviewed recommended developments in policy and practice which would ensure that prenatal programmes encompass HIV testing in a manner which is sensitive to both the needs of the pregnant woman as well as the prevention of HIV transmission. Several women remarked on how the focus for HIV testing during pregnancy is related to the foetus and not to the pregnant woman's wellbeing *per se*. In addition, it was felt by a number of women that removing the exceptional nature of HIV testing during pregnancy may help to reduce the stigma that is still often associated with HIV testing at other points across a woman's lifespan.

Very few women commented on having access to any information on antiretroviral treatment to reduce the risk of transmission to their baby . . .

In terms of best practices, most of the women interviewed in Nova Scotia felt that their physicians were the individuals best suited to offer HIV testing in their pregnancies. However, they also pointed out the need for greater standardisation of pre- and post-test counselling to reduce the variability in the way the test is offered to pregnant women and under what circumstances. Some women interviewed felt that they either had sufficient levels of HIV knowledge prior to their physician suggesting the test or were given this in the course of their prenatal care. Several others, however, felt that more emphasis ought to be placed on providing information on the treatment options for women who are found to be HIV positive during pregnancy. Very few women commented on having access to any information on antiretroviral treatment to reduce the risk of transmission to their baby, leading some women to report that they would abort the foetus rather than risk carrying it to term and potentially giving birth to an HIV infected baby.

There was consensus among those interviewed that preventing PTCT is an important issue and that additional information and resources could be used to increase the visibility of the purpose, the procedure and the use of the test results. In addition to the pamphlet produced by the Canadian Public Health Association on women and AIDS, it was felt that other pamphlets, videos, websites or toll-free hotlines are needed, particularly for those women who live in more remote areas of the province.

In Ontario, most pregnant women interviewed supported the provincial policy. They saw the offer of an HIV test in pregnancy as the first step in accessing, if necessary, the choice of treatment for themselves and preventive interventions to reduce transmission to their unborn children. However, many women were very clear that pregnancy was not the most appropriate time to raise the issue of HIV infection with women or to offer testing. Pre-conception – before deciding on pregnancy or at the time of an annual pap smear or physical examination, for example – was favoured by many women because knowledge of their HIV status would have been a factor in their decision to become pregnant. Other perspectives on the timing of the offer of antenatal HIV testing included the idea that the issue should be raised early enough in the pregnancy to allow the pregnant woman access to a range of options,

. . . women wanted information about how women can contract HIV and how it is transmitted to the foetus.

which might include termination. It was also suggested that the discussion around the offer to test for HIV should be carried out over several visits, which would allow for personal reflection and discussion with the woman's family and partner as appropriate. An issue of particular importance for women in Ontario was the recommendation that HIV testing should be the focus of a prenatal visit and not combined with other routine tests offered in pregnancy, in particular the offer of maternal serum screening.

As in the two other provinces, their doctor was the first choice of most Ontario women to raise the issue of the opportunity to test for HIV in pregnancy. For some women, their doctor was their preferred health care professional as they felt that the discussion around HIV testing would remain confidential; for others it was because they had an established relationship with their doctor based on trust. However, some women would choose the health care provider who is most accessible to them in terms of the time they have available and suggested nurses attached to physicians' practices, public health nurses and midwives.

Finally, most of the women in Ontario, as in the other two provinces, wanted much more information than was offered to them before they took the test. In addition to describing the information they needed from their health care provider, they made suggestions for the contents of a brochure to be made available to every pregnant woman or woman considering pregnancy in Ontario. They suggested that this could be distributed at the point of sale of feminine hygiene products and pregnancy home-testing kits.

In Alberta too, women's responses provided further insights into best practices for HIV counselling and testing. A few women also identified nurses, in addition to physicians, as possible people to deliver HIV VCT. They felt that nurses have more time and would be more likely to be more accessible than physicians, particularly in more remote areas of the province. As well as information about treatment, women wanted information about how women can contract HIV and how it is transmitted to the foetus. Although Alberta has produced brochures with this information, most of the women in the study had not seen them. This was also the case with respect to the brochures produced in Ontario. The majority of the women in Alberta supported the routine testing programme and several advocated mandatory testing. They noted that the routine nature of the testing resulted in less stigma because it was less stressful and embarrassing than having to request the test. However, many women said they would ask for an HIV test if they had concerns.

In order for pregnant women to increase control over their own health and that of their unborn children, there is clear value in all pregnant women being afforded the opportunity to know their HIV status. However, in efforts to reduce PTCT, it is essential that a pregnant woman's needs and rights to best practices in HIV counselling and testing are protected. Failure to attend to the quality or variability of the experiences of HIV counselling and testing in pregnancy will result in programmes that fail to increase testing acceptance rates and fail to provide women with the resources they need to make the best decisions for themselves and for their children.

Source: Leonard, Gahagan, Doherty and Hankins, 2001

. . . violence against women is a leading cause of death globally, accounting for more deaths among females aged 15–44 than traffic accidents, malaria, cancer or war.

Case Study: Involving Men in Preventing Gender Violence and HIV Transmission (International)

Stepping Stones targets men, particularly young men, and works with them and women to redefine gender norms and encourage healthy sexuality.

Geeta Rao Gupta (Gupta, 2000a)

HIV/AIDS has reversed hard-earned development gains and introduced into society new fault lines for discrimination and violation of individual and community rights. At the same time, violence against women is a leading cause of death globally, accounting for more deaths among females aged 15–44 than traffic accidents, malaria, cancer or war. HIV and gender violence are linked. Rape and other forms of sexual violence carry transmission risks, and the threat of violence inhibits the ability to talk openly about sexual issues such as condom use.

Some of the biggest challenges to preventing gender violence and HIV transmission are:

- *Tackling silence, denial and stigma.* Shame and fear lead to unwillingness to address the issues openly.

- *Challenging the acceptability of gender inequality in sexual relationships and decision-making*. Too often, culture is used as an excuse to justify a whole range of practices and structures that violate women's human rights. Traditional social and cultural expectations harm men as well, by denying them the opportunity to develop skills of nurturing, caring, communication and non-violent conflict resolution.

- *Moving from awareness to behaviour change*. Many interventions and campaigns are built on the false assumption that information leads automatically to behaviour change. There is insufficient support to enable individuals and communities to bridge the gap between knowledge and practice.

To meet these challenges, Stepping Stones was first developed in 1995 in Uganda. It has since been used by over 2,000 organisations in 104 countries worldwide. Local groups have translated and adapted it for their own use in many different countries, including Sri Lanka (Sinhala), Cambodia (Khmer), Russia, urban South Africa, Tanzania (Ki-swahili), Argentina (Spanish) and Mozambique (Portuguese). It is based on the following principles:

- The best solutions are those developed by people themselves.

- Men and women each need private time and space with their peers to explore their own needs and concerns about relationships and sexual health.

- Behaviour change is much more likely to be effective and sustained if the whole community is involved.

Rather than concentrating on individuals or segregated 'risk' groups, Stepping Stones works through groups of peers of the same gender and similar age (older women, older men, younger women and younger men). The groups work separately much of the time so that they have a safe, supportive space for talking about intimate issues and then periodically meet together to share insights. All the work is based on people's own experiences, and the use of role-play, drawing, song and dance means that everyone can take part, without needing any formal education background.

The workshop sessions

It is suggested that a total of 18 separate workshop sessions be held over a period of 9–12 weeks in a community. Spreading the sessions over several weeks like this enables community members who want to join the workshop to put what they have learned into practice between sessions. The sessions cover four themes:

Co-operation and communication. This helps each peer group to bond together and creates a safe, friendly atmosphere in which to explore sensitive issues. The facilitator or trainer of each group is the same gender and age as the members so that everyone feels comfortable as peers.

Relationships, HIV and safer sex. The men's and women's groups each have a chance to assess their own priorities in sexual health and family life, in the context of greater understanding of their potential vulnerability to HIV. Domestic violence – often linked to alcohol abuse – is an issue frequently highlighted by both men's and women's groups.

What influences us to behave the way we do. This includes, crucially, society's expectations of men and women (gender roles) which are often closely linked to cultural tradition.

How to practice and sustain change. The final sessions of the training workshop address "ways in which we can change" and explore assertiveness skills and non-violent conflict resolution.

The culmination of the process is a 'special request' from each peer group to the whole community, presented in the form of a role play, which illustrates the change each group sees as a top priority. The issues raised are then discussed by everyone present. This enables young women, for example, to present the dilemmas which they face with 'sugar daddies' who pursue them for sexual favours in return for school fees; or for older men to present the loss of self-esteem that turns them to drinking when they are made redundant. This sharing between groups enable everyone in the community to develop more awareness of the needs and difficulties of others around them, as well as increasing their own self-esteem and self-respect through having their own needs appreciated more clearly. This reciprocal experience of growth in self-knowledge and in awareness of others has a powerful and positive effect on community cohesion. Such meetings produce many comments such as, "I never realised that …" and "now I understand why …" As the community members begin to understand themselves and one another more, the foundation stones for change are laid.

Since people cannot be expected to change their approach to life on the basis of nine weeks' work, however, the workshop can only be seen as the starting point for changes within a community. So workshop participants are encouraged to continue meeting by themselves after the last session is completed. These continued meetings enable participants to sustain the changes that they have decided to make in their lives and act as a support group. They enable people to compare and share their successes and failures and to renew their determination to do things differently in future – something made easier by sharing the experience with a group of similarly committed people.

How Stepping Stones motivates and mobilises men

- Preparation for Stepping Stones' work in a community involves participatory needs assessment and discussion with community leaders, resource persons and existing grassroots groups, thus creating prior interest in the process among influential men.

- By dividing participants into age and gender groups, the workshop respects cultural norms of dialogue on sexual health issues. This motivates participation by men.

- Facilitators of men's groups are always men of similar age, usually from the community where the workshop is being conducted.

- The groups themselves decide the venue and time for their meetings, ensuring the process is built around their convenience and commitments. This encourages men's regular attendance.

- The approach helps men deal explicitly with their own mortality, and prepare for the security of their families through will writing. This is empowering in that it allows men to feel valued and retain the status of head of the household even when dealing with death.

- The methodology is not restricted to a community context but can also be used in schools and colleges, as well as the 'shop floor' context of industries, mining and other workplace environments.

Positive changes that can happen after using Stepping Stones

Sixteen months after a Stepping Stones workshop had been conducted in a community in Uganda, each of the four separate groups involved was interviewed separately about the changes they perceived in the community. It was a useful cross-reference to see that each reported change was mentioned by at least two separate groups. Young men and young women reported that they now had a better sense of trust between them. Previously, each had been blaming the other group for spreading AIDS – now, however, members of both these groups described how they had realised that they had to work together to overcome the challenge.

Young men also reported that they were starting to visit and help people with HIV and their carers in the community. Whilst older women had been doing this anyway, the young men said that they had previously just ignored or even ridiculed such people. Now, however, they reported that they had decided to do something to help them.

Most of the groups (which had not existed prior to the workshop) had also continued to meet regularly over the ensuing months. This would appear to be another key ingredient to sustained change. The one group which did not continue to meet was the older men's group, leading to some reported problems.

Conclusions

Learning about something, especially something as frightening as HIV, rarely influences people sufficiently to change their actions in a sustainable manner. Stepping Stones offers women and men of all ages and backgrounds the possibility of feeling safe about exploring – and learning to take more control of – the most personal details of their lives. When people feel able to begin to address these issues, about which they have immediate felt concerns for themselves, they are also helping to challenge conventional attitudes about women's rights, about traditional gender roles and about their own behaviours. They also begin to meet their own sexual and reproductive health needs.

In this way, sex, death and gender can begin to become less taboo subjects and therefore less fearful, and the causes and consequences of gender conflict can begin to be tackled. Work in such areas will also decrease vulnerability to HIV transmission and enable it to be addressed as an extension of these other issues, rather than as an isolated and insurmountable problem which bears no relation to the rest of people's lives.

Source: ActionAid, 2000; Welbourn, 1999

Case Study: The School Without Walls: Sharing Knowledge and Skills with Community Groups (Southern Africa)

The tortoise knows how to embrace his wife.

West African proverb

Introduction

Since the beginning of the international response to HIV in 1986, there have been numerous 'training programmes' designed to transfer North American expertise to Africa. The common approach of these programmes is to 'trickle down' the knowledge of a small group of northern experts, through a 'training of trainers' mechanism, to a large group of African field workers. Meanwhile, many African organisations developed extraordinary skills and knowledge because they had to find ways of living with a very serious situation affecting them directly. However, little attention was paid to validating and disseminating this local knowledge. This issue was identified in 1993 by community-based organisations supported by the Southern African AIDS Training (SAT) Programme. In response, SAT launched an initiative called School Without Walls (SWW).

The School Without Walls combines 18 Southern African organisations active in specific areas of the response to HIV, who have committed themselves to transfer their knowledge and skills to emerging community groups. The SAT Programme provides assistance to facilitate this transfer. The SWW approach is based on learning by seeing and doing in real settings, using results-oriented training that emphasises 'how to do' rather than 'what to do'. The transfer of skills within the SWW is from organisation to organisation.

. . . people facing challenges to life and livelihood tend to work out solutions long before international experts even grasp the nature of the problems.

The conception of the School Without Walls

When the world first woke up to the reports of a potentially serious HIV epidemic in Africa, the understandable immediate reaction was to mobilise all available expertise to stop the spread of the virus. This was the origin of the 'war against AIDS', introduced by the first Director of the Global Programme on AIDS. Many things have since been learned about HIV, however. The virus does not present itself as the convenient object of war. It does not 'attack' people and communities but is part of people and communities. How big a part depends less on the nature of the virus than on the environment in which transmission occurs. Although the necessary condition for an HIV epidemic is the presence of HIV, the shape of the epidemic is determined by many other factors of social structure and organisation.

As Africans confronted the emerging HIV epidemics in the continent, two errors of the early international campaigns stand out prominently: The focus was on the crisis rather than on the response; and there was too much reliance on theoretical disease prevention models, ignoring the fact that societies living with the virus were already applying their local knowledge to dealing with the situation. In retrospect, it should have been recognised that people facing challenges to life and livelihood tend to work out solutions long before international experts even grasp the nature of the problems.

The Southern African AIDS Training Programme (SAT) was set up in 1990 with Canadian government support and started building partnerships with groups in Southern Africa who began to organise to meet the emerging needs generated by the HIV epidemic. Initially most took a narrow view of these needs and developed their response within restrictive margins. Some groups were active in health education, others specialised in peer group activities among sex workers, some developed home care programmes and others confined their activities to supportive counselling. Some of the SAT partners did not explicitly include the response to HIV in their mandate. These were groups working for child welfare, groups who saw their main mandate as preventing domestic violence and groups lobbying for the legal rights of women or for human rights. Many of the groups were religious and mission based, reflecting the prominent role of the churches in providing health and social services in rural areas of Southern Africa.

Throughout the 1990s, the HIV epidemic in Southern Africa expanded to unprecedented levels.

Throughout the 1990s, the HIV epidemic in Southern Africa expanded to unprecedented levels. The groups and organisations trying to respond to the growing social and health needs came under pressure to expand their response, both in magnitude and in scope. Organisations that had started with the offer of specific prevention programmes had to integrate counselling and care in their services. Groups that had formed with a mandate to help victims of domestic violence were flooded by demands of women who were abused because of their HIV infection. Service organisations working for the protection of children from sexual abuse saw an increasing clientele of sexually abused orphans whose parents had died of AIDS. The social and AIDS service organisations had no difficulty knowing what needed to be done but faced the problem of not knowing how to do it. The issues that confronted them were new and there was little organisational experience in formulating an appropriate and functional response.

In 1993, a group of Southern African organisations met with SAT Programme staff and raised the following challenge: How can we access the expertise and skills developed by local groups who have found solutions to the problems we are facing every day? Clearly, these organisations did not want another series of lectures and workshops designed by experts. They did not need more 'AIDS awareness' or more generic 'programme management training'. They wanted facilitated access to local solutions developed by their peers. This was the birth of the School Without Walls. The event was a milestone in the SAT Programme philosophy as the word 'training' in its name changed its meaning from the transfer of expertise to Africa to address problems identified in North America to the validation and diffusion of African solutions to problems identified in Africa.

What is the School Without Walls?

Today, the School Without Walls is a loose network with 18 organisations at its core, each with a unique and specific experience in conducting activities relevant to the response to HIV in Southern Africa. The types of activities of the School Without Walls partner organisations are:

- Providing comprehensive HIV prevention, care and social support services;
- Addressing issues of HIV in the workplace through policy and peer education programmes;
- Providing counselling and palliative care services;
- Conducting programmes to prevent domestic violence and providing services for women and children who are victims of violence;
- Supporting peer action programmes for HIV prevention and care among female sex workers and other marginalised groups;
- Producing material for public education on HIV.

Through the School Without Walls, the organisations provide training in their specific areas of expertise with co-ordination and financial support from the SAT Programme. The training mandate extends to the whole of the Southern African region but is most involved in Zimbabwe, Zambia, Tanzania, Malawi and Mozambique. The methods of training include:

Structured study visits

Less experienced groups or organisations who want to introduce new programme areas visit more experienced organisations to observe their programmes in action. The visiting and host organisations are carefully matched to ensure the relevance of the concepts and skills to be transferred.

Organisational mentoring

Experienced organisations take on a mentoring role for new groups over a period of several weeks to several months. During this time, experienced staff of the mentoring organisation help design programmes, supervise and monitor the activities, and solve technical and administrative problems on the basis of need and demand. Mentoring often develops into long-term organisational relationships of mutual benefit to both parties.

Apprenticeships

Apprenticeships are usually organised in the context of mentoring relationships. They are an attachment of personnel for periods of one to four weeks to a well established programme, to gain practical experience in areas such as counselling, home care, managing of peer education programmes or providing services for victims of domestic and sexual violence.

Skills clinics

Skills clinics are practical group exercises usually lasting two to five days organised by the School Without Walls training organisations within their own working environment. They comprise personal coaching, group exercises and field visits. Skills clinics are a means for new organisations and for new personnel to rapidly acquire the basic knowledge about how to do what it is they have set themselves to do. The orientation of the clinics is towards basic project implementation skills in common areas of work.

Specialised skills clinics

Specialised skills clinics have a somewhat different objective. They are organised and hosted by one School Without Walls training organisation with a specific activity profile. The participants usually come from the entire region and may include other organisations with the same level of expertise in the subject. The skills clinics thereby function not only as a one-way transfer of know-how from trainer to trainee, but also as a forum to exchange programme experience and to find solutions to problems mutually encountered. Specialised skills clinics are organised on a variety of themes, such as domestic violence, child sexual abuse, counselling for survival skills among people living with HIV, home care, palliative care and bereavement counselling.

Thematic networks

Thematic networks are not strictly a method for capacity transfer but rather a mechanism of mutual support and learning for specialised organisations. The networks may be national or regional and often evolve from specialised skills clinics. Network members include all organisations with interest or activities in specific areas such as supportive counselling, home care and human rights advocacy. Although supported by the SAT Programme, the networks extend well beyond SAT and the School Without Walls and often include government representatives of the relevant ministries and programmes.

Cross networking

Cross networking is organised and directly managed by the SAT Programme using the School Without Walls structure. The purpose is to widen the goals and perspectives of organisations working in areas related to the response to HIV. For instance, a series of cross networking meetings organised by SAT brought together activists on gender equality, human rights activists and AIDS activists from several countries in Southern Africa. This allowed the different organisations to identify common areas of activity and interest. As a result, some AIDS and gender activist groups formed a common approach to address the issue of property rights for widows and achieved significant results in terms of public awareness and legal reform.

The School Without Walls programme and approach has become well established in Southern Africa. Institutional mentoring, site visits, apprenticeship exchanges and thematic networks are being organised well beyond the boundaries of the SAT Programme, supported by a large number of international donors. It has become a practical model of South–South collaboration and is a viable alternative to the trickling down of not necessarily appropriate theoretical knowledge to field workers via the sometimes very tenuous information chain of ‘training of trainers’.

Source: Beatson and Decosas, 2000

Case Study: Integrating Sexual and Reproductive Health Programmes (Bangladesh)

In Bangladesh, the International Centre for Diarrhoeal Disease Research (ICDDR,B) and the Bangladesh Rural Advancement Committee (BRAC) joined forces to integrate sexual health interventions and education into existing rural health services. For economic and other reasons, the integration of HIV/AIDS activities into existing programmes offers a viable approach to controlling the pandemic. A narrowly focused HIV/AIDS programme may fail to mobilise the community for effective control and prevention and may even meet with opposition. Integrated programmes that deliver a wide range of services can be more effective and attract support from many segments of society. Another reason for including HIV/AIDS components in ongoing programmes is the need to ensure sustainability of prevention efforts.

The goal of the joint project was to improve the sexual and reproductive health of the rural poor in Bangladesh, especially women and adolescent girls. In an effort to reach this goal, the project undertook a number of steps that are needed to successfully integrate STI/HIV activities into existing health services. These included:

- Conducting a needs assessment (interviews and focus groups) within the community to identify the socio-cultural factors contributing to the need for sexual and reproductive health services among community members. This allowed the programme to explore:
  - myths, beliefs and taboos about sex and HIV/AIDS;
  - relationships between men and women;
  - knowledge, attitude and practices in HIV/AIDS prevention;
  - populations in need of services;
  - level of community interest in the programme;
  - types of services needed.
- Identifying and training community members interested in becoming peer educators and counsellors.

- Training community health workers to integrate sexual and reproductive health education into their work. The workers began to discuss sexual and reproductive health issues with their clients during their regular visits, regardless of the nature of the visit (i.e., birth attendants, pharmacists and traditional healers added sexual health education to their regular routine). Community members began to view the health providers as resources on sexual problems in addition to their existing roles.
- Creating educational materials based on the results of their needs assessment. The materials included picture stories containing information about physical development, reproduction, STIs and hygiene. The materials were used to train the health workers and peer educators.
- Conducting an evaluation of the integrated health services.

Through the project's efforts, 68 health workers and 1,890 community members were trained to integrate sexual and reproductive health services into their work. The trained personnel talked to hundreds of community members, providing them with the information and resources to deal with sexual health problems in addition to the regular services provided.

Source: UNAIDS, 2001a

Sexual health not only requires appropriate levels of knowledge about sexuality. It also requires the capacity to develop fully one's potential for sexual expression . . .

Case Study: Gender Differences in Sexual Health Promotion among Adolescents (Canada)

Sexual health not only requires appropriate levels of knowledge about sexuality. It also requires the capacity to develop fully one's potential for sexual expression (Blonna and Levitan, 2000). Such capacity is particularly important for adolescents and young adults as they begin to explore issues of sexuality and sexual activity. With sexual exploration comes the very real potential for unintended pregnancies as well as exposure to sexually transmitted infections (STIs), including HIV.

Many efforts have been undertaken to reduce the incidence of STIs and unintended pregnancies among adolescents. However, the types of healthy sexuality messages targeted at this population are often at odds with the way young men and women are socialised. For example, programmes for adolescents that place a significant emphasis on contraceptive choices for pregnancy prevention may have the effect of inadvertently shifting these messages from both males and females to an issue for females alone. Differing definitions of healthy sexuality and differences in areas of sexual interest between young men and women may also serve to reinforce traditional gender stereotypes and sex roles that portray females as passive and males as active sexual beings.

Since 1996, the community of Amherst in Nova Scotia, Canada, has been making efforts to help young people with this aspect of their lives through health promotion efforts targeted particularly at prevention of STIs and unintended pregnancy. During this time, the Amherst Association for Healthy Adolescent Sexuality (AAHAS), a voluntary non-profit organisation, has been conducting community education, largely through a campaign making use of local media, workshops for parents and continuing professional education, all directed at improving the sexual health of Amherst's adolescents. A health centre located at Amherst Regional High School (ARHS) has been established to provide educational and clinical services to students through a nurse-educator. These services include contraceptive and sexual health counselling and referral, and the provision of free condoms.

In order to assess the success of this programme, students at ARHS were asked to complete self-administered questionnaires in November 1996 and again in November 1999. They were asked about their sexual health knowledge, their attitudes towards various aspects of sexuality and their use of barrier protection and oral contraception. Questionnaires were administered in the classroom setting, supervised by teachers. Approximately 80 per cent of eligible students completed surveys in both survey years. The mean ages of students by gender were very similar, as were proportions of eligible males and females responding.

Some of the results of surveys were that:

- Sexual activity was similar in 1996 and in 1999 for males and was seen to decrease slightly in females.
- Sexual health knowledge scores increased in both age groups in each gender, both overall and in those who were sexually active. Absolute differences were similar for

females, both overall and for those who were sexually active. Males who were sexually active had a smaller increase in knowledge than that seen in males overall.

- For males overall, attitudes towards condoms remained the same from 1996 to 1999, but the attitudes of sexually active males became less positive. Females in both groups showed more favourable attitudes.
- Females had significant increases in their perception of societal support for their use of condoms, while males indicated decreased perception of such support.
- Use of a condom at last intercourse increased significantly in females from 1996 to 1999, but was essentially unchanged in males.
- Females' use of oral contraception at last intercourse increased from 49 per cent to 58 per cent.

There was also an approximately 31 per cent reduction in the pregnancy rate in Amherst in 1998 attributable to the intervention effect.

The changes in young women's sexual health attitudes and behaviours, and in rates of pregnancy observed in association with this programme, are very encouraging. Young men, however, did not show much in the way of change over the three-year period. In fact, though males showed an increase in knowledge, changes in attitude towards condoms and perception of societal support for their use were essentially the same in both years, and attitudes to condoms in fact became less positive. This was reflected in the finding that males' condom use at last intercourse remained unchanged. Despite the efforts made to include both male and female students' needs in sexual health promotion messages in both school-based and community programmes, young women responded more favourably to these messages than young men. This finding is similar to those seen in other investigations (Gupta, Weiss and Mane, 1996).

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Some authors suggest that such results may be related to differences in levels of maturity between adolescent males and females. Others argue that this is a reflection of a sexual double standard, whereby young women are socialised to accept a greater degree of responsibility for sexual and reproductive outcomes than their male counterparts (Blonna and Levitan, *Educational interventions which include role-play, question and answer sessions, and computer-based information and sexual health assessment tools have been found to be very useful among adolescents.*

2000; Goma, 1996). It could also be the case that the community's health promotion efforts may not have sufficiently taken into account the needs of the young men it was attempting to reach. Efforts to reduce the spread of STIs, including HIV, as well as unintended pregnancies, must acknowledge the variability of high school aged individuals' sexual experiences in addition to the gender differences in sexual socialisation between young men and women. Additional sexual health promotion programming efforts in this community will need to take measures to ensure that young men feel a sense of 'buy in' with such efforts and do not feel as though they have been written out of the safer sex discourse.

Perhaps negative attitudes seen among the young men in this study are a reaction to a new sense of empowerment on the part of young women in Amherst. Culturally dominant ideas or gender stereotypes regarding sexual roles and responsibilities for high school aged individuals can present formidable challenges in the prevention of STIs, HIV and unintended pregnancies, and should be considered by those involved in such efforts.

Providing sexual health information to young people might be more useful if it also provided the means to change behaviours in the context of their own unique social and cultural frameworks. The decisions made by young people regarding prevention in the area of sexual health are often informed by social and cultural values that reflect the social context in which more general decisions regarding sexuality are made (Kowalewski et al., 1997). Several authors have pointed to the need to go beyond simply attempting to increase awareness of risks to sexual health. Reference also needs to be made to the numerous risks confronted by young people in the context of their daily lives (Schieman, 1998; Poppen and Reisen, 1997; Smith and Katner, 1995).

Educational interventions which include role-play, question and answer sessions, and computer-based information and sexual health assessment tools have been found to be very useful among adolescents. A number of authors call for interventions which allow both young men and women to act out and discuss inconsistencies between levels of perceived risk and imposed responsibility and actual risk behaviours. Others report that stereotypical sex roles will continue to undermine prevention efforts unless adolescents have access to resources and environmental supports to sustain such efforts (Rhodes et al., 1997; Rotheram-Borus et al., 1995; Stevenson et al., 1995). Issues of the context in which sexual risk behaviours occur need to be addressed, together with the impact of gender roles – including sex role stereotypying and the sexual double standard – on sexual risk-taking behaviours. Until then, many young people will continue to find themselves at enhanced risk of unintended pregnancies, STIs and HIV infection.

Source: Langille, Gahagan and Flowerdew, 2001