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Special Issue: "Men's Sexual and Reproductive Health: Lessons from the Field"
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Men and Sexual and Reproductive Health: The Social Revolution

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An overview of the state of men's sexual and reproductive health since the 1994 Cairo Conference is presented. Men's involvement in contraception and family planning, paternal involvement, and violence toward women are noted. The five articles in this special issue are introduced. The authors conclude, "Cairo gave us our blueprint for action. The examples here [the five articles] give voice to the slow but important progress of engaging men in achieving this vision of true gender equality."

Keywords: International Conference on Population and Development, ICPD, Cairo Conference, men, sexual, reproductive, health, gender revolution, gender equality

In 1994, delegates from 180 countries met in Cairo at the International Conference on Population and Development (ICPD, or the Cairo Conference). These delegates included leading advocates in the field of sexual and reproductive health nominated by their governments as well as official representatives from national-level governments. Reflecting and deliberating on the field of sexual and reproductive health, the delegates included in the Plan of Action the following statement:

Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; maternal and child health; prevention of STIs, including HIV; ... shared control and contribution to family income, chil-

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dren's education, health and nutrition; and recognition ... of the equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children. (United Nations, 1994)

While the Cairo Conference was seen as focusing on sexual and reproductive health, and much of it did, the Plan of Action was no less than a manifesto for a gender revolution: namely, men should be fully engaged in achieving gender equality in their family lives and intimate relationships. The Cairo Conference is rightly considered a fundamental moment in the growing international field of promoting men's positive involvement in sexual and reproductive health. It was, and still is, for those of us who are advocates in the field of engaging men in achieving gender equality, our rallying cry.

When we consider the domain of reproductive and sexual health, women's concerns have always been at the forefront. Maternal mortality and morbidity, family planning and contraception, safe and legal abortion services, and reproductive tract infections are issues that have traditionally been associated with women. Men's concerns seem to appear only when sexually transmitted infections and HIV/AIDS or adolescent health are added to this list, and even then, their inclusion has been limited. Men have sometimes been included in these issues because in many parts of the world they largely control women's decision-making related to health care and decisions related to sexuality and reproductive health. Thus some programs have sought to encourage "appropriate" influence or behavior on the part of men without questioning underlying structural gender inequalities. This limited instrumental approach for engaging men has been rightly criticized for maintaining the status quo of gender equality.

However, the Cairo Plan of Action is a manifesto—not for merely "involving" men in instrumental or small-scale ways—but for true gender equality. The Cairo Plan of Action is based on the principles of equal human rights for all, of nondiscrimination and equality of women, and the elimination of all forms of violence and coercion. These principles draw their inspiration from the Universal Declaration of Human Rights, the International Covenant on Economic Social and Cultural Rights, and the Convention on the Elimination of all Forms of Discrimination against Women, among others. The Cairo Plan of Action thus represents the application of human rights principles to population and reproductive health-related programming. The call for gender equity and equality and involvement of men is grounded in the principles of human rights and the belief and assertion that all human beings are equal in dignity and rights. In sum, Cairo does not merely call for engaging or involving men in sexual and reproductive health, but in overturning the inequitable gender order.

Eleven years out from the Cairo Conference, the relevant question before us is: Have we achieved the goals set out in the Cairo Plan of Action for engaging men fully in family life and in sexual and reproductive health? The answer is complex, but the short response is: We've come a long way, but we still have a long way to go.

If we take men's use of contraceptives as one indicator of gender inequality, we find that women continue to bear the burden. Currently, the four methods of contra-

ception that require male cooperation or male initiative are condoms, vasectomy, withdrawal, and periodic abstinence. Worldwide, among women using contraception, about one in every four, or 26 percent, say they are relying on a method used by their male partner. Seven percent rely on vasectomy, another seven percent on condoms, and 12 percent rely on either periodic abstinence or withdrawal. The majority (74 percent) of currently married women worldwide who use any contraceptive method use a female contraceptive method. Of these, female sterilization is the most common at 33 percent (U.S. Agency for International Development, 2000).

In addition, the international HIV/AIDS epidemic has wreaked havoc on individuals, communities, and public health systems; in some countries in sub-Saharan Africa, HIV prevalence rates in adults has surpassed 30 percent. As of 2002, worldwide HIV infections and AIDS deaths in men outnumber those in women on every continent except sub-Saharan Africa. More than 70 percent of HIV infections worldwide occur through sex between men and women. By the end of 1999, 10 million African men were living with HIV, as compared with 7.5 million infected men in the rest of the world combined (UNAIDS, 1999, 2000). In addition to their own risk of contracting HIV, men's greater power—physical, social, and economic—in sexual relationships and the fact that women are more biologically vulnerable to acquiring HIV during sexual intercourse mean that men's sexual behavior is key to HIV transmission in women.

Furthermore, data suggest that worldwide fathers contribute far less time to direct childcare, although there is tremendous variation across countries and among men. Studies from diverse settings find that fathers contribute about one-third to one-fourth of the time that mothers do to direct childcare (Population Council, 2001). Of course, even if not as involved in childcare, fathers make decisions about use of household income for children's well-being, education, and healthcare, in addition to direct income contributions.

Men's use of physical violence against women is another area where gender equality has not been achieved. More than 30 well-designed studies from around the world show that between one-fifth and one-half of women interviewed have been subject to physical violence by a male partner (Heise, 1994). The causes and factors associated with men's use of violence against women are multiple, complex, and interwoven. But clearly the reasons or underlying factors related to male violence against women are deeply rooted in the social constructions of masculinity and inequalities of power in family life.

If the story is mostly negative, there are some bright lights. While large-scale impact is yet to be achieved, there is a growing array of program initiatives, research, and policy initiatives seeking to engage men in meaningful ways in reducing gender inequalities. These include clinic-based efforts to engage men, either in primary healthcare or in specialized reproductive and sexual health clinics. Condom education and distribution programs now exist in virtually every country. As a result, worldwide, men's knowledge of male condoms is extremely high. National surveys with married men in 21 developing countries find that 50 percent to 99 percent of men know about condoms (depending on the country) (Drennan, 1998). However, consistent condom use in men's heterosexual relationships is low and generally associated with casual partners, including sex workers (Finger, 1998). Recent

condom promotion efforts have included social marketing efforts (promoting condom sales at reduced prices through alternative means). Other projects have engaged outreach workers or peer promoters (men from the same social background engaging other men) and condom distribution to men in special-risk situations, such as men in the armed forces, truck drivers, and men who are clients of commercial sex workers (prostitutes), among others.

Men's roles as fathers have also been the subject of international seminars, program development, and advocacy. In 2003, an international summit on fatherhood, held in the U.K., brought together researchers, advocates, and program staff from nearly 25 countries. In some countries, public health facilities are encouraging men to participate in childbirth. Other initiatives engage men in promoting maternal health by educating them on warning signs of maternal complications. UNICEF and other UN agencies have begun to discuss ways to engage men more fully in promoting the health and development of their children. A handful of nongovernmental organizations (NGOs) in Latin America and parts of sub-Saharan Africa have started educational sessions, group discussions, or support groups for fathers, including both adult and adolescent fathers. Others have carried out mass media campaigns to promote positive images of men's involvement in the lives of children, images of fathers actively engaged to counter prevailing negative versions.

In terms of HIV/AIDS, programs in parts of sub-Saharan Africa and elsewhere are engaging men to prevent mother-to-child transmission, and a few organizations have started support groups for HIV-positive fathers to promote their own health and well-being but also to encourage them to support their partners and children. UNAIDS (the UN agency responsible for coordinating UN HIV/AIDS prevention efforts) focused its 2000-2001 World AIDS Campaign on men and boys with the slogan "Men Make a Difference." This campaign prompted many countries to target specific HIV prevention efforts on the sexual behavior of men (UNAIDS, 2000). In some settings, the silver lining of the HIV/AIDS epidemic has been increased attention of the need to engage men in rethinking their sexual behavior. Some of these efforts have paid off. Condom use among men has increased in many countries, particularly among younger men.

In terms of gender-based violence, in North America and Western Europe, much of the focus has been on providing legal protection for women who have suffered from violence from a male partner. However, since the early 1990s, a number of important initiatives are working with men. Many of these programs reach men who have used violence against women (via alternative sentencing, court-mandated counseling programs), but more promising still is the number of campaigns and educational activities to engage men in preventing violence against women. One important example, the White Ribbon Campaign, a movement of men working to end violence against women, started in Canada in the early 1990s, is now active in more than 30 countries.

All this is to say that a vibrant and creative field of engaging men in achieving gender equality is emerging. There are enough of us now working with men in promoting gender equality to fill up conference halls. In many rural and urban communities, more men are coming up to fulfill their contraceptive responsibilities, participate in childcare, or speak out about violence against women.

However, engaging men in these issues is still too often seen as an appendage, as something quaint, in the field of gender studies and women's rights. There is still considerable debate among advocates in the field about the specific aims of promoting men's participation in sexual and reproductive health, some of which has already been alluded to above. There has also been concern among some organizations working on behalf of women that new resources going to programs for men's sexual and reproductive health needs would drain resources from reproductive health programs for women. There are also lingering doubts among some in the field about whether men can fundamentally change.

One major challenge that has to be addressed to give full expression to this social revolution is to bridge the gap between the personal and the public realm. The first revolution for gender equality, which was spearheaded by the women's movement, was built on this premise. Men, too, must follow a similar process. Men who are researchers, program managers, social activists, service providers, and policy-makers must carry out this revolution in their personal, political, and professional lives. As men, we need to define a new vision for ourselves—a vision where men can be egalitarian, respectful, self-critical, concerned, and empathetic. Indeed, the success of the gender revolution will be in not only helping others claim a new social reality but also being part of the new reality ourselves. Clearly, the behavior of men in their intimate relations, family life, and sexual and reproductive health is rooted in how societies view what it means to be men. This change in mindset cannot be achieved or measured by interventions that simply count numbers of men adopting a particular contraceptive but by challenging existing social norms and constructing and reproducing new ones. It may also require identifying and reinforcing traditional forms of caring and gender-equitable behavior that many men already carry out.

With this introduction and within this context, in September 2003 an important cadre of these programs came together in Washington, D.C., at the "International Conference on Men and Reproductive Health" (organized by PATH, EngenderHealth, the Population Reference Bureau, and other partners) to exchange lessons learned, to push the field, and to take stock of advances and lessons learned since 1994. One of the most important results of the conference was an affirmation that we have evidence that men can be engaged in sexual and reproductive health in meaningful ways and that such programs can show impact. The conference included presentations from more than 65 program experiences, the vast majority from the Southern majority world (what some call developing countries) and the vast majority of those with evaluation data. A major trend among many if not most of the presenters was that of working with men in context—that is, finding ways to redress gender inequalities at the level of families, couples, and communities and not just focusing on individual men in isolation. Indeed, ecological models have in many cases substituted overly simplistic cognitive behavior change models, recognizing the multiple ways that gender norms are constructed and reconstructed at broader cultural levels, in social institutions, and internalized in individuals.

The conference was also an important moment to take stock of our ongoing challenges. One of those is the fact that there are too few linkages between programs. Programs are too often compartmentalized—for example, focusing on men and maternal health or men and HIV/AIDS or men and gender-based violence pre-

vention—rather than approaching these issues in an integrated way. Men are complex subjects, contradictory at times, gender-equitable in some domains, and inequitable in others. Their needs are multiple and must be approached with this multiplicity. Another ongoing challenge is that of translating small-scale program experiences into policy initiatives. Indeed, too many programs still focus on counting or promoting some narrow aspect of men's behaviors—for example, how many contraceptive methods they know or how many men came into a clinic setting, without understanding that real revolution is changing what it means to be a man.

However, there were examples of organizations that are now focusing on the root of the problem: the ways that boys and men are socialized into rigid notions of manhood or masculinities. From Nigeria to Brazil to India, a growing body of programs were described that are engaging boys and men in group educational activities or carrying out community campaigns or awareness-raising to promote more gender-equitable attitudes and behavior on the part of boys and young men. Some programs are starting this as early as age 8. Emerging impact evaluation is finding that these programs can in fact change young men's attitudes and behavior with direct implications for sexual health and reducing gender-based violence (Barker et al., 2004).

In this volume, we feature five of the approximately 65 papers presented during the Washington conference. These were selected from among program presenters who submitted a full paper to the journal for consideration; in selecting the articles, a strong emphasis was placed on programs featuring evaluation data and those that went beyond mere service provision or outreach activities to include discussions about gender norms in general.

The five programs presented here are illustrative of the priority regions at the conference—Africa, Latin America, Asia, North America—and of the range of program experiences, including broad-based community outreach to engage men, engaging men in traditional rites of passage settings, in clinic settings, and in schools. Bonnie Shepherd describes APROFE's experiences in Ecuador of addressing STIs through male clinics and analyses the extent to which interventions can address practical and other strategic gender interests—that is, looking at ways not only to meet the immediate needs of clients but also how to question gender inequalities in relationships. Men's own gender stereotypical perceptions about themselves as well as their dominance of women emerge as strong barriers to implementing strategies to promote gender quality. Dean Peacock and Andrew Levack present the Men-as-Partners initiative in South Africa, a large-scale, multi-pronged approach to engaging men to reduce violence against women as well as HIV. The intervention uses a human rights approach, and the paper describes the changes in knowledge, attitudes, and behavior that were documented among the participants.

Elizabeth Grant and her colleagues discuss the possibility of using the traditional seclusion period around male circumcision for health and sexuality education among adolescents in Kenya. Using ethnographic methods with a wide variety of respondents, they conclude that this tradition offers an appropriate and strategic opportunity to engage young men with messages about adopting healthier lifestyles and rethinking gender norms. The RISHTA project in Mumbai, India, is evaluating the use of the Narrative Intervention Model through an integrated community and clinical male health intervention. Stephen Schensul and his colleagues discuss the

interim results of the project in terms of its potential to reduce “risky” sexual behavior and the prevalence of STIs. Finally, Pat Mosena and her colleagues describe a peer education project among African-American adolescents in Chicago. The paper discusses how the peer advocates not only emerge as effective outreach agents but also as potential role models as well. In all five papers, we find promise and remaining challenges. Men are willing to be engaged in discussing gender equality, and programs are making inroads, but much must be done to take the ideas to scale.

In sum, in these program experiences and from the 2003 conference itself, we conclude that the Cairo Plan of Action is still a dream; many of its goals seem distant still as we look at data on gender-based violence, female infanticide, rates of coerced sex, inconsistent condom use, and limited progress in reducing HIV/AIDS in some settings. Too few societies, male leaders, and organizations are willing or able yet to fundamentally question rigid views about the roles of men and women. There are also voices of dissent—conservatives in many settings who would maintain traditional gender inequalities, who do not believe that women and men are equal, or who espouse narrow religious doctrine and are unwilling to take a full public health and human rights perspective. But in communities, cities, villages, and households where real people live and negotiate their lives, the gender revolution has started. Cairo gave us our blueprint for action. The examples here give voice to the slow but important progress of engaging men in achieving this vision of true gender equality.

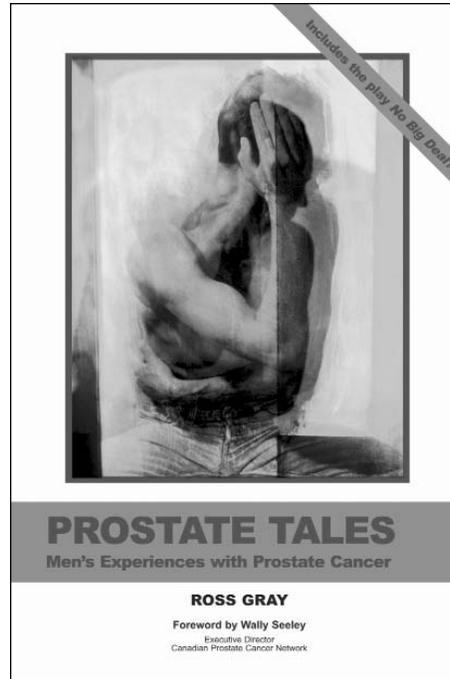
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Prostate Tales: Men's Experiences with Prostate Cancer

BY ROSS E. GRAY

Prostate Tales vividly portrays men with prostate cancer, bringing their experiences out of the shadows where they usually lie hidden. Drawing on extensive research interviews, the author avoids the usual dry academic report, instead using stories and drama to display men's crises, struggles, sorrows, challenges and triumphs. In the process he provides readers with a strong visceral connection to the social realities of prostate cancer, and reveals how prostate cancer affects different men in profoundly different ways. This is not a sentimental piece of work; it aims to tell stories that feel true, that honor the courage, humor and strength of individual men while not hiding from everyday realities like fear, depression and confusion. The book is primarily for men with prostate cancer and their families and friends, but health professionals will find it helps them better understand ill men. *Prostate Tales* is a must read for anyone interested in innovative approaches to education and the effective communication of research findings.



Ross E. Gray is co-director of the Psychosocial & Behavioral Research Unit at the Toronto-Sunnybrook Regional Cancer Centre and assistant professor in the Department of Public Health Sciences at the University of Toronto. Gray's areas of expertise include men's health, qualitative methods, psycho-oncology, and research-based drama.

Prostate Tales

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Addressing Gender Issues with Men and Couples: Involving Men in Sexual and Reproductive Health Services in APROFE, Ecuador

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This article is based on a study of the male-involvement initiative of APROFE (Association for the Benefit of the Ecuadorian Family). It analyzes the lessons learned from a mix of strategies to increase the number of male clients attending APROFE's sexual and reproductive health services. Based on provider interviews, the study describes the gender and privacy issues that arise when treating heterosexual couples in health services and highlights the dynamics between each member of the couple and the service provider in the case of STI diagnosis. The study revealed clear benefits from male involvement—for both members of the couple. At the same time, the limitations of the health service setting in resolving gender issues that underlie sexual health problems are clear from the findings.

Keywords: sexual health, reproductive health, male involvement, gender, sexually transmitted infections, sexual health services

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This article¹ focuses on the male-involvement initiative of APROFE (Association for the Benefit of the Ecuadorian Family). The initiative began in the late 1990s and dovetailed with APROFE's efforts to become more financially sustainable, to improve quality of care, and to increase attention to gender equity throughout its national network of 20 reproductive health clinics in 17 cities.

In the male-involvement initiative, providers systematically encouraged women to bring their male partners to the service. APROFE then used mass media to encourage other men—both individually and in couples—to use APROFE's services. As the number of men using the services began to rise dramatically, health providers were confronted with new issues related to quality of care, gender, and users' right to privacy that had to be dealt with systematically throughout the organization, not just on an ad-hoc basis.

The data for this study comes from two main sources: APROFE documents, mainly monitoring data and gender training program reports and minutes,² and interviews conducted by the author in 2000 with providers of all levels at four clinics: 28 semi-structured individual interviews and four group interviews.³ The clinics in the study represent distinct Ecuadorian cultural areas and clinic sizes, and the gender training team evaluated them all as having a positive response to gender training.

The interview guides focused on providers' experiences with and opinions about gender training as well as examples of how the staff incorporated gender issues into their daily practice. Male involvement and the issues arising during STI diagnosis emerged as a central theme in the interviews; it was not the original focus of the study.

BACKGROUND

With 13 million inhabitants, Ecuador is one of the smallest and poorest countries in Latin America. In 1998, 62.6% of the population lived below Ecuador's official poverty line, and 26.9% were classified as indigent.⁴ According to UNICEF statistics for 2000,⁵ the maternal mortality rate is 130 per 100,000 live births, and infant mortality is at 27. Recent studies in Ecuador show that the fertility rate has fallen to 3.4.⁶ With almost universal primary school enrollment, the literacy rates for adults of both sexes are in the high 90s.

APROFE's experiences with promoting male involvement closely parallel those of the family planning field as it transformed into the field of sexual and reproductive health. From the 1970s through the 1990s, like most International Planned Parenthood Federation's (IPPF) affiliates in Latin America, APROFE concentrated on family-planning services. From 1984 through 1994,⁷ most family planning agencies' initiatives on "male involvement" were limited to promoting men's increased use of birth-control methods—condoms and vasectomies—and their decreased opposition to women's use of contraception. Within this framework, APROFE's experiment with a male clinic to promote male family planning methods in the early 1990s did not prosper, leading them to re-think their strategy.

IPPF's "Vision 2000" in 1992 and the International Conference on Population and Development (ICPD) Programme of Action⁸ in 1994 provided a new direction for male "participation and responsibility," placing it within the framework of women's empowerment and comprehensive sexual and reproductive health. Men

were to assume an equal role in caring for sexual and reproductive health, in shouldering their fair share of domestic responsibilities, and in promoting equality between the sexes.⁹ Downward trends in external funding in Latin America provided an additional incentive for APROFE to reach out to men. By 1995, it became clear that their main donors—USAID and IPPF—would be significantly decreasing their support, and in the case of USAID, would halt aid altogether by the end of 2001. For reasons of economic survival, APROFE had to concentrate on increasing its income by raising service fees and increasing its number of clients. Diversifying services, increasing marketing, improving quality of care, and attracting more men were the cornerstones of the strategy to attract more paying clients. APROFE leadership viewed attention to gender issues as an integral part of its quality of care initiative and as a tool to serve both men and women more appropriately.¹⁰ The marketing strategies were designed to attract men by changing APROFE's public image as a women-only clinic and publicizing new sexual health and urology services. The availability of these services also helped women persuade their partners to come to their next visit. APROFE's Director of Evaluation, Agustín Cuesta, explained in an internal document:

Involving men in sexual and reproductive health, either through having them accompany women or through having them be users in their own right, makes it possible to ensure their support for women's decisions and helps us keep users coming regularly. [Involving men] also means that we can attract a population that has never come to our services before.

As Cuesta suggests, these strategies succeeded both in attracting more users overall and in dramatically increasing the number of male clients so that APROFE's push toward self-sufficiency has been very successful. As of February 2003, the organization survives mainly on service fees.¹¹ Unfortunately, the loss of external support affected the user profile, which includes fewer low-income clients than before.

In summary, these strategies not only brought about greater sustainability but also helped the institution incorporate the principles endorsed at ICPD, such as commitment to gender issues and to a more comprehensive sexual and reproductive health framework.

OBSTACLES TO MALE INVOLVEMENT

Numerous obstacles to male involvement are documented in the literature and also in this study. Perhaps the best-known obstacle is that professionals in reproductive health recognize that it is more difficult to get men to use reproductive health services than it is to get women into a clinic.¹² The reason for this gender-based discrepancy is that men are less willing than women to admit that they are ill or to take care of their health in general.¹³ Often men will seek medical care only when their illness has advanced to the point that it is difficult if not impossible to treat. This behavior is apparently based on the expectation that men are not supposed to show weakness or to complain about pain.¹⁴ One APROFE doctor commented:

Men do not like to go to the doctor or to be sick, because for a real macho sicknesses do not affect them. It is part of the patriarchy and ancestral customs. For this reason, a man will not come to see a doctor until he is really badly off, at which point it may be too late to help him.

Male discomfort in the submissive role of the “patient” may be so pronounced that often when wives accompany their husbands the husband is silent and the wife does all the talking, which is the reverse of the more common pattern of conversations being male-dominated.¹⁵ To avoid what they consider the demeaning experience of going to a doctor, men tend to self-medicate in pharmacies following their friends’ or pharmacists’ advice, a practice that often fails to address their health problem appropriately.¹⁶

Other logistical and sociocultural barriers can hamper male involvement. For instance, clinic hours often need to be adjusted so that men who work full-time or more can make their clinic appointments without jeopardizing their livelihoods. Also, according to APROFE providers, men sometimes care for the children so that women can visit the clinic.

Once men arrive in the clinic, other sociocultural barriers arise. APROFE providers observed that male stereotypes perpetuated by providers as well as female partners can create an obstacle to men’s involvement. APROFE’s gender training program had to overturn providers’ long-held assumptions about men’s unwillingness and disinterest. Providers must then work with women’s assumptions. Low expectations are self-fulfilling when they lead to failure to invite men to services.

Sometimes the woman anticipates his response and says, “He won’t want to [come to the clinic].” We assume that he is machista, but maybe he isn’t, and we are just prejudiced. [Sometimes] when we [finally] talk with the male partner he says, “See, I told you that I could help out.” However, there are also cases of men who are much more resistant. Maybe in the clinic they seem to accept our advice, but once they leave, they don’t. (Clinic supervisor)

Furthermore, men’s traditional roles make them less willing to put up with disrespectful treatment or other problems with quality and less willing to tolerate the hierarchical nature of the doctor-patient relationship. APROFE conducted both a male focus-group study¹⁷ and user satisfaction studies that pointed out the need for a serious quality-of-care initiative because clients who were paying higher fees and men of all economic classes would not use the services unless quality of care improved.

Finally, of course, women get pregnant and men don’t, which reduces men’s perceived need for sexual and reproductive health services. In light of all of these obstacles, strategies to attract men must be multifaceted, emphasizing the importance of their and their partner’s health.¹⁸

FROM MALE CLINICS TO MALE INVOLVEMENT

APROFE's first efforts to involve men in the early 1990s corresponded to several experiments with male clinics in the IPPF/WHR network. As in several other countries, APROFE abandoned the experiment after two years; the clinics were under-used and extremely costly per person served, in spite of all their marketing efforts.¹⁹ APROFE's directors decided that they needed to better understand men's knowledge of and attitudes toward sexual and reproductive health as well as their views on sexuality, on APROFE's services, and on how they wanted to be served. APROFE's male focus-group study took place in six cities in Ecuador, differing by size and by cultural region, including low-middle-income and middle-income men. The results provided important information about male patterns of sexuality, including acceptance of multiple partners, a period of high risk before marriage, and sexual and physical violence against women. Men would not inform wives of an STI diagnosis and were unwilling to use condoms or have vasectomies. They expressed no preference for male-only services, as long as they were treated well and received high-quality service.

These results pointed to simple changes in providers' behavior—in reception areas and in counseling—to make men feel welcome and to help dispel the perception that APROFE's services are for women only. With this orientation on how services needed to adapt and improve in order to serve male clients, APROFE began its concerted efforts to attract more male clients, while the findings from the study informed intensive training in quality of care and in gender issues institution-wide.

APROFE'S CURRENT MALE INVOLVEMENT INITIATIVE: SUCCESS IN ATTRACTING MEN TO CLINICAL SERVICES

APROFE used three strategies to attract more men to its clinics:

- Standard protocols for providers mandated that they encourage female users to involve male partners. The first directive to all personnel was in 1998, but the invitations in many of the main clinics started in 1997.
- Radio campaigns advertising that APROFE provided services for both men and women began in 1996, with little effect. Beginning in 2000, however, urology services were advertised on both radio and television.
- Clinic hours were adjusted to men's schedules. In big cities, all APROFE clinics see patients on Saturdays, and many have extended their weekday hours until 7 p.m.

These strategies have proven successful. From 1999 to 2000, the clinics in this study doubled the number of users who are accompanied by their partners from 545 to 1,121 on average per month.²⁰

In Guayaquil, between 2000 and 2001, the average number of users accompanied by partners increased by 74%, whereas the total number of users increased only 11%.²¹

Using urology visits in all APROFE clinics as the other main indicator for male usage, the number of male users has steadily increased since 1996, with a notable

Table 1
Average Number of Visits per Month to Five Guayaquil Clinics

	Jan.-June 2000	Jan.-June 2001	Increase	Percent change
Couples	1,627	2,828	1,201	+74%
Individuals	14,573	16,209	1,636	+11%

Note: Table constructed by author from APROFE statistics

increase of almost 3,000 male users in 1998, when the first directive to APROFE providers went into effect to encourage female users to invite their male partners. This sharp increase clearly supports APROFE's hypothesis that spousal encouragement was the main initial factor responsible for the significant increase in men's clinic visits. Another above-average increase of more than 2,000 male users occurred in 2001, when APROFE increased its mass-media marketing of urology services. In other words, after APROFE had established a stable base of male clients and solidified its public image as providing care for both sexes, then mass-media advertising played a greater role in attracting men.

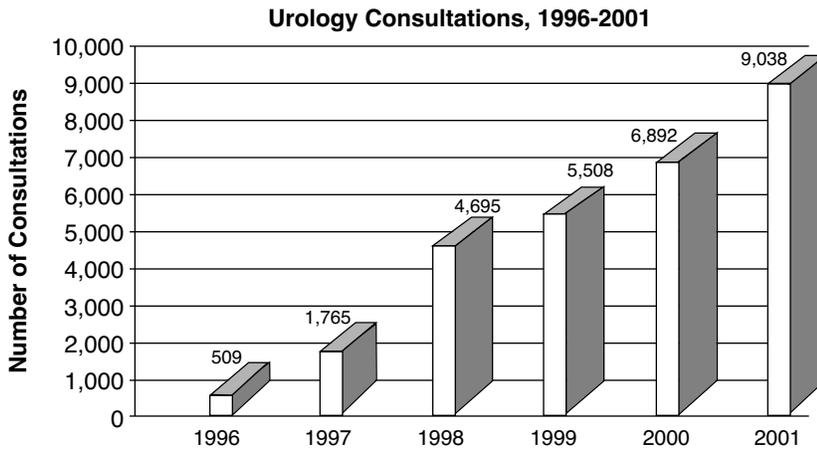


Figure 1. Yearly increase in urology visits at APROFE Clinics: 1996–2001.

Note: Figure constructed by author from APROFE statistics

However, attracting men to its clinics presented APROFE with many issues: How do gender issues manifest themselves when both male and female partners are involved? Difficult questions arise in the process of “mainstreaming gender issues,” which should include a policy of zero tolerance for abuse of women's rights, when

serving those men who abuse their female partners. Is it possible to halt men's abuse of power while promoting the rights and well-being of the men being served? How do providers deal appropriately with couples whose relationships are characterized by the traditional male-female roles of domination and subordination? Can services help men deal with the aspects of male gender roles that put men at risk? How can the right to privacy of both men and women be protected?²²

APROFE's experiences in protecting an individual's right to privacy and confidentiality and encouraging involvement of both sexual partners are instructive. Mainly, its efforts had focused on ensuring women's right to privacy; but when its providers began treating men, they realized that men's right to privacy was just as crucial, especially in regard to STIs. APROFE's providers found that close teamwork and clear communication among clinic staff were necessary to protect privacy, and Information, Education, and Communication Department (IE&C) staff used training and supervision to continually reinforce the need to adhere to clinical protocols that mandated getting women's consent before involving her partner. Providers have had to be creative in finding ways to ascertain privately whether a user wanted his or her spouse present at each stage of the clinic visit.

Many APROFE providers who have been confronted with such dilemmas have found ingenious ways to resolve the presenting health problem, thus meeting both women's and men's short-term practical needs. Is it possible for providers to take the next step of addressing underlying gender inequities.

The following section takes an in-depth look at the situation of couples receiving STI diagnoses as a window into the lived reality behind these questions.

APPLYING GENDER FRAMEWORKS AND INVOLVING COUPLES TO PREVENT AND TREAT SEXUALLY TRANSMITTED INFECTIONS

The distinction between meeting practical interests versus strategic interests is useful in considering the application of gender frameworks in sexual and reproductive health programs.²³ In gender theory, practical interests are related to material problems, such as an STI diagnosis, that have a short-term solution but may arise from gender inequities and gendered sexual norms. Strategic interests are related to the root causes of these short-term problems, often gender-related inequities, sociocultural norms, and discrimination.

In most cases, APROFE providers reported successfully involving men in preventing and treating STIs²⁴ but offered few examples of interventions that addressed power dynamics within the couple that block communication and thus make it more difficult to prevent and treat infection. Using the gender lens, curing a STI serves both the man's and the woman's practical interests. Following standard guidelines, APROFE's staff focused on involving men sufficiently to cure the infection; possibly the information they provided would prevent future infections, but this was not a given. Curing an infection by treating the couple was an important advance over treating women only—an advance in which the providers justifiably took considerable pride. However, without addressing the gender dynamics at the root of the infection, the couple's strategic interests were not served.

One obstacle to addressing strategic gender interests shows up clearly in this study: diagnosing couples with STIs created emotionally charged situations for both the couple and the provider. The short time period of the typical clinic visit made it imperative that the providers concentrate on providing information and treatment and not on the counseling that was needed. Furthermore, most providers in such clinics are biomedically trained professionals with limited training in counseling, and the demands of the situation usually exceed their level of preparation. In the larger APROFE clinics, their teamwork with the intake counselor or with the in-house psychologist (in two of the large clinics) was an essential part of APROFE's services.

APROFE'S STANDARD APPROACH TO STIS

How can biomedical professionals be trained to handle the stress and emotional issues that arise after diagnosing an STI? APROFE promotes strategies that discourage mutual blaming and encourage focus on treatment. In this manner, they report that they are able to treat most couples for STIs, thus addressing women's and men's immediate interests.

One of the first issues that APROFE's quality of care and gender training confronted was providers' tendency to withhold the diagnosis of an STI from a user, fearing an emotional reaction.²⁵ This doctor described some of the deficiencies of treating STIs before gender training was offered:

Before we tended to conceal some of the facts about STIs, but they taught us in the gender course that full factual disclosure is important. For example, we have to say that the [symptoms of] herpes or condiloma [HPV virus] can get better, but there is no cure. Sometimes this scares people. (Doctor)

The gender-training course and the follow-up training team have helped providers follow a standard practice for dealing with STIs, which is to disclose all the medical facts, focus on the cure, and move ahead with treatment. "Let's not focus on who is to blame" was the refrain APROFE providers used when speaking to couples who have been diagnosed with STIs. Ideally (as in the next example), the provider recognized when the couple needed help to deal with the emotions provoked by the diagnosis and offered to refer the couple to a psychologist or intake counselor who has been trained in psychology or social work.

I would like to point out . . . conflicts when we try to apply gender perspectives in cases of STIs. The woman asks me, "So, the transmission is solely sexual? So he gave it to me?" I respond, "I can't say that. We are not here to place blame; this is a disease within the couple. Talk with him." There are men who admit that "I [might have gotten infected] in that place," but rarely will they say this with their partner present. Then I give her informational pamphlets. . . . This is when integrated teamwork is so important. They

have the option of returning to the intake counselor, because this is difficult; it is a shock for the patient and for the couple.... I have to tell them that it is an STI, but that there is a solution [this is a case of a curable STI].... I encourage them to focus not on the problem but on the solution. (Doctor)

Naturally, the standard procedure does not always work. Furthermore, the clinician may not have the time or the opportunity to address the underlying sociocultural causes of infection, thus requiring a professional trained in counseling and gender issues to be available for the important follow-up sessions. However, most small clinics do not have personnel who are trained to deal with these sensitive issues and need to establish referral networks.

CASES IN WHICH MALE INVOLVEMENT IS NOT POSSIBLE

In some couples, the woman does not consent to involving her partner because of the man's dominance and mistrust and/or her fear of her partner's aggression, making male involvement impossible. The dynamics of the couple's relationship are too unequal and fear-ridden to allow proper medical treatment, which means the infection cannot be eradicated. These cases clearly illustrate how gender-related power inequalities within couples pose important obstacles to preventing and treating STIs. When a woman is so fearful of her husband that she does not dare tell him the diagnosis, how can this and future infections be treated and prevented? The following anecdote exemplifies these gender dynamics.

Many times when women come alone and we diagnose an STI, we explain the situation to them, and they prefer to say nothing to their spouses . . . because their husbands are aggressive, and they will think that the wives have had sex with other people. The women prefer to keep silent and treat themselves with herbal remedies, waiting until the men realize that they are infected and seek treatment. (Doctor)

In this case, the woman does not know whether her husband is treating himself and whether she should treat herself simultaneously. With so much fear and so little communication, the couple will just keep reinfesting each other, yet APROFE providers must respect the woman's decision. If she does not want her husband to know, they can do nothing except point out to her the medical consequences of her decision. These dynamics are also a clear signal of violence in the relationship. Unfortunately, the follow-up to APROFE's gender training program did not deal adequately with this issue.

In cases such as these, the only way to involve men may be to offer a community education program on sexual and reproductive health issues that includes STIs and addresses gender issues with a special emphasis on violence against women.

MEETING PRACTICAL BUT NOT STRATEGIC GENDER INTERESTS

Several anecdotes illustrate both the benefits and the problems with men's involvement in sexual and reproductive health services, where it is difficult to address strategic gender interests in relationships characterized by male dominance and sometimes violence. The provider below and several others worked within the limits of a patriarchal system by using their authority to convince the male partners of the importance of following the doctor's orders, especially when these involve abstaining from sex. At least three doctors in the study found male partners so difficult to convince of the infection's severity that they had these men look at their partners' infected cervix. In these cases, the doctor's power and legitimacy made the treatment work, because the woman did not have enough power in the relationship to convince the man to comply with treatment. The doctor's authority provided the only way to correct the power imbalances within the couple during the clinical visit. Then, once the man was convinced, he usually became involved and complied with the doctor. However, one account alerts us to the risk that the man might also assume control of the woman's treatment, removing all agency from her.

When we have found cervicitis and lesions and given treatment with cauterization, we have had problems when we tell a woman that she cannot have sexual relations for a month. . . . When we see that the spouse does not understand, we invite him in to explain the condition. . . . If the woman consents, we have him come into the examining room so that he can see the cervicitis and see that when his wife complains of pain during sexual relations, it is not because she doesn't want to have sex with him or because she no longer loves him, but because she is physically sick. He sees the lesion, and the situation improves, because he begins to participate in her treatment and makes sure that she takes her medicine and comes in for her follow-up visit. . . . [They come to follow up and he says,] "Here, doctor, I've brought her in; check her to see how she is, to see if everything is all right." (Doctor)

This situation is better than the one in which the levels of fear and mistrust are so high that the man cannot be involved at all. In this case, the man was actively involved in promoting his partner's health and in the process protected his own as well. The infection could then be cured when previously it could not. However, the woman still had little protagonism or power in protecting her health or the couple's health. She still needed the doctor's legitimacy to do this for her, and then her male partner took control of her treatment.

Gender roles, users' rights, sexual rights, and cultural taboos are all raised when diagnosing and treating an STI. In the following example, in which the man was participating in the clinical visit but not in the physical examination, the provider was able to understand the causes of an intractable infection only after the woman confided in him privately (i.e., "behind the curtain"). The midwife then had to figure out

how to deal with the man's denial of his sexual practices that were causing the infection and with the power dynamics that made the woman unable to refuse painful sexual practices. Undeniably, these complex and sensitive situations are very hard to address in the limited time of a clinic visit.

I had one patient who had terrible [vaginal] infections that did not respond to treatment. One day I asked them about anal sex, and the husband answered, "No, we do not do that." But then the wife told me behind the curtain, "Yes, we do that, and I don't like it. Please tell him that I don't want to do that." Well, I could not exactly say that, but [after the examination] I said to both of them that if by chance they ever had anal relations, this and that could occur, and it would be another reason why the infection could not be cured. I had to convince him indirectly. (Midwife)

This is another example of dealing with practical gender interests—the immediate problem—without addressing strategic gender interests. Although the woman has not gained any more power to protect her own health or rights in this relationship, the provider can intercede on her behalf so that she will no longer be subjected to a sexual practice that she dislikes, and her infection will be cured.

As mentioned previously, serious conflicts often arise with this diagnosis. One strategy that averts such conflicts emerged from interviews with providers. In this strategy, the providers suggested that one member of the couple—usually the husband—may have contracted the infection before the marriage. One clinic supervisor remarked, "I try to explain that maybe she is infected because her husband had a relationship before marriage and that the symptoms are only appearing now."

Especially for younger couples, this convenient "excuse" may actually be true. The advantage of this strategy is that it minimizes tensions, thus allowing the couple to comply with treatment.

While the convenient maybe-it-happened-before-marriage strategy may simply be sacrificing strategic interests for practical ones, on closer analysis the relative costs and benefits are not so clear. If the infection was indeed contracted prior to marriage, the provider is acting responsibly and helping to minimize conflict by offering this possibility. However, this strategy does not encourage couples to communicate frankly and may leave one of them with lingering doubts about whether the STI was due to infidelity. Such doubts can later poison the relationship. In addition, the strategy does not directly address the gendered double standard within marriage that permits men to have multiple partners but does not tolerate such behavior in women. In many cases, however, in the interest of keeping their relationship positive and offering the benefit of the doubt, both members of the couple may prefer this possible explanation. If the diagnosis and subsequent counseling gives the man (or the woman) enough of a scare and enough information to prevent future infections, at least their future sexual health has been protected.

ADDRESSING BOTH STRATEGIC AND PRACTICAL GENDER INTERESTS

APROFE's experiences suggest that the STI clinic visit proved to be a difficult context in which to promote strategic gender interests. When such strong emotions are involved, most providers' efforts may go to trying to contain them—within the limited time frame available—so that the couple can take responsibility for treatment and future prevention.

A few providers trained in psychology or social work—such as the following intake counselor—reported positive experiences in which they could successfully address both gender and sexual health issues.

Generally, providers send couples back to me when a homemaker is diagnosed with an STI because this creates a conflict within the couple. I explain that the infection may have been dormant for years [author's note: again, the convenient explanation] but I also explain that men . . . have been socialized and pressured to have sexual relations with no protection. This is how I introduce the gender focus so that they do not focus on blaming the other, but rather on treating the illness. This helps unite them because they come together for the treatment. (Intake Counselor)

This counselor was directly alluding to the sexual health risks caused by socialization of men, which pressures them to be sexually active and to take risks. She presented this information in an effort to defuse the anger of a woman who was diagnosed with an STI and to keep her from assigning blame. The counselor implied that after talking with the woman the next step was a joint visit for treatment. Ideally this second visit would include a counseling session for the male partner to discuss the health risks associated with male gender norms encouraging multiple partners. The crucial step, then, in addressing strategic gender interests is to begin to educate users on how traditional gender roles augment their health risks and to urge them to consider changing their behavior. This could be accomplished through a follow-up visit to a counselor and through a variety of educational interventions in the clinic and the community.

MAINSTREAMING A COMMITMENT TO GENDER EQUITY:
CLINICAL AND COMMUNITY-BASED STRATEGIES

The study of the gender-training program in APROFE illustrates that incorporating a gender-based framework required a three-step process.²⁶ The first step is to accept that gender roles are socially constructed and not innate. Typically, this is the first educational goal of gender-training programs and the essential base for any further training on the subject. Interviews with many APROFE providers gave ample evidence of their awareness of this key principle. The second step is to understand the epidemiological aspects of gender roles, i.e., those that pose risks to health. To this end, the IE&C Department has constructed protocols of gender-related health risks for training purposes. Several providers were able to discuss some of these risks and

provided examples of using them in their counseling.²⁷ The final and most challenging step is to actively promote gender equity with male and female users and within the communities served. Being aware of inequities and their relationship to health risks is one thing, but working actively to end gender inequities is a step that most health services do not take. For APROFE and most organizations worldwide, community-based advocacy and education is the next step in the gender-mainstreaming process and one in which it is important to involve both men and women.

This study illustrates the many constraints of healthcare providers in dealing with gender issues. They are not trained to provide in-depth counseling on highly emotional issues. They often have lines of users waiting to see them, so that spending more time than usual with one person may serve that user's or couple's interests at the expense of several other users. The provider is only one actor in a person or couple's life, and usually a minor one. Finally, there are many socioeconomic structures and dynamics related to reproductive health, sexual health, and gender inequities over which providers have no control and which put members of the community at high risk for sexual and reproductive health problems.

Yet, within this limited sphere of influence, health providers have an important opportunity to be a positive influence in an individual's or a couple's life. This study gave some examples of how providers can intervene to promote gender equity while counseling clients.

One doctor stood out for her grasp of common gender issues behind sexual problems reported by women.

Many times we see patients with sexual problems who . . . think that the cause is physical, when in fact we find that the sexist customs within the couple cause her to submit to sexual relations when she has no desire to do so. . . . Using a gender focus we help her to understand that she can say when she feels desire and when she does not, whether due to some physical cause or being tired from housework. We invite her spouse so that we can explain to both of them the importance of equal participation in the sexual relationship. The women complain that they have never had an orgasm and tend to think that they are at the root of the problem, when actually their partners are not helping them [to get excited].

Besides face-to-face interventions, other important educational interventions to promote gender equity within the clinic setting include the availability of brochures on gender-related subjects, videos and talks in the waiting room, and posters on the walls.

Due to all the sociocultural obstacles to male involvement in clinical health services discussed above and to the limitations of the clinic setting, effective prevention efforts in sexual and reproductive health are best served by complementing service-related strategies with community-education strategies, whether through media campaigns, direct community outreach, or both. While services can play an important part, outreach to men within a community is always an important part of any effort to promote gender equity as well as sexual and reproductive health. APROFE recognized this need for complementary community education; in 2001, they reached more

than 2,000 people in Guayaquil alone with workshops on a variety of gender issues, including women's rights, violence against women, and gender issues and health.

Other ways to promote gender equity within a community might involve participating in advocacy for women's rights or establishing joint educational programs with the local schools, thus reaching male and female youth. Investment in such community-based health promotion and advocacy is an important indicator that an organization is not just paying lip service but is truly committed to promoting gender equity.

In summary, although a clinic visit can be an important short-term intervention for curing an infection and delivering information to prevent recurrences, long-term results require sexual- and reproductive-health services to distribute information about preventing STIs throughout the community and within the services themselves. All messages should discuss those aspects of both male and female gender roles that put people at risk, which would also help promote gender equity and address some of the root causes of people's vulnerabilities.

CONCLUDING THOUGHTS

Agencies that successfully attract men to their sexual- and reproductive-health services face important challenges in regard to promoting gender equity. APROFE's providers found that in treating couples patterns of male domination can silence women, and providers have to use great creativity to protect the privacy of each individual and great tact so that a woman can express her point of view and provide other information without discouraging the man's participation. Conversely, when a man is ill, he may be reticent, believing in the stereotypical attitude that men should not be weak or sick.

This study illustrated the stresses that arise for providers and couples alike when addressing sexual health issues and involving couples. Strong emotions in response to an STI diagnosis complicate treatment. Key constraints are the limited time of a clinic visit and health providers' lack of training for dealing with such emotionally charged situations. APROFE's protocols made the best of a difficult situation but at the time of the study needed improvement in order to address instances of suspected violence against women and to incorporate HIV/AIDS prevention into counseling and referrals of STI clients.

Males' use of sexual- and reproductive-health services creates new situations, challenges, and dilemmas. The main challenge is to involve men while maintaining a commitment to gender equity and users' rights. Precisely because gender equity practices run counter to accepted sociocultural norms, progress is necessarily uneven within any given institution—some staff are more receptive than others, constant reinforcement is necessary, and ground is lost with staff turnover. Therefore, one-shot training interventions do not produce the desired result. Providers need regular training and supervision mechanisms first to understand and accept gender differences and then to understand the different problems men and women have as well as the risks that arise from their gender roles. APROFE recognized this need, and after the gender training the IE&C team carries out technical follow-up visits to half their clinics each year; these visits provide in-depth coaching on quality of care and gender issues.

Finally, the culture of an organization needs to incorporate a commitment to promoting gender equity at every opportunity. Without ongoing training and supervision to reinforce this transformation in the culture of an organization, countervailing cultural tendencies will erode the gains of gender training programs.

NOTES

1. The article is based on Shepard (2003)—a longer working paper on incorporating reproductive health principles and gender issues into APROFE's program. APROFE is the affiliate in Ecuador of the International Planned Parenthood Federation's Western Hemisphere Region (IPPF/WHR).

2. APROFE documents that describe meetings and events related to the gender-training process were written by the Director of Evaluation, Agustín Cuesta, and the members of the Information, Education, and Communication (IE&C) Department, which consists of four professionals and one assistant who are in charge of all training and professional development within the organization. The director of the department is Miriam Becerra, and at the time of the study the other members of the IE&C staff were Abigail Carriel, trainer; Aurora Contreras, psychologist and trainer; Maria Quindé, psychologist, trainer, and coordinator of a community-based program for youth and women's development; and Vanessa Arica, administrative assistant. This study interchangeably refers to the "gender training team" and the "IE&C team."

3. The author interviewed members of the IE&C department in charge of the gender training, APROFE authorities, and a range of providers—from clinic supervisors and obstetrician/gynecologists to nurse's aides and receptionists—at four of the clinics where gender training took place in the cities of Machala, Cuenca, and Guayaquil (Alborada and Mapasingue). One of the group interviews was with three female doctors from three different clinics. The interviews took place during a 10-day period in July 2000 and were transcribed by Graciela Fort-Magnon and Elena Aguila and coded/organized into themes by Doreen Montag.

4. Programa de las Naciones Unidas para el Desarrollo (2001), 12. Many observers believe that these 1998 statistics have worsened since the severe economic crisis in 2000. The economy was dollarized just before the study visit.

5. Data retrieved from the UNICEF "Child Info" Web site on February 10, 2005, for maternal mortality (<http://www.childinfo.org/areas/maternalmortality/countrydata.php>) and for infant mortality (<http://www.childinfo.org/cmr/revis/db1.htm>).

6. Preliminary results of the 1999 demographic survey ENDEMAIN conducted by CEPAR. Retrieved September 2000 from <http://www.cepar.org.ec/documentos/ende99.pdf>.

7. The decade between the International Conference on Population and Development (ICPD) in Mexico City in 1984 and the ICPD in Cairo in 1994.

8. Programme of Action Paragraphs 4.24 – 4.29. Report of the International Conference on Population and Development, 5-13 September 1994, UN Doc. A/CONF.171/13.

9. These paragraphs in the Programme of Action stimulated much attention to the subject of male participation in the sexual and reproductive health literature and

among national and international agencies. See Web site retrieved February 10, 2005, (www.rho.org/html/menrh_bibliography.htm) for a comprehensive annotated bibliography of literature on the subject.

10. Miriam Becerra commented that APROFE's IE&C staff noted instances of inappropriate colluding with traditional patriarchal male roles by staff in attempts to persuade men to use male methods of contraception.

11. IPPF continues to support APROFE but at a much lower level than previous years. In 2001, APROFE received a \$100,000 grant from the William and Flora Hewlett Foundation, channeled through IPPF, to open an adolescent program. They plan to continue the program on their own resources when the grant ends in July 2003.

12. See Robey & Drennan (1998), 16.

13. INPPARES views this as the major obstacle to attracting clients to their male clinic. Personal communication, Angela Sebastiani, October 2002. See also Best, 1998, 37; Claux, 2001, 8-9; Green & Pope, 1999; Sanhueza, 2001, 1.

14. See Greig et al., 2000, 22.

15. Health providers interviewed by the author both in APROFE and in Profamilia, Colombia, spoke of this tendency.

16. Interviews with Agustín Cuesta, APROFE, and Alfonso López Juárez, Executive Director of MEXFAM. Best (1998) also refers to this problem.

17. See Cuesta (1998).

18. See Wegner et al., 1998, 32.

19. Shepard (2003) discusses the experience with male clinics in APROFE and several other IPPF affiliates in Latin America.

20. Comparing the five-month periods from January through May in 1999 and in 2000. Statistics provided by the Evaluation Department of APROFE.

21. From statistics provided by the evaluation department, APROFE. These statistics correspond to the five Guayaquil clinics.

22. Shepard (2003) provides a full account of how involving couples presented challenges to the services with regard to guaranteeing the right to privacy and how the services addressed these challenges.

23. This is a standard theoretical construct in gender theory, first advanced by Molyneux (1985). Moser (1993) built on this contribution and standardized it into the "Moser framework."

24. At the time of this study, APROFE did not offer HIV/AIDS testing or counseling, and in the interviews there was no evidence that providers routinely referred those testing positive for STIs for HIV testing. Such users should be informed that they are at risk for HIV/AIDS.

25. Social science researchers on medical ethics in Latin America have found that doctors' tendency to "spare the patient" by not fully disclosing unpleasant diagnoses is very widespread, especially with diagnoses of fatal or incurable diseases. Author's notes from meeting at CEDES (Centro de Estudios del Estado y Sociedad, in Buenos Aires) with social scientists and ethicists in mid-1990s.

26. A separate draft chapter on APROFE's experiences in gender training was not included in the final working paper cited in note 1 but is available from the author as a working draft.

27. This study took place in the initial stages of mainstreaming these concepts, before APROFE's IE&C Department had disseminated their protocol, so that awareness of these concepts among the providers was uneven.

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The Men as Partners Program in South Africa: Reaching Men to End Gender-Based Violence and Promote Sexual and Reproductive Health

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This article presents lessons learned from the Men as Partners (MAP) Program in South Africa. MAP is an ongoing, multi-faceted intervention designed to engage men in reducing gender-based violence and to promote men's constructive role in sexual and reproductive health, including HIV/AIDS. The program is carried out through a partnership of civil society organizations collaborating with governmental and academic institutions to transform the behaviors of men and the norms of masculinity. This article is based on (a) qualitative interviews with professionals from MAP Network organizations and a summary of a small-scale evaluation carried out with MAP participants; and (b) on reflections by the authors, who are directly involved in the ongoing implementation and management of MAP in South Africa. The article provides a case study of a complex intervention seeking to change men's attitudes and behaviors through the use of an ecologic approach that utilizes strategies at many levels to effect personal and social change. As such, it has important implications for work with men in South Africa and elsewhere.

Keywords: gender equality, HIV/AIDS, gender-based violence, prevention, South Africa, men

Ten short years after celebrating the end of apartheid, South Africans now find themselves faced with yet another bitter struggle. This time the battle is against

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HIV/AIDS and violence against women—twin epidemics that are both driven in critical ways by social norms about gender, power, and violence and that currently threaten the lives of millions of South Africans.

The statistics make startlingly clear the extent and severity of these two public health crises. With an adult HIV-prevalence rate of more than 20 percent (UNAIDS, 2002), South Africa's AIDS epidemic is one of the most severe in the world. In some provinces, more than 30 percent of women of childbearing age are estimated to be infected (Dorrington, Bradshaw, & Budlender, 2002). In 2002, it was estimated that there were 6.5 million people in South Africa living with HIV/AIDS (Dorrington, Bradshaw, & Budlender, 2002).

The HIV/AIDS epidemic disproportionately affects women's lives both in terms of rates of infection and the burden of care and support they carry for those with AIDS-related illnesses. Indeed, young women are much more likely to be infected than men. A recent study by the University of the Witwatersrand indicates that women make up 77 percent of the 10 percent of South African youth between the ages of 15-24 who are infected with HIV/AIDS (Pettifor et al., 2004).

Women's greater vulnerability to HIV/AIDS is in part explained by the very high levels of sexual and domestic violence reported across the country. For instance, 10% of sexually experienced females aged 15-24 reported that they had ever had sex because someone physically forced them, and another 28% reported that they did not want to have their first sexual encounter, indicating that they were coerced into sex (Pettifor et al., 2004). Research also indicates that many women continue to experience violence throughout their lives; a study in 1991 reported that violence was present in 50 percent to 60 percent of marital relationships (Vogelman & Eagle, 1991).

Estimating the incidence of rape in South Africa is challenging, yet all analyses lead to the conclusion that sexual violence in South Africa is at epidemic levels. South African Police Service (1999) statistics chronicle 51,249 cases of rape reported to police in 1999, while Rape Crisis Cape Town (2001) believes that the real figure is at least 20 times higher—the equivalent of one rape every 23 seconds. These figures give South Africa the highest per capita rate of reported rape in the world (Rape Crisis Cape Town, 2001). Considering these figures, it is not surprising to learn that a 1998 survey found that one in every three Johannesburg schoolgirls has experienced sexual violence at school (Andersson et al., 1998).

OVERVIEW OF THE MEN AS PARTNERS PROGRAM

In 1998, spurred by the need for a response to HIV/AIDS and violence against women, and recognizing the centrality of working with men to achieving this goal, EngenderHealth and the Planned Parenthood Association of South Africa (PPASA) initiated the *Men as Partners (MAP)* program. The purpose of the MAP program was defined in two ways: to challenge the attitudes, values, and behaviors of men that compromise their own health and safety as well as the health and safety of women and children; and to encourage men to become actively involved in preventing gender-based violence as well as in HIV/AIDS related prevention, care, and support activities. To achieve its goals, the MAP program was launched in eight of

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South Africa's nine provinces, establishing a presence across the country, including urban, semi-urban, and rural communities.

Building on the success and visibility of its early work, EngenderHealth has expanded substantially and has collaborated with a wide range of partners. These have included:

- multilateral bodies such as the Commonwealth's Secretariat on Gender, HIV/AIDS and Human Rights, the United Nations Development Programme, UNIFEM, UNICEF, the Global Coalition on Women and AIDS, the UN's Division for the Advancement of Women and UNAIDS;
- government departments and institutions such as the Department of Social Development, the Department of Health, the Office on the Status of Women, the Commission on Gender Equality, and the South African National Defence Force;
- tertiary education institutions in the Western Cape: The University of Stellenbosch, the University of Cape Town, the University of the Western Cape, Cape Technikon, and Peninsula Technikon;
- national NGOs, such as Hope Worldwide, and research focused organizations, such as the University of Witwatersrand based Perinatal HIV Research Unit and Reproductive Health Research Unit, as well as the Population Council's Frontiers Programme;
- arts-focused programmes, such as the Artist Proof Studio, Youth Channel Group, and the Youth Empowerment Programme.

The wide array of organizations involved in the MAP Network have developed many successful MAP initiatives and activities and, in the process, have provided training and technical assistance to a broad range of key stakeholders, including various government departments at the national and provincial levels as well as traditional healers, faith-based leaders, the police, youth-serving organizations, in- and out-of-school youth, teachers, and other CBOs and NGOs. MAP Network members have also built on the successes of the MAP workshop process by conducting a series of community education events—each of which has included the participation of between 300 and 600 people and received substantial media attention. As a result of this work, across the country, thousands of men participate in MAP workshops and community activities each month, often expressing a firm commitment to gender equality and to reducing risk behaviour.

MAP APPROACH

While the central foundation of the MAP programme has historically been the implementation of workshops that explore gender roles, the programme has expanded its activities substantially over the past few years and now works more broadly to promote gender equality and to reduce the spread and impact of HIV/AIDS. At present the programme works to effect change using the following strategies: workshops aimed at changing knowledge, attitudes, and behaviour; mobilising men to take action in their own communities; working with media to pro-

mote changes in social norms, collaborating closely with other nongovernmental organisations and grassroots community-based organisations to strengthen their ability to implement MAP programmes, and advocating for increased governmental commitment to promoting positive male involvement.

USING A HUMAN RIGHTS FRAMEWORK

MAP workshops use a human rights framework to enable men to recognize the ways in which contemporary gender roles mirror the oppressive relations of power characteristic of apartheid. This oppression has devastating health consequences for women, placing them at risk for violence, limiting their ability to negotiate the terms and conditions of sex, and severely compromising their sexual and reproductive health, including increasing their vulnerability to HIV/AIDS and placing the burden of care and support for people living with AIDS squarely on women's shoulders. In the service of promoting gender equality and protecting women from HIV/AIDS, MAP draws the connections between sexism and racism and other forms of oppression and strives to get men to see the ways in which gender equality is a fundamental human right of comparable importance to those fought for during the anti-apartheid years. This approach connects gender equality to South Africa's rich tradition of social justice activism and situates it squarely within human rights discourses and traditions embraced by most South African men. Many MAP educators come from activist backgrounds and apply their expertise to devising strategies that get men to take a proactive stand for gender equality and against women's oppression. MAP activist Dumisani Rebombo put it this way:

If you think of South Africa during the Apartheid regime, most white people directly or indirectly benefited from the system. Most of them didn't care much, it was not an issue; they just lived their lives. In the same way, gender inequalities benefited me as a man, or perhaps as a black man over a black woman. It was life as usual. Power is enjoyable, I guess. I accepted the status quo. Being introduced to gender education made me stop and start thinking and feeling. Then I started looking at the traditions of my culture and things that are done, which, in my eyes, are very oppressive to women. I looked at the safety of women in general on the street in this country—you see young men forcefully pulling young girls, and it is accepted. I looked into the education system—I think it favours the men. I looked at the teachings of the Bible, such that today I am very uncomfortable with the sermons that are preached. I came to this conviction that gender is not a woman's thing. There is a tendency to label gender as a woman's thing. But masculinities are spoken in relation to femininities. How we construct these masculinities is the issue. We need to construct them in such a way that no-one gets hurt, no-one gets oppressed. (Engender-Health, 2004)

Mbuyiselo Botha, of the South African Men's Forum, a MAP Network member organization, reinforced the link between gender inequality and broader issues of social justice. He said:

What has kept me going is the philosophy that says, our own liberation as men, as black South Africans, cannot be removed from the total liberation of women in this country. That has been a driving force. It would be very hypocritical to talk of liberation when you know that a large section of the society is still in bondage. They still face violence, still face death, they still face rape on a daily basis, as if it is business as usual. (EngenderHealth, 2005)

HELPING MEN TO SEE THE DOUBLE-EDGED NATURE OF CONTEMPORARY GENDER ROLES

To challenge men's power and control over women and to promote gender equality, MAP workshops utilize a second strategy—helping men to see that the benefits and privileges conferred upon them in a sexist society come at a prohibitively high cost. MAP makes this point in a number of ways.

First, contemporary gender roles can compromise men's health by encouraging men to equate a range of risky behaviors—violence, alcohol and substance use, the pursuit of multiple sexual partners, the domination of women—with being manly, while simultaneously encouraging men to view health-seeking behaviors as a sign of weakness. A number of studies demonstrate clearly that such gender roles leave men especially vulnerable to HIV infection, decrease the likelihood that they will seek HIV testing, and increase the likelihood of contributing to actions and situations that could spread the virus. Noar and Morokoff (2001) documented the effects of “masculinity ideology” on condom usage and sexual and reproductive health in general and indicate that traditional men's gender roles lead to “more negative condom attitudes and less consistent condom use” and promote “beliefs that sexual relationships are adversarial.” Similarly, a recent study of antiretrovirals treatment in Johannesburg conducted between April and June of 2004 reported that women accessing ARVs “outnumbered men by a ratio of 2 to 1” (Hudspeth, Venter, Van Rie, Wing, & Feldman, 2004). This same study reported that women's CD4 count at initiation of treatment was also significantly higher than men's (100 cells/ μ l in women and 85 cells/ μ l in men) and concluded by saying, “The observation that two-thirds of patients were female, with 23% of women referred from prevention of mother to child transmission programmes, underscores the need for programmes that target HIV-infected men” (Personal Correspondence, 2004). These findings were similar to those reported in a study of VCT uptake in the Khayelitsha clinic outside Cape Town, South Africa, where fully 70 percent were women (Coetzee et al., 2004).

Second, MAP workshops encourage men to reflect on the ways in which they, too, are affected by men's violence against women. Men are encouraged to consider the ways in which they and countless other men are affected by the pain suffered by victims they know and care about—their daughters, mothers, sisters, friends, colleagues. They are also given the opportunity to consider the ways in which they, and

men in general, are cast as potential perpetrators and have their relationships with intimate partners and acquaintances infused with fear and distrust by women's pervasive fear of violence. In workshops and community activities, MAP helps men to see that the use of violence and the domination of women may grant some men a fleeting sense of power, but that, in the long run, the values and attitudes endorsing this behavior inevitably also produce men who are disconnected from their own humanity, isolated, and often hell-bent on a futile and self-destructive quest to prove their manhood. Sgidi Sibeko, a MAP coordinator working for Hope Worldwide, captured these sentiments when he said:

I attended a workshop in which there was an activity looking at positive role models for men, and participants mentioned Mandela and people like that. The facilitator asked us to "bring it home" and to think of role models in our own lives. And I couldn't find any in my life. I thought of my father, I thought of my uncle, I thought of the men around me, and I was blown away because I could not come up with a man as a positive role model. That challenged me a lot. It was very hard to think that I might be associated with the bad image that men have—as perpetrators and so on. I was really impacted by the bad image of men as the perpetrators of violence, men are the rapists. So I said, I want to change, I want to make a difference, I want to play a positive role in other young boy's lives. (EngenderHealth, 2005)

STRATEGIES AND ACTIVITIES OF MAP IN SOUTH AFRICA

MAP uses programmatic strategies at many levels to effect changes in men's attitudes, values, and practices. These levels currently include workshops aimed at changing knowledge, attitudes, and behavior; mobilizing men to take action in their own communities; collaborating closely with other nongovernmental organizations to build their capacity to implement equivalent MAP programs; and advocating for increased governmental commitment to promoting positive male involvement.

MAP WORKSHOPS

Since its inception, the MAP program has conducted educational workshops with groups of men and mixed-sex groups in a wide variety of settings, such as workplaces, trade unions, prisons, military bases, faith-based organizations, community halls, and youth clubs.

Workshops are typically carried out with various groups of men and mixed-sex audiences over a period of four to five days. The process employed is participatory and nondirective, acknowledging the experiences that all participants bring with them. The approach is built on principles of adult learning that explore participants' values about gender, traditional gender roles, power dynamics that exist based on gender, gender stereotypes, and male and female perspectives on gender. All of the activities strive to increase men's awareness of the inequities that exist between men

and women. They also allow an opportunity to share progressive views of gender relations in an environment that is safe and supportive. Information on HIV/AIDS prevention, healthy relationships, sexual rights, sexual violence, and domestic violence follows the initial activities, and the exercises on these health issues constantly refer back to the subject of gender. For example, an activity about HIV will explore the ways in which gender roles can increase the likelihood that men engage in unsafe sex or deter men from playing an active role in caring for and supporting those left chronically ill by AIDS. Similarly, facilitators might use role playing to examine men's attitudes toward health-seeking behaviors and challenge the notion that a "real man" uses health services only when he's already seriously ill. Using interactive gender-values-clarification activities, workshop participants share and discuss their attitudes toward family planning, antenatal care, and parenting and examine the ways in which gender roles restrict the choices available to both men and women. A common question that workshop facilitators ask during the discussion of any activity is "how does this issue affect men and women differently?"

The workshops are carried out by a cadre of well-trained MAP educators from an extensive network of partner NGOs, CBOs, and governmental organizations. All MAP educators are required to undergo an intensive training process. The importance of adequate training for MAP educators cannot be understated. In order to facilitate MAP workshops effectively, educators must be well prepared to challenge harmful attitudes that condone violence and the oppression of women. Without substantial training an educator runs the risk of facilitating a workshop that could further perpetuate harmful attitudes and beliefs. Therefore, educators begin their training by experiencing a MAP workshop as participants. This allows educators an opportunity to adequately explore and reexamine their own personal values about gender and health. After the initial workshop, educators are required to carry out "teach-backs," in which they facilitate a MAP workshop in a community setting. The teach-backs provide an opportunity for new educators to receive substantial feedback from their peers and MAP master trainers. Once trained, MAP educators continue to receive ongoing technical assistance through additional trainings offered by members of the Men as Partners Network.

Recruitment strategies for MAP workshops vary, since some workshops are carried out with participants in workplace settings or prisons, while for others outreach workers and peer educators from MAP partners organizations invite volunteers to convene at a particular site in a community. In no instance are men paid for their participation. However, workshops usually provide a catered lunch and a small reimbursement for transportation. Unemployment in South Africa is variously estimated at between 30 and 40 percent, depending on whose statistics one uses (Kingdon & Knight, 2000), and can run even higher in some of the communities where MAP workshops are provided. Some men, therefore, attend MAP workshops in an attempt to gain skills that will assist them in the job market. This poses a difficult ethical dilemma for MAP workshop organizers. The current MAP curriculum does not provide job-skills training, even though it is a major priority for a large number of workshop participants. While no research points conclusively to a link between unemployment and higher rates of men's violence or risk-taking behaviour, HIV prevalence is especially high in marginalized communities, and men often cite

unemployment as a risk factor for violence against women. As a result, the MAP Network is currently developing a set of activities intended to open up discussion among men about their experiences of unemployment, including explorations about possible relationships between perceived loss of self worth and increased sexual risk taking.

The MAP workshops are usually carried out over a period of five days and typically entail a total of 35 hours of educational activities. The number of MAP workshop participants varies but ideally consists of about 20 participants. Workshop content is drawn from the *Guide for MAP Master Trainers and Educators*, jointly developed by EngenderHealth and PPASA. Each day focuses on a particular theme. Day One looks at the gender socialization process and power imbalances between men and women. Day Two examines how gender issues impact sexuality, parenting, and relationships between the sexes. Day Three looks at the intersection between gender socialization, health-seeking behaviors, and HIV transmission. Day Four focuses on domestic and sexual violence. The final day focuses on ways that men can redefine masculinity and play an active role in their communities to address gender inequality, responsible fatherhood, HIV/AIDS, and gender-based violence.

MOVING BEYOND WORKSHOPS: COMMUNITY ACTION TEAMS

MAP workshops are an important strategy for increasing men's involvement in HIV/AIDS related prevention, care, and support and for getting men to take a more proactive stand against violence against women and girls. However, much contemporary research suggests that positive change promoted by an intervention such as a workshop is likely to be eroded once individuals return to their families, communities, and day-to-day lives. Sustained change, research suggests, is best promoted by a more ecological approach. Ecological approaches recognize that individuals often reflect the values of their families, communities, and societies and that "effecting sustained change requires addressing the multiple problems of (the individual) wherever they arise; in the family, the community, the health care and school systems" (Currie, 1998). One young MAP participant illustrated this point:

Before the workshop, I thought that a man was the head of the house and that women could not work in the mines and do heavy-duty work but should take care of the family. Now I do believe that we are all equal and women can do whatever they want to do. But when I talk to my friends about this, they say I am crazy. (EngenderHealth, 2005)

Successfully addressing public health problems, especially endemic problems like HIV/AIDS and violence against women, requires going beyond individually focused solutions. To address this, the MAP program has introduced Community Action Teams—a practical way to mobilize men to take action at the local level and sustain their commitment to gender equality. During workshops, participants are invited to plan and join Community Action Teams designed to promote and sustain change in their personal lives and in their communities. Community Action Teams

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work closely with trained staff from NGOs and CBOs within the MAP Network to support events such as health fairs, theatre and performance pieces, and painting of murals with gender-related themes. Other less formal activities by Community Action Teams include one-on-one counselling and condom distribution. A key element to the Community Action Teams is the support that members of the teams provide each other. Through joint participation in the group, team members reinforce a social norm of men taking an active stand for HIV/AIDS prevention and the elimination of gender-based violence.

BUILDING A “BIG TENT” TO REACH LARGER NUMBERS OF MEN

EngenderHealth and PPASA have worked hard to expand the reach of the MAP program by establishing close working relationships with organizations capable of reaching millions of South African men. These include the Solidarity Centre, an umbrella organization that works with the three major labor federations representing more than three million union members; the AIDS Consortium, representing 800 community-based HIV/AIDS focused organizations; and the South African National Defense Force, with a membership of about 65,000. Together EngenderHealth and PPASA provide ongoing training and technical assistance to a core group of staff in each of these organizations, who in turn run workshops in their unions or community-based organizations or in the military. In addition, to make sure that the MAP approach is integrated into more clinical settings, EngenderHealth also works with Hope Worldwide, a national NGO working in the area of HIV/AIDS prevention, care, and support, and with the Peri-Natal HIV Research Unit at Africa’s largest hospital, the Chris Hani Baragwanath Hospital in Soweto.

EVALUATION OF THE MAP PROGRAM

In March 2002, PPASA and EngenderHealth implemented a quantitative evaluation in order to test the impact of the MAP workshop methodology on men’s knowledge, attitudes, and practices related to a variety of reproductive health issues (Kruger, 2003). The study enrolled 209 men who successfully completed a five-day MAP workshop. Eleven MAP workshops were carried out for the study. Interviews were conducted with participants before the workshop, immediately after the workshop, and three to four months later. The evaluation instrument focused on questions related to the exercises that were covered during all the workshops. These included knowledge, attitude, and practice related questions on male and female gender roles, HIV/AIDS and other STIs, relationships, gender-based violence, and practices between partners related to reproductive health.

Out of the 209 post-workshop participants, 139 interviews were completed three to four months after the training. In total, 66 percent of all the participants who completed the training were traced three or more months after the training had been completed. Challenges existed in tracking workshop participants because many of the participants were young men who were transient and unemployed. Tracking of participants was also difficult because physical addresses and telephone numbers were not always readily available for the men.

The findings presented in the evaluation have been calculated using only the 139 respondents who completed a pre-training interview, an immediate post-training interview, and a three-month post-training interview. The mean age of these participants was 33, and ages ranged from 18 to 74. Fifty-nine percent of the participants were unemployed; 67 percent had completed secondary school.

CHANGES IN PARTICIPANT KNOWLEDGE

The data indicate that factual knowledge related to HIV/AIDS increased immediately after the training and that the knowledge generally continued to increase three months after the training. Before the workshop, only 26 percent of the men could successfully respond to the question related to how HIV could be transmitted; three months after the workshop, 45 percent of the men could successfully respond to this question. Before the workshop, 73 percent of the men could correctly answer the question about how condoms should be stored; three months after the workshop, 89 percent of men could correctly answer this question.

CHANGES IN PARTICIPANT ATTITUDES

Participants demonstrated positive attitudinal changes for most of the issues covered in the training. There was a sustained attitudinal change for most questions related to male and female gender roles. For example, before the workshop, 54 percent of the men disagreed or strongly disagreed with the statement that men must make the decisions in a relationship; three months after the workshop, 75 percent of the men disagreed or strongly disagreed with this statement.

Participants also demonstrated some attitudinal changes related to HIV/AIDS issues after the training. Before the workshop, only 57 percent of the men thought it was okay for a woman to refuse to have sex without a condom; three months after the workshop, 70 percent of the men thought it was okay for a woman to refuse to have sex without a condom.

In general, the data indicate that there has been a general positive attitudinal shift regarding issues related to sexual violence and relationships. Before the workshop, 43 percent of the men disagreed or strongly disagreed with the statement that sometimes when a woman says "no" to sex, she doesn't really mean it; three months after the workshop, 59 percent disagreed or strongly disagreed with this statement. Before the workshop, 61 percent of the men disagreed or strongly disagreed with the statement that women who dress sexy want to be raped; three months after the workshop, 82 percent disagreed or strongly disagreed with this statement.

CHANGES IN PARTICIPANT PRACTICES

In terms of practice-related questions, all except one question illustrated a positive behavioral shift after three months, although in some cases the shift was minimal. Before the training, 70 percent of the men indicated that they had jointly decided with their partner whether or not to use contraception; after three months, 79 percent

of the men indicated that they had jointly decided with their partner whether or not to use contraception.

Before the training, 58 percent of the men said that they did not control the finances in the house; this increased to 71 percent after the training. Regrettably, the survey did not inquire about reported condom use or reported acts of violence toward a partner.

MAP EDUCATOR PERSPECTIVES

The process of change evident in the research findings is also captured in the words of MAP educators and activists. Gertie Mbhalata, one of a small number of women using the MAP methodology, described her experiences as a young woman sometimes working with elders and with men:

I think that one of my biggest challenges is that I am young and I am a woman and I have to concentrate on males. Because we are in a rural area where people still believe or trust their traditional leaders, [I thought] it would be best to market the program to the leaders first. So it was very challenging for me to approach them because there is this myth that a young person can't discuss [sexuality] with an older person—the older person is the one who knows all of these things. But . . . I broke the myth that a young person can't discuss that with older people and that a young woman can't really discuss that with older men. (EngenderHealth, 2005)

Boitshepo Lesetedi, MAP Coordinator at PPASA, put it this way:

I realized it was impossible to work around issues of gender when you haven't started with yourself, because I was carrying my own baggage, and own myths and stereotypes. So it became more of my own life than work, realizing how much freer I could be when I don't have to be doing what has supposedly been men's role. (EngenderHealth, 2005)

Finally, MAP educator Patrick Godana described his involvement in the following way: "Being involved in MAP work has helped me to see the beauty of life" (EngenderHealth, 2005).

FURTHER EVALUATION PLANS

Together with the Frontiers Programme of the Population Council and Hope Worldwide, EngenderHealth has begun a three-year impact study to determine the efficacy of the MAP approach. This evaluation will examine changes in interpersonal behaviour among MAP programme participants and will also assess the impact that the intervention has had at the community level. To date, extensive baseline research

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has been carried out in 16 intervention sites and 16 control sites in communities near Johannesburg.

LESSONS LEARNED AND CONCLUSIONS

PRESENT MEN AS POTENTIAL PARTNERS CAPABLE OF PLAYING A POSITIVE ROLE IN THE HEALTH AND WELL-BEING OF THEIR PARTNERS, FAMILIES, AND COMMUNITIES

Despite high levels of male violence against women, it is important to recognize that many men care deeply about the women in their lives, including their partners, family members, coworkers, neighbors, and community members. Given the opportunity and the know-how, many men are eager to challenge customs and practices that endanger women's health and support the well-being of women. Asset-based approaches that redefine men's involvement in the promotion of gender equality as examples of strength, courage, and leadership have been especially useful in this regard.

ENCOURAGE MEN TO PLAY AN ACTIVE ROLE IN CARE AND SUPPORT FOR THOSE ILL WITH HIV/AIDS RELATED ILLNESSES

Much attention has been paid to the ways in which contemporary gender roles condone men's violence against women and compromise women's ability to make choices about their sexual and reproductive health. Less attention, however, has been granted to the ways in which gender roles also create the expectation that women will assume the burden of responsibility for taking care of family and community members weakened or made ill by HIV/AIDS. A 2002 household survey conducted in South Africa reported that "in more than two thirds of households women or girls were the primary caregivers. Almost a quarter of caregivers were over the age of 60 and just under three quarters of these were women" (Henry Kaiser Family Foundation, 2002). To date, then, little has been done to develop interventions that explicitly encourage men to play a more active role in care and support activity. Therefore, it is imperative that men begin to share this burden of care and support.

A 1998 UNAIDS study conducted with men in Tanzania shed light on men's lack of involvement in care and support and revealed that on occasion "male heads of households would wish to do more when their partners fall ill but were curtailed by cultural definitions of maleness and the roles defined which determine masculinity" (Aggleton & Warwick, 1998). These findings have been supported by EngenderHealth's experiences working to promote greater male involvement in HIV/AIDS related care and support. In focus groups conducted in Soweto in March 2003, many men identified traditional gender roles and the fear of losing respect from their peers as significant deterrents to participating in care and support activities. When asked what might prevent other men from playing a more active role, men identified a number of obstacles. In one group, participants answered that some men would see doing work traditionally performed by women as an "affront to their dignity" (Kruger, 2003). Others answered that many men simply did not have the knowledge or skills necessary to provide support or to be more involved in domestic activities

and would not want to risk being seen as ignorant or incompetent. Additionally, some men discussed being afraid that their involvement in care and support activities might create the perception that they, themselves, were HIV positive, which they feared might lead to stigma and social exclusion (Kruger, 2003).

These focus-group discussions suggest that it is imperative that interventions focus not only on increasing men's awareness of the need for their involvement in care and support but also on the need to explore and shift social norms at the community level so that more men can provide the support their conscience tells them is necessary.

BUILD ORGANIZATIONAL CULTURES THAT ARE COMMITTED TO WORKING WITH MEN

No amount of training and capacity building is likely to be effective without the buy-in of senior leadership within partner organizations. To ensure that each organization remains committed to working with men to prevent HIV/AIDS and violence against women, the MAP program includes workshops with senior management and other key staff within each organization on the relationship between gender equality, violence against women, and HIV/AIDS. To ensure that MAP programs complement the other work of the organization, EngenderHealth assists partner organizations to integrate male involvement strategies into their existing efforts so that these are enhanced and made more effective.

PROVIDE ONGOING SUPPORT TO GENDER ACTIVISTS TO AVOID SECONDARY TRAUMA AND BURNOUT

Given that the MAP methodology asks educators to talk about violence and abuse in every workshop, it is important to provide educators with the support that they need to process their own experiences with violence. In addition, educators run the risk of experiencing secondary trauma resulting from constant exposure to other people's stories of violence. Reuben Magoni of Hope Worldwide made this point clearly:

I used to be one of those guys who were abusive. It was really difficult for me to come to terms with that. Actually, I asked to be excused from facilitating that because I feel really conflicted with that. I couldn't talk about it for two or three workshops. But I spoke about it with my other colleagues and I went through a healing process. A month later I could talk about it. I felt great because I could talk about my experiences openly, then help other people to talk about theirs. (EngenderHealth, 2005)

Sgidi Sibeko, of Hope Worldwide, described the impact of a MAP workshop in which rape and sexual assault were being discussed:

This participant said that if he found a man raping a woman, he would kill him. I thought, let me probe around that issue and ask him more what does he mean. And the guy said that his mother

had been raped by a man who was considered a family friend. “And as a result I was conceived. I am a product of rape and from that day on my mum hated me.” One lady cried and another one said that a lady that she lived with was raped on her way to work. And then she started crying. This gentleman stood up and left and the two ladies went outside as well. And then another participant said that a friend of hers was raped as well at a party at knifepoint by some guys. Now the mood changed. Unfortunately, that day I was alone. I stopped the workshop briefly and went outside to counsel the participants there and some other participants who had been to our workshops before helped. Now that obviously poses a challenge for support because you are opening up a wound and you’re doing nothing to help heal that wound. So there is a lot of emotional support that is needed, through counseling for example. But also in the form of support groups of men that are committed to change, of men who want to do things differently, where they can go and draw their strength. Because it is a difficult thing when you are a man alone trying to do things differently. (Engender-Heath, 2005)

Similarly, there is tremendous pressure on men to conform to traditional gender roles. There are, for instance, many prohibitions on men being visibly involved in “domestic” activities (EngenderHealth, 2005). Comments by MAP educator Steven Ngobeni make clear just how important it is to provide ongoing support and break the isolation that many men feel as they begin to resist traditional gender roles:

When you talk about changing norms and values, it’s not easy. The moment I decided to get married I told myself I wanted to be an example of change in my community. One thing I became very strong with was when they said she must go to the veld (bush) and fetch firewood. Just because she is the wife, it is what she is expected to do! But even when I made the means to get the firewood there, there were still some problems because it is not the firewood that they want. They want to see this woman go into the veld and fetch that firewood and come back with the firewood on her head. It is a very challenging situation. Some people are saying horrible things against me and my wife, [but] I have to take a stand so the society can see that change is inevitable. (Engender-Health, 2005)

DEVELOP COHERENT, COORDINATED, AND STRATEGIC PROGRAMMING

Consumed with the task of reconstructing the country after years of apartheid rule, the South African government’s response to the HIV/AIDS and violence against women has been inconsistent, characterized at times by inadequate resource allocation, confusing public statements, and poor coordination with and inclusion of the

NGO sector. This lack of coherence has also been true at times of both civil society and the private sector. Existing within this context, the already inadequate social service infrastructure inherited from the apartheid regime has quickly become overwhelmed. To address this, and to improve the cohesion of NGO and private sector responses to HIV/AIDS and violence against women, the MAP methodology now includes a focus on facilitating relationships between collaborative partners. The MAP Network meets on a monthly basis to learn from each other's successes and challenges, to benefit from diverse skills, and to avoid duplication and wasting scarce resources. More recently, EngenderHealth worked with a range of national government departments to establish the National Coordinating Committee on Men and Gender Equality, consisting of key stakeholders from civil society, government, and business, which will promote greater collaboration among government departments and between government and civil society.

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**“Seizing the Day”:
Right Time, Right Place, and Right Message
for Adolescent Male Reproductive Sexual
Health: Lessons from the Meru of Eastern
Province Kenya**

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For AIDS prevention programmes, finding the right time and the right place in which to impart the right message is critical. This ethnographic study asks if the traditional seclusion period following male circumcision among the Meru in Kenya may be a “moment to seize.” Interviews were conducted with boys undergoing circumcision, adult Meru men, traditional circumcisers, and hospital staff carrying out circumcision. Traditionally, during the seclusion period following the circumcision, cut boys, already physically “made into men,” were taught how to behave, feel, and function as men. Ingrained in Meru culture is not only an expectation of social, psychological, sexual, and behavioural change but teaching/social mechanisms to facilitate change. A pilot health education programme, held during circumcision seclusion, appears to be an acceptable and effective means of modifying risk-taking behaviour, though further rigorous evaluation is required. The

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Meru imperative for circumcised youth to “learn the ways of men” presents an opportunity to reach young men with health messages.

Keywords: male circumcision, Kenya, adolescence, sex education, HIV/AIDS, timely intervention

This paper will examine the context of male circumcision among the Meru of Kenya (see Nyaga, 1997) to explore if the traditional moments of education within the male circumcision rite are still important moments for today’s youth in zones where adolescent circumcision is still practised, and outline an intervention project aimed at seizing the day to reach adolescent boys with youth-friendly health messages.

The Meru live on the eastern slopes of Mount Kenya in the central part of Kenya, home to the Meru people (Bell, 1955). The area once boasted a profitable cash-crop economy, but failing harvests and changing rhythms in world coffee production have reduced its stability. Many inhabitants of this region remain subsistence farmers. The provincial capital of the area, Meru, has an HIV prevalence of 35%. Its environs are famous for the *miraa* or *Khat*, a stimulant leaf chewed in Eastern Africa.

The Meru are traditionally a male-dominated, patriarchal society. Disciplining through violence, particularly within family relationships, provided a means of control. Young Meru people struggle for employment, the division of land through the years having reduced its capacity for substantive returns. Many describe a general apathy and cite idleness as a major problem in their lives and a reason why alcohol, *miraa*, and cannabis (*bhang*), which is grown in the forests of Mount Kenya, are so abused. An estimated 3,929,000 of Kenya’s total population of 32 million are between 15 and 24 years old. In this group, 15 percent of the females and 9 percent of the males are HIV-positive. More than 1.1 million adults are HIV-positive in Kenya. Life expectancy dropped in 2001 to 49 years from 57 years in 1990, largely due to AIDS.

On ethnographic maps, all societies in the central Kenyan highlands are shown as practicing male circumcision (Bongaarts, Reining, Way, & Conant, 1989; Caldwell, Orubuloye, & Caldwell, 1997; Dodge & Kaviti, 1965; Moses, Bradley, Nagelkerke, Ronald, Ndinya-Achola, & Plummer, 1990). Meru oral history indicates that they have practiced male circumcision at least since arriving in the area in the late 18th century (Greeley, 1977).

Chogoria Hospital, in the South Meru region, is the largest NGO health provider in the area and serves a population of 528,000. Chogoria Hospital was founded in 1922 by Clive Irvine, a zealous Scottish missionary doctor with far-sighted ideals for women’s education, industry creation, and public and preventative healthcare. In 1926, Irvine offered hospital-based circumcision as an alternative to traditional circumcision of the field and forest. He retained the particular Meru cut. Several traditional techniques of circumcision (*gutanwa*) have been identified among the Meru people alongside the period of seclusion and male-only supervision

and nursing care (Brown, Micheni, Grant, Mwenda, Muthiri, & Grant, 2001). This hospital service has continued since the 1920s and forms the basis of the intervention programme that this paper will describe.

At the conclusion of their primary education, all Meru boys are expected to be circumcised, regardless of whether they plan to attend secondary school or not. Between mid-November and mid-January, boys are admitted to the hospital for a period of one week, during which time they are circumcised.

METHODS

An ethnographic methodology was adopted to understand the context and significance of circumcision, past and present. Information was collected from a variety of sources: adult Meru men (55 of the boys’ guardians or family-appointed men who accompanied the boys to hospital for circumcision, two traditional circumcisers, 20 traditionally circumcised local men, and 30 male nurses performing circumcision within the health clinic and hospital setting), 140 adolescent boys before and after their circumcision; and old and recent hospital records, local newspaper reports, and literature published on the subject, which were examined to provide corroborating evidence on the traditions and their changes throughout the years.

We used purposive sampling to capture perceptions across a range of age, religious belief, location in Meru, and employment status. All male hospital staff involved in circumcision were interviewed. After initial identification of five adult men traditionally circumcised, we used snowballing techniques to identify another 15 men. Their ages range from early 20s to 90 years.

During what we estimated to be the busiest week of circumcision, from previous hospital records, we interviewed each boy until we completed 100 interviews. Fifty-five guardians who came to collect their initiates at the end of this week were also interviewed. A further 40 interviews were completed the following year during the same week.

The authors carried out interviews and focus groups with the older Meru men and hospital staff. Second-year male nursing students carried out the interviews with the initiates and with their guardians. The interviews were conducted in the local language. Interviewers recorded and then translated the interviews into English. We analysed the interviews thematically by coding the interview scripts, focus group material, and supporting documents (i.e., records, local paper clippings). Codes were allocated to emerging themes, which were tested through further discussion among key informants. Support was offered from the principal of the nurse training school and male community health advisors.

INTERVIEW FINDINGS

The qualitative individual and focus-group interviews with adult Meru men explored their memories of their own circumcision, their age set’s circumcision, and their perceptions of present-day circumcision in Meru.

Meru men explained that the whole Meru community still believe that an uncircumcised male, regardless of his age, will always be regarded as a child, unable to

own land, marry, or have sexual relations. Traditionally, circumcision took place in a field, near a river, the boy being held in a line by his guardian while a traditional circumciser cut, in quick succession, each of the boys. After the cut the initiates and their guardians were brought from the field to a “seclusion” hut in the forest. As the circumcision cut healed, initiates received teaching about “the ways of men,” clan business, secrets of the clan, and male-female relationships. They adopted a new name and learned a new language, enabling them to communicate about sexual or clan business in a secretive way. They emerged from their time in seclusion as new people with a new identity. They returned to their home village, now to live in a separate hut, away from their mother and younger brothers and sisters. As children there was a strong taboo against engaging in sexual relationship. It broke clan law, and it was said to bring uncleanness into the clan. But as men, returning from circumcision, sex was permitted, even encouraged. The expression “cleaning the sword” was used frequently and referred to the act of first sex after circumcision. The constant theme that emerged throughout the data collection was that the “way of childhood was gone forever”; those who were circumcised were now men.

Information gathered from guardians indicated that hospital or clinic circumcision has become increasingly popular among the Meru. The fear of HIV/AIDS, exacerbated by the risk of infection through shared unsterile circumcision knives, has encouraged many more families to choose the hospital for the boy’s circumcision. Guardians indicated that families expected the boys to learn how to become men and assumed that within a hospital setting information they received would be appropriate and safe.

Interviews conducted with initiates undergoing circumcision focussed on two issues—life before circumcision and their expectations of life after circumcision. Themes emerged that paralleled descriptions given by the older men of their lives before circumcision.

CIRCUMCISION: BEFORE AND AFTER

The boys described how they were treated as children by everyone in their family compound and village. They were not allowed to leave their family compound at night, talk to girls about sexual topics, or engage in any sexual activity. Boys described how their family and community prohibited sexual activity between children. They were also forbidden to drink local beer or go to male meeting houses or bars. “I cannot take beer, or go with my father and uncles when they leave at night to go to the village *dukas*.” They could sit and eat in their mother’s kitchen and play with younger children, though. “I still eat with my mother in her place, the kitchen, but soon I will eat with the men.” Theirs was the life of a child, but they explained that circumcision was going to change this.

They all saw circumcision as an essential rite. The boys explained that circumcision would allow them to “be ready for secondary school and avoid beatings from older pupils” and “be free from household chores.” Every boy said that circumcision was the responsibility of all Meru men, affirmed and demanded by clan law. They explained how their whole family was involved in circumcision, how they had said goodbye to younger children and their grandparents, and how special feasts would

be prepared for them on their return to mark the change they had undergone. They talked of how they expected to be recognised as men on leaving the hospital. They spoke of “learning the ways of men,” a key part being how to interact with women. They hoped to learn new words and expressions when returning to the community that would allow them to communicate to other men in a way not understood by uncircumcised boys or women. They believed they would have a different relationship with the elders and adult men of their compound; while still being obedient to them, they would now be able sit with them, listening to their stories and learning how to behave and how to deal with political and social problems.

They described how they anticipated having new relationships, new freedoms, and new opportunities on leaving the hospital. They looked forward to being able to speak openly to girls and bring girls to their own rooms. A number said they now could have sex. “I am not hindered from having sex now. I cannot share my mother’s kitchen with females, but I can share my room with girls in my separate house. I have full freedom to go out in the evening.”

“I can walk at night alone and can sleep with girls. There will be no restriction to sex with girls of my age.”

They believed that by being circumcised they would be able to “ejaculate properly.” Some boys also talked of the importance of having sex as soon as possible after their circumcision. “If one does not have sex soon after circumcision, the penis will remain soft forever.”

The interview findings provided evidence that, although shorter now, the period of segregation and seclusion at circumcision still retains the expectation of change and newness. Boys and their families still desire teaching on sexual matters and life skills. They also expect that circumcision and the teaching will bring about a profound life change.

PUTTING THE FINDINGS TO WORK

Using information about traditional seclusion teaching on the ways of men and framing it within the boys’ own expectations, a health education intervention was developed focussing on the themes of:

- becoming a man—physical, psychological, and social changes of puberty and of circumcision;
- interpersonal relationships with girls, peers, parents, and community;
- HIV-AIDS and other sexually transmitted infections (STIs);
- Community expectation—Meru clan systems, chiefs, and sub chiefs;
- substance use and abuse;
- psychology of youth – peer pressure, group identity, risk taking;
- setting goals and achieving them—secondary school life including bullying, self-confidence and self-maturation, and religious commitment.

The themes from the research indicated not only areas of learning expectation but also highlighted areas of potential risk, which the programme sought to deal with.

The programme focussed on choice under the theme “Climbing to Manhood.” The intervention was designed to replicate the traditional seclusion teaching on the “ways of men”; provide clear information on current and pertinent youth issues; encourage peer group discussion, active involvement, bonding, and positive peer pressure; and encourage community leaders to reflect on their role of modelling healthy living to young people.

Programme trainers were chosen selectively from the community, reflecting the traditional method of choosing older Meru men to pass on the “ways of men” to the new initiates during their seclusion period. These men, from different professions — teaching, church ministry, government, business, and health — were involved in developing the programme and shared a two-session training plan with hospital staff before the commencement of the programme. An introduction to this training of the trainers session was given by the Community Health Department, highlighting the ethos and the messages that the programme anticipated giving.

Initiates can register for hospital circumcision on any day and usually stay one week after their circumcision. The rolling programme ensured that regardless of the day of entry the initiate received teaching on all the themes.

The programme approach incorporates principles of good practice learned from other youth HIV/AIDS prevention programmes in sub-Saharan African communities. Considerable emphasis is placed on personal capacity and self-confidence building, coping with negative peer pressure, and setting personal development goals to enable the possibility of abstaining from sexual relationships until older.

The programme adheres to the traditional requirements of male-only care throughout the period of operation and seclusion. Special “circumcision” foods are still prepared for the initiates. While limited accommodation and cost made it impossible for each initiate to have his guardian with him throughout the seclusion period, a representative guardian, a head boy of the local boys’ school, provided a role model and support. As all circumcisions take place during the December school holiday period, this representative guardian was able to stay with the boys throughout the entire circumcision period.

Programme tools such as videos and educational board games are used. A youth magazine (designed by staff) called *Climbing to Adulthood* complements the educational sessions. While the programme planners actively espouse gender equality, the format and content of the programme has not placed enough emphasis on developing such issues, particularly the rights and role of women. The faith-based component of the teaching does encourage mutual respect for men and women and provides a lifestyle plan that advocates appropriate female respect and understanding.

An active attempt has been made to challenge stereotypical male roles with their associated acceptance of violence. The programme has invested significant effort in ensuring that the traditional beatings and disciplining, very much a part of the rite of circumcision, are prevented and initiates are given the opportunity to explore the abuse of violence. The boundaries provided by the physical walls of the hospital ward and the psychological walls of the traditional seclusion period offered an intense and secure opportunity for boys to discuss issues of significance.

DID THE PROGRAMME WORK?

While there is significant anecdotal information on the successfulness of the programme, no rigorous full-scale evaluation has been carried out. An evaluation meeting, held three weeks after the end of the first circumcision season, brought together all who had participated in the planning and teaching. The community trainers reported comments from young people in their locality. The mentality of “it could never happen to me” had clearly been challenged during the programme. A trainer described how two boys had told him that they had known men could get AIDS from “sleeping around with many women and loose women,” but they had not previously understood that sex with just one girlfriend who was infected could lead to them becoming HIV+. Eight months after the first programme, an evaluation session with the initiates was held. Invitations were sent to 50 young men chosen at random from the circumcision register. Though held during the school holidays, only 24 attended. Those who attended described the pressures from other pupils to try drugs, alcohol, and sexual experiences. They gave examples of how they had resisted unhealthy peer pressure. Some explained that they were laughed at because they did not experiment, but they had learned that they could become addicted, their work could suffer, and they could be thrown out of school. They knew that drugs might seem exciting but had many unpleasant, even dangerous, side effects.

Some said that knowledge and fear of STIs had prevented them from engaging in sex. One young man explained that, after seeing the video on STIs, he had resolved never to engage in risky sexual activity that could lead to such infections; he dreaded having to ask his father for treatment money. In his own words, “I would be so ashamed when my father asked me what the money was for, and I would have to show him the awfulness of that disease.” Another boy said that when schoolmates were tempting him to engage in sex, he kept remembering that he could become ill with AIDS, and he felt “no experience is worth dying for.”

CONCLUSION

During traditional circumcision, teaching about the “ways of men” was provided in a time and space rich with the expectation of change and newness. Although shorter now, the period of segregation and seclusion still retains the expectation of change and newness. Boys and their families still desire teaching on sexual matters and life skills. They also expect that circumcision and the teaching will bring about a profound life change.

Enormous resources are being targeted at adolescents in AIDS preventative programmes throughout sub-Saharan Africa. Models of good practice indicate the importance of peer education, gender-appropriate messages, and role modelling. However, information giving during this period, while increasing knowledge, does not necessarily change behaviour. Understanding the significance of both the individual and the community commitment to change and the challenges of reconciling programmes to facilitate personal and societal positive choices remains key in health educational practice.

This paper explores the possibility of identifying cultural moments of ripeness for change, of engaging with the past to provide indicators for change in the future, and of exploring the possibilities of transition rites as formation periods for healthy living. African traditional societies teach us that there is a right time and a right place to give important, life-changing messages. The individual commitment, coupled with the social bonding and community expectation, around the time and place of circumcision creates an environment where behaviour change is possible. With the crises of AIDS and the disillusionment of the young in so many parts of the Western world as well as in rural Africa today, the right message at the right time and place is crucial. Even when traditional rites of passage for young people have faded or appear to be fading, as in Western society, there may still be important opportunities to engage with people in their time of transition. It is time once again to learn from the elders; identifying the moment and then “seizing the day” must be a priority of health educators in all countries and communities.

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Responding to Men's Sexual Concerns: Research and Intervention in Slum Communities in Mumbai, India

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Much of the responsibility for the transmission of HIV/STD lies with men involved in sexually risky behavior. While there are many programs aimed at reducing men's risky behavior, insufficient attention has been paid to men's perspectives on sexual health and the cultural context within which men engage in risky behavior. This paper reports on a multi-year, multi-level research and intervention project to assess men's culturally based sexual health concerns and to utilize those concerns in the development of HIV/STD risk reduction and treatment programs in urban poor communities in Mumbai (Bombay), India. The intervention approach consists of community-level education, training of both public allopathic and private nonallopathic providers and a treatment modality that centers on syndromic diagnosis and management, behavioral change, and a therapeutic approach based on narrative and cognitive therapy termed the "narrative intervention model." The project's pre-post, control, and experimental design allows evaluation of impact at each intervention level.

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Much of the literature with regard to men's involvement in reproductive health emphasizes men's reluctance to address their own health, the health of their sexual partners, and the health of their children. As a result, programs directed toward men and reproductive health have emphasized expansion of their health knowledge, a redefinition of their gender roles, a reduction of their risky behaviors, and an increased utilization of healthcare services. Intervention programs, however, must cope with current realities: Men have poor knowledge of their own health, let alone of the health of women and children; a significant number of men will not easily conform to calls for gender equity; in most locales men underutilize healthcare services; and men are more prone to engagement in such risky behaviors as smoking, alcohol and drug use, and extramarital sex that put themselves and their families at risk.

Although the challenges and obstacles have been apparent, the answers have not been so easily forthcoming. Though there is a commitment to change men's behavior, much of that change is based on concerns and concepts that have been exogenously generated, particularly when directed toward men who must also cope with a wide range of economic, environmental, and structural deficiencies that undermine attention to their own health and the health of their families. This paper suggests that before we move to the change mode, we need to carefully and systematically listen to and observe men within local communities to identify their unique concerns and utilize that knowledge for the development of change opportunities. One such opportunity emerged in the assessment of men's sexual health problems and development of prevention programs for HIV/STD risk reduction in slum communities in Mumbai, India.

The concern about men's sexual health and the health of their sexual partners is set in the context of the rapid spread of HIV/AIDS and increasing rates of STDs in India. It is now estimated that more than five million individuals are living with HIV/AIDS in India, a prevalence of 0.9% (National AIDS Control Organization, 2004; UNAIDS, 2004). Kumar (1999) has estimated the actual burden of HIV-infected people as 1.5% or 11.5 million individuals already infected with HIV, whereas Eberstat (2002) estimated 30-140 million new cases of HIV/AIDS in the period of 2000-2025. Although the actual and projected figures are in some dispute, it is generally agreed that AIDS will emerge as the single most important cause of adult mortality in India in the coming decade (UNAIDS, 2004).

The state of Maharashtra and the city of Mumbai have been severely impacted by the spread of STDs and HIV/AIDS. In Mumbai, surveillance data indicate a steady progression of HIV-positive individuals among patients attending STD clinics rising from a low of 1.6% in 1987 to 64.4% in 1999, with HIV prevalence increasing in the city from 1% in 1993 to 3% in 1999 (UNAIDS/WHO, 2000). A screening of female sex workers and their clients attending an STD clinic in Mumbai showed that 42% were seropositive for HIV, 72% for herpes simplex virus-2, 38% for syphilis, and 26% for gonorrhea. Findings also indicated that members of

high-risk cohorts suffered from multiple STDs, which increases the risk of subsequent HIV infection (Das, Yemul, & Deshmuk, 1998; Hawkes & Hart, 2000).

The predominance of HIV/STD infected individuals in India are men; estimates in 1994 indicated a male to female ratio of 5:1, with female cases being mainly sex workers (Pais, 1996). More recent estimates indicate a 2.5:1 ratio (UNAIDS, 2002). Heterosexual contact with sex workers, both before and during marriage, has been considered the major source of infection in men. The increasing proportion of HIV-infected women is seen to result from men having risky sex and then having sex with their wives (Bentley et al., 1998; Jacob, John, George, Rao, & Babu, 1995; Jain, John, & Keusch, 1994). In Mumbai, 2-4% of pregnant women have tested positive for HIV in public hospitals (Maniar, 2000). Data from Pune in Maharashtra have shown a relatively high prevalence rate among presumably low-risk, married, monogamous women whose only risk factor was sexual contact with a husband who had experienced an STD (Gangakhedkar, Bentley, & Gadkari, 1997; Newman et al., 2001).

Multi-country studies have shown that men of all age groups have reproductive health concerns but tend to ignore minor illnesses and avoid seeking treatment for their conditions (Nataraj, 1994; Singh, Bloom, & Tsui, 1998). Many men do not realize that they have a problem needing treatment, whereas others are embarrassed and do not seek treatment until the problem reaches an advanced stage (Raina & Malhotra, 1998). For many men, reproductive health services are synonymous with maternal and child healthcare, and the structure of service delivery discourages them from seeking reproductive health treatment and other services (Ndong, Becker, Haws, & Wegner, 1999).

In recent years, there have been a number of pilot projects developed to increase male involvement and improve male-oriented services with the objective that if men are effectively brought into reproductive health services, there will be positive reproductive outcomes for both men and women (Raju & Leonard, 2000). These projects have developed a series of key principles for an effective male-oriented reproductive health service: (a) ability to communicate in culturally and socially appropriate terms about men's sexuality (Grenon & Tazeem, 1996); (b) provision of information, education, and counseling on a variety of health topics in a sensitive, direct, and honest manner without judgment (George, 1997; Helzner, 1996; Ndong et al., 1999; Raina & Malhotra, 1998; Raju & Leonard, 2000; Sachdev, 1997; Verma, Khaitan, & Singh, 1998); (c) promotion of communication, education, testing, and treatment for both partners in order for STD programs to be effective (Bloom, Tsui, Plotkin, & Bassett, 1999; Ndong et al., 1999; Singh et al., 1998; Wegner, 1998); (d) diagnosis, treatment, education, and partner notification in relation to sexually transmitted infections integrated into male-focused reproductive healthcare (Shelton 1999; UNAIDS/WHO, 2000); and (e) promotion of condom use for both family planning and prevention of disease transmission (Hawkes & Hart, 2000; Raju & Leonard, 2000). Although these pilot programs have shown selective effectiveness, many more community-level interventions need to be undertaken to fully understand and implement effective male-oriented reproductive health programs in India and other parts of the world. This paper describes formative research leading to an intervention focused on enhanced provider services as a means of addressing sexual disease transmission in slum communities in Mumbai.

PRELIMINARY DATA

Research conducted over the past decade in India has shown that men living in both urban and rural areas of India have widespread anxieties associated with sexual matters (Kulhara & Avasthi, 1995; Peltó, Joshi, & Verma, 1999; Verma et al., 2001, 2003). Men in India are dealing with many of the universal male sexual health problems including premature ejaculation, impotence, infertility, nocturnal emission (wet dreams), feelings of guilt associated with masturbation, and concerns about penis size (Verma et al., 1998). South Asian and Indian culture amplifies these concerns through the concept of *gupt rog* ("secret illness" in Hindi), which refers to culturally defined illnesses that belong to the secret parts of the body. What makes these issues even more problematic in India is that sex is often associated with matters of pollution and purity (Savara, 1993). Many of the sexual health problems reported by men in India are described in terms of semen impurity and are viewed as caused by excessive sexual intercourse, wrong types of food, excessive exercise, grief, and loveless sexual intercourse (Bhugra & de Silva, 1995). According to Indian tradition (writings in the *Upanishids*), semen is known as *virya*, derived from a Sanskrit word that means bravery, power, or greatness (Nag, 1996; Verma et al., 1998) and is considered the source of physical and spiritual strength. The loss of *virya* through sexual acts or imagery (including masturbation and nocturnal emission) is considered harmful both physically and spiritually. The focus on semen loss makes premature ejaculation, nocturnal emission, and masturbation special concerns among Indian men (Verma et al., 1998). Although nocturnal emission and masturbation are the main sources of sexual release in the years before marriage among the majority of males, they are also major causes of anxieties among unmarried young men in South Asia (Bhende, 1994; Watsa, 1993). Closely related to concerns about masturbation are erectile deficiencies and early ejaculation (Jain et al., 1998). Reports of impotence resulting from old age, excessive semen loss due to jealousy and drunkenness, semen and penile conditions, fear, anger, and incompatibility with a sexual partner have been extensively reported by men in India (Bhugra & de Silva, 1995). Since the etiology and diagnosis of *gupt rog* problems are outside the allopathic tradition, they have generally been ignored, demeaned, and seen as a relic of the cultural past by cosmopolitan health services. As a result, when men seek treatment for these problems, they go to the traditional, nonallopathic doctors in their communities.

R.K. Verma and his research team at the International Institute for Population Sciences in Mumbai conducted a study (1995-2000, Ford Foundation) of men's sexual health in a slum community in Mumbai. The team conducted a survey of a random sample of 1,344 men; among many questions, respondents were asked about whether they had a sexual health problem in the past two months, and if so what was the nature of the problem. The resulting list of problems were divided into those that were primarily *not* a result of sexual contact (*noncontact*) including nocturnal emission, sexual weakness, white discharge, early ejaculation, masturbation, poor quality and quantity of semen and erection problems; and those STIs or STI-like symptoms that were seen to be a result of sexual transmission (*contact*). In all, 43.7% (458) reported at least one of the *noncontact problems*, and 4.8% reported at least one *contact* problem. Bivariate analysis showed that respondents who report a noncontact problem have a signifi-

cantly greater frequency of contact problems ($\chi^2 = 22.76$, $df = 1$, $p < .001$). In addition both contact and noncontact problems were significantly related to men with a riskier life style ($\chi^2 = 3.59$, $df = 1$, $p < .05$) as defined by smoking, drinking, gambling, alcohol use, and visiting sex workers (Verma & Schensul, 2004). These survey results and additional qualitative data showed that men identified noncontact problems at 10 times the frequency of contact problems and that culturally defined, noncontact problems are a mechanism with which to address both contact problems and risky behavior. The results demonstrated that it would be highly inappropriate for any behavioral change-oriented program seeking to address sexually transmitted diseases in the community to ignore noncontact *gupt rog* problems.

THE RISHTA PROJECT

The interrelationship of noncontact and contact sexual health problems and risky lifestyle has been the basis of a five-year (2001-2006), NIMH-funded (RO1-MH64875) research and intervention project in three slum communities (including the community in which Dr. Verma and his team worked) in Mumbai. The collaborating partners for the project are the Center for International Community Health Studies at the University of Connecticut School of Medicine in Farmington, CT, the Institute for Community Research in Hartford, CT, and the International Institute for Population Sciences in Mumbai, the apex demographic institution in India. The project, and a supplement for women funded by the Office of AIDS Research of the National Institutes of Health, formed the basis for the IIPS program, "Research and Intervention in Sexual Health: Theory to Action (RISHTA, meaning "relationship" in Hindi and Urdu). The project team consists of an interdisciplinary mix of anthropologists, demographers, physicians and psychologists, and a field staff of community residents and those experienced in research and intervention in similar communities. The project objectives were to (a) test the proposition that noncontact problems predict higher rates of risky sex and STD; (b) determine the degree to which an intervention focused on culturally based sexual health concerns can attract men into HIV/STD education, sexual risk reduction, and early identification of HIV/STDs; and (c) develop and test a culturally based therapeutic approach to male sexual health problems that could result in positive social, psychological, and health outcomes for male sexual health problems. The project called for formative research, which would provide the empirical base for the development of the intervention, and evaluation of the effectiveness, integrity, and acceptability of the intervention among patients, providers, and the community as a whole, utilizing a pre-test, post-test control group design and qualitative evaluation methods. This paper will focus on the formative research and the translation of those results into an innovative intervention for men in the experimental communities. With less than a year since the initiation of the intervention, sufficient outcome evaluation results are not yet available; however, we will present preliminary results of process evaluation to comment on the acceptability and integrity of the intervention to date.

FORMATIVE RESEARCH RESULTS

The primary aim of the formative research was to learn more about men in the three study communities, with particular emphasis on sexuality and sexual health problems and the providers who treat those problems. To achieve this objective the project team, in the period of February 2002-September 2003, conducted in-depth interviews with 52 men, carried out a rapid assessment of all private providers in the three communities, conducted in-depth interviews with 45 private allopathic and nonallopathic private providers, and conducted a baseline survey of 2,408 randomly selected men and STD testing with a sub-sample of 640 men.

THE COMMUNITY

The project is being conducted in three low-income, “slum” communities that have grown rapidly in the past two decades with a large number of illegal and unauthorized structures added by migrants coming from various parts of the country. The population is mixed Hindu and Muslim, with the majority coming from Uttar Pradesh and other poor states in northern India and rural Maharashtra and Tamil Nadu in the West and South. These communities are typical of overcrowded Mumbai slums with many lanes and by-lanes, unplanned and ad-hoc structures, and many “joints” such as tea and *paan* (betel nut) shops, beer bars, country liquor outlets, and illegal gambling establishments.

Table 1
Self-Reported Sexual Health Problems and Treatment Seeking in the Previous Three Months by Men Living in Three Slum Communities in Mumbai (n =2408)

Sexual Health Problem	Experienced		Sought Treatment ^a	
	%	(#)	%	(#)
Early ejaculation	16.1	(388)	19.6	(76)
Itching on genital organs	13.9	(335)	79.9	(263)
Burning urination	11.5	(276)	37.8	(104)
Nocturnal emission	10.5	(178)	5.3	(9)
Pain in lower abdomen	9.6	(125)	53.3	(65)
Hot urine	9.2	(221)	18.6	(39)
Loss of sexual desire	7.7	(185)	15.2	(28)
Thinning of semen	4.3	(104)	16.2	(17)
Masturbation	3.9	(37)	2.6	(1)
White discharge	3.2	(78)	33.8	(26)
Quantity of semen	2.7	(64)	12.3	(8)
Pimples on the genital organs	2.3	(55)	56.4	(31)
Small penis	2.2	(52)	3.9	(2)
Bent penis	2.1	(50)	2.0	(1)
Loss of erection	2.0	(27)	17.0	(8)

^a Percentage of those reporting the respective problem

A stratified random sample of 2,408 married men ranging in age from 21 to 40 was drawn from the three study communities. The average age of men in the sample is 31 years, with a mean education at sixth standard (grade). The sample is 53% Muslim, 43% Hindu, and 4% other. Men's average income is Rs. 3272 (\$70) per month. Participants are currently living in households with a mean of 5.6 people per household, with 1.2 rooms or approximately four people per room.

In the RISHTA project survey, the men in the survey sample were given a list of 33 symptoms and asked if they had ever experienced a problem, in the past three months and currently. Table 1 present men's self-reports for the leading symptoms over the previous three months.

Overall, 1272 (53%) of married men reported at least one sexual health problem in the last three months, with 40% reporting a *noncontact* problem and 36% a *contact* problem. Early ejaculation was the number-one sexual health problem in these communities, with itching on the genital organs, burning urination, "hot urine," loss of sexual desire, and nocturnal emission also of relatively high frequency.

SEXUAL HEALTH CONCERNS FROM THE MEN'S PERSPECTIVE

Four themes emerged from the men's discussion of their sexual health problems: (a) definition of symptoms, (b) concepts of masculinity; (c) the nature of the marital relationship; and (d) involvement in a risky lifestyle. Illustrations of each of these themes follow.

Definitions of Symptoms. In terms of the definition of symptoms of noncontact problems, one man said: "I suffered from the problem of bent penis, lack of desire for sex, erection difficulty, early ejaculation." Another interviewee described his *problems* as "loss of sexual desire, joint pain, black circles around eyes, and early ejaculation." "Those who are suffering wet dream and do excessive masturbation, their semen becomes weak and [are not able to do] intercourse. In this case, they should not marry." "Before marriage I used to masturbate . . . by which I wasted semen to a great extent, for which I suffered the problem of bent penis, lack of desire for sex, erection problem, and early ejaculation." "Due to anxiety and hesitation, I ejaculated beforehand." "[During first sexual experience] I was scared to do sex with her; I was not getting a proper erection." Other men cited reasons related to perceived male and female roles (e.g., failure of man to be dominant), having sex too frequently (e.g., if sex daily, "there is no semen in the penis, how can I get erection?"), lack of physical strength, and external factors such as income and arranged marriages. Descriptions of contact problems are summarized in one man's description of STD-like problems, "I suffered from . . . pus discharge, burning urination . . . also the penis became red." Men viewed their sexual health problems as stemming from previous sexual experiences with partners they perceived as risky (older women, sex workers, eunuchs, multiple partners). "People say if we do sex with eunuchs then there is a chance of suffering from [STD-like symptoms]."

Concepts of Masculinity. Concepts of masculinity and self-perceptions of manliness showed a clear link to their concerns about sexual health problems, emphasizing the

importance of cultural-specific role definitions. “A real man or manliness is [one] who can satisfy his wife and should be ready for sex whenever his wife asks for sex. If he has relation with more than one woman, he should be able to [satisfy] all...” “He can produce a male child, also females should be attracted to him.” “Man should be able to control himself till her orgasm.” “A real man should have control on masturbation.” “[A real man should be] able to do sex for a longer period, at least for 30 minutes.” “The sign of manliness is the size and thickness of penis.” Presence of sexual health problems was seen as contrary to manliness: “[A real man] is not suffering from such problems like early ejaculation and loss of semen.” “In case the wife initiates [sex], that means her husband is a eunuch.” “Wife should never take initiative in sex; rather she should feel scared about sex. She should always be satisfied during sex.” “When I need sex it takes place; no need to give any special indication.” “I also don’t ask her about satisfaction. As it is penetrative sex, she gets the semen inside her vagina, by which I know that she is satisfied.” Men also associated masculinity with forced sex: “Unless the man forces his wife [for sex], he will not be called a real man; in other words forceful sex is a sign of manliness.” “A real man is he who can do sex till his wife cries in pain.” Men’s definitions of masculinity, and thus their self-perceptions, were closely tied to sexual health. This link is critical in the treatment of men’s sexual health problems.

Nature of Marital Relationship. Relationship with spouse was closely linked to male sexual health concerns. Men spoke primarily about the actual or potential impact of their sexual health problems on their marital relationships or wife’s health. “From a health point of view, there should not be any sexual health problems. So he [husband] will be able to satisfy the sexual urges of his wife, and in turn marital relations will be good.” Men also expressed concerns about the failure to satisfy their wives, “If my wife is not satisfied, she will get attracted to other males.” The men also talked about the negative reactions of their wives to sexual difficulties. For example, “[in response to early ejaculation], she becomes annoyed and teases me for this;” or “she sleeps with anger and doesn’t talk to me.” The potential impact on the wife’s health is exemplified in the following quote: “She also has pimples around her genital organs. She also has the problems I suffer from ... complains about pain in her abdomen, burning urination, white discharge; she looks like a TB patient.”

The men spoke of forced sex as typical in their own marriages, “She always says no to sex. But I always force her.” “As per my knowledge everyone does forceful sex in the first night [of marriage], so I also did forcefully.” “But this is my right to have sex forcefully, which I do frequently.” “Friends also told me in the first night ... the bride would feel shy and hesitate ... forcefully I had sex for two times.... But the second night she completely refused for intercourse and told me she is getting severe pain in vagina due to forceful sex at first night. I shared the experience with my friends ... they told me nothing is wrong in this, every women search some excuses to avoid sex ... when women are getting pain, they enjoy more.” The interviews revealed the presence of conflict and physical violence in men’s marriages, “I beat her furiously.” “I got angry and slapped her.” “Sometimes, due to alcohol, I use to beat her.” “Last night I drank a bit; when I went near her she said I am stinking, so I should stay away. Then I got angry and slapped her.” “So

always my wife fights with me for the luxurious amenities, which I can't provide her. Once I became very upset and slapped her." The men's narratives clearly indicate that domestic violence is an issue that warrants attention and may be part of a pattern of marital dissatisfaction that includes sexual dissatisfaction.

Involvement in Risky Lifestyle. Risky lifestyle of the respondents was evident in their comments about extramarital sex, sex with commercial sex workers, perceived norms about acceptable sexual activity of men, and attitudes toward condoms. The men spoke about engaging in sex with commercial sex workers before and during marriage. There were many references to having sex with sex workers. The men provided several reasons for engaging in extramarital relationships, particularly with sex workers. They cited sexual dissatisfaction in their marriages: "CSWs are prepared to do sex in different ways, as we saw in blue films, which we can't do with our wives. So I went to the CSW;" "with CSW I can enjoy as I wish within Rs. 50/." They spoke also of general marital dissatisfaction: "I am fed up of my family. Nowadays I am involved with a Nepali girl. First time I met her is at a beer bar." They also cited perceived norms that support premarital and extramarital sex, "Who is a saint these days? Everybody experiences sex before marriage.... Everybody gets bored with their wives. If one wants true enjoyment, then he should go out and keep someone for that, no matter he has to spend money for that." "I experienced it [first sexual experience] with a CSW, when I was around 20 years." And "I had extramarital relation [with sex workers]." "We enjoy sex together rather than one by one. She [CSW] does masturbation to all. I prefer to do intercourse, so I used to have intercourse first; after that my friends enjoy with her in different ways as shown in blue films."

A number of studies have indicated that men are more concerned about performance issues related to semen loss than they are about sexually transmitted infections (Pelto et al., 1999). Strongly held cultural beliefs cause the vulnerable individual to develop concerns about sexual performance, thereby leading to anxiety that may then act as a mediator for the genesis and perpetuation of problems (Bhugra & de Silva, 1995; Shah, 1998; Verma et al., 1998). The role of women and the prevalence of arranged marriages bringing together strangers on the wedding night may also contribute to sexual dysfunction (Bhugra & de Silva 1993; Verma et al., 1998). A study in Pune reported that young men had sex with sex workers only a few days before marriage, either due to peer pressure or performance anxiety (Raju & Leonard 2000). Concerns about sexual performance are a primary reason for non-marital sexual experience in India (Pelto, 1999; Savara & Sridhar, 1992; Singh et al., 1998; Verma et al., 1998). One of the motives for seeking out compliant sexual partners and being involved in risky sexual contacts (with sex workers or with multiple partners) is to avoid the perceived dangers and debilitating effects of excessive semen loss believed to result from masturbation; there is a widespread belief among Indian men that the loss of semen during sex with partners is less and therefore not as dangerous as the loss of semen in masturbation (Deepak Charitable Trust, 2000).

THE PROVIDERS

Healthcare services available to residents in the study communities include public hospitals located near the community, with inpatient and outpatient facilities, government-run urban health centers located in the community and conducted jointly between the Mumbai Municipal Corporation and medical colleges, government-run health posts; and private practitioners located on almost every lane in the three study communities. Men are reluctant due to fear, stigma, and embarrassment to bring their *contact* problems to the STD clinics in the area. A significant number of men (46%) report on the survey that they obtain antibiotics from chemist shops in the communities for *contact* symptoms. Since *noncontact* problems are seen in a negative light by the allopathic system, they are almost never brought to the governmental facilities, which see few men anyway since they primarily provide maternal and child health services. As a result, when men want to see a provider for a *gupt rog* problem, they go to either private nonallopathic providers or allopaths (MBBS) in their communities.

In the current terminology of the Ministry of Health in India, nonallopathic doctors are now called AYUSH (an acronym meaning “life”) and include Ayurveda, Yoga and Naturopathy, Unani, Sidha, and Homeopathy. The Rapid Assessment of Providers (RAP) identified 245 practitioners in the three study communities that could be categorized into the four disciplines: ayurveda (79, 32.2%); homeopathy (73, 29.8%); unani (67, 27.3%), and allopathy [MBBS] (26, 10.6%). The average age of the nonallopathic providers is 36.6, with a reported 17.6 years of education and training. Of the 245 providers, 22 (8.9%) are women. In general, the AYUSH providers are an established group; they have an average of 9.3 years of practice and an average of 7.2 years of practice in one of the study communities. More than 60% have never practiced in another location, and almost 90% of their patients come from the same community where they have their practice. The nonallopathic providers see an average of 28 patients per day, and the allopaths see an average of 42 patients per day. The overall breakdown of patients, as reported by the private providers, is 44.2% adult men, 34.8% adult women, and 21% children. It is notable that men, who generally underutilize healthcare services in most locales, are the highest consumers of community-based private practitioners.

Based on the provider reports of utilization given on the RAP, it is estimated that the 245 private practitioners see more than 6,800 patients daily in the three study communities. Furthermore, the private practitioners see more men (an estimated 3,000 per month) than any other sector of the healthcare system in Mumbai. Based on RAP results, providers see a monthly average of more than 2,400 male patients with sexual health problems and an estimated 1,350 individuals with STD-like problems. These data suggest that the private practice providers, of which the AYUSH practitioners represent more than 90%, are a major resource for addressing the general health of communities and are an important resource for men, particularly for men with sexual health problems.

THE INTERVENTION

The application of current empirically supported models of HIV/STD prevention to male cultural and national realities represents a challenge for the development of appropriate interventions. Most men in India have a very clear culturally derived sense of sexual-problem priority (e.g., performance over disease), etiology (inappropriate semen loss), consequences (threats to masculinity), and treatment approach (self-medication or treatment by a nonallopathic provider). At a time of increasing incidence of STD/AIDS, these cultural concepts, beliefs, and actions strongly contrast with the usual intervention focus on disease prevention, risky-behavior reduction, early allopathic treatment, and accurate sexual health information. The RISHTA project takes the perspective that these concepts are not simply barriers to proper action but can be a gift to the interventionist who is willing to be open to the realities of the healthcare system and to men's narratives as a base for behavior change.

Current intervention models are based in psychological theories, with a particular focus on cognition and behavior of the individual (e.g., Azjen & Fishbein, 1980; Fisher & Fisher, 1993; Kelly, 1995). These interventions are directed toward providing information, fostering attitudes, influencing motivations, and teaching skills that support engagement in health-promoting (or risk-reducing) behavior. Despite the documented effectiveness of these approaches, there are several limitations. First, they have been developed and tested primarily within the U.S. (O'Reilly & Piot, 1996). Second, these approaches focus on individual change and do not typically include community-oriented components to address the environmental factors (e.g., economic, political) that support risky behavior. Current approaches have typically neglected the sociocultural aspects of illness and health—in particular, how culture influences patients' and health providers' interpretations of physical illness and psychological distress (Kleinman, 1986).

To facilitate a broader understanding of sexual health problems in India and the development of culture-specific interventions for prevention and risk-reduction of HIV/STDs, the RISHTA project has utilized an interdisciplinary approach that is consistent with recent thinking about health promotion (Leviton, 1996) and our earlier work on sexual risk in South Asia (Nastasi et al., 1998-99; Silva et al., 1997). The RISHTA project is based on a culture-specific intervention for HIV/STD risk reduction and prevention—Narrative Intervention Model (NIM). This approach integrates principles and strategies from narrative therapy (Eron & Lund, 1996; Howard, 1991; McNamee, 1997; McNamee & Gergen, 1992; Sarbin, 1986), cognitive therapy (Beck, 1976; Ellis, 1962), and cognitive-behavioral approaches to sexual risk prevention and risk reduction (Azjen & Fishbein, 1980; Fisher & Fisher, 1993; Kelly, 1995). The theoretical underpinnings of NIM reflect social construction (Berger & Luckman, 1966; Nastasi et al., 1999; Vygotsky, 1978; Wertsch, 1991), bioecological (Bronfenbrenner, 1989, 1999), anthropological (Kleinman, 1986; Pelto & Pelto, 1997; Wallace, 1961) and social-psychological perspectives (Abrams & Niaura, 1987; Azjen & Fishbein, 1980; Bandura, 1986; Jemmott & Jones, 1983; Miller et al., 1993; Fisher & Fisher, 1993). The RISHTA model posits that human behavior (specifically, behavior related to sexual health) is influenced by the interaction of biological, psychological, and sociocultural factors. Behavior is influenced

by cognitions (ideas, attitudes, beliefs) that are developed or transmitted primarily through social (interpersonal) interactions. Through these interpersonal interactions, culture (ideas, beliefs, values, norms) is transmitted and influences the development of cognitions and behavior patterns. Culturally transmitted cognitions influence not only behavioral responses but also the interpretation of internal responses (e.g., emotions, perceptions, bodily processes) and external contextual (physical and social environment) experiences. Through repeated experiences, individuals develop narratives or scripts that guide their behavior. Among Indian men these narratives intimately link performance issues, masculinity, and risky sex and complicate primary relationships with wives or other sex partners.

Any approach to issues of behavioral change requires knowledge of the individual's sociocultural history and a sense of how to structure interpersonal interactions (e.g., between provider and client) that can lead to reconstruction of the relevant personal narratives. Through the use of focused interpersonal interactions, trained practitioners can help individuals to (a) identify the narrative related to the presenting problem (construct the narrative), (b) critically examine the psychological and socio-cultural factors that influence or maintain the problem (deconstruct), and (c) create a revised narrative that leads to solving the problem (reconstruct). The construction-deconstruction-reconstruction process leads to the development of a personal narrative that supports the development of health-promoting and risk-reducing behaviors related to HIV/STDs prevention and treatment.

Consistent with cognitive-behavioral intervention models (e.g., Fisher & Fisher, 1993), we emphasize the role of cognition in guiding behavior and assume that changes in thinking (e.g., ideas, beliefs, values) are critical to behavior change. The importance of culture in guiding human behavior reflects our anthropological focus and is consistent with bioecological perspectives in psychology. Narrative therapy, based in social constructionist thinking, is focused on the use of clients' stories (narratives) to assess the affective, cognitive, behavioral, and sociocultural elements of the presenting problem and to facilitate change in these elements through a systematic deconstruction and co-construction of the narrative. Thus, a primary limitation of extant cognitively oriented approaches—failure to focus adequately on social and cultural factors—is addressed directly through the use of narrative.

With this theoretical base and the empirical results generated by the formative research, a multi-level intervention plan was generated that would reflect the NIM at three levels: the community, the provider, and the patient. All three of the study communities received community-level health education. Two communities were selected for experimental interventions, with the third community as the control. In the first experimental community, all nonallopathic providers were provided training to upgrade their skills in dealing with sexual health problems. In the second community, an allopathic intervention was established in which a male health clinic was organized in the community's urban health center in conjunction with a Mumbai-based medical college. The male health clinic, one of the first to be organized in India, provides services to men with all problems three days per week at times that are convenient to working men and do not overlap with the use of the health center by women.

Community-Level Intervention. The objectives of the community-level intervention are to (a) create, on the part of the community at large, a revised narrative that links noncontact sexual problems to issues of masculinity, lifestyle, and primary sexual relationships and supports the development of health-promoting and risk-reducing behaviors related to HIV/STD prevention and treatment; and (b) create awareness on the part of the experimental communities of the presence and accessibility of RISHTA project-trained providers who will address their sexual health problems with respect, comprehensiveness, and efficacy. The components of the community level intervention include:

- *Street dramas* depicting the linkages of hypermasculinity, poor marital relationships, and a risky lifestyle to *gupt rog*. Street dramas are presented in each section of the three communities on a rotating basis. To date, more than 60 street dramas have been presented involving three rotating scripts.
- *Follow-up meetings* are conducted on the day after a street drama is held and approximately a week thereafter. RISHTA staff holds the first meeting to debrief men concerning the content and messages of the street dramas. A second meeting is held to answer men's questions concerning sexual health and prevention of disease. To date, the RISHTA program has held 45 sets of follow-up meetings.
- *Community meetings* involve systematic coverage of leaders of community-based organizations (CBOs) including *parush mandals* (men's organizations) and service organizations. Eventually the RISHTA staff will work with these organizations to address the sustainability of its community and provider interventions.
- *Community events* include health camps, educational sessions, festivals, and religious holidays in which RISHTA program staff set up a booth and supply sexual health information. To date, a single event has been held in each of the three communities.

The primary messages of these community education activities focus on positive masculinity, reduction of intimate partner violence, the negative effects of excessive alcohol use, communication and negotiation between spouses, the dangers of extramarital sex, condom use as means of prevention of disease, and the need for appropriate treatment by trained providers for both noncontact and contact sexual health problems. Based on previous research with the target population and specifically men's narratives about their sexual health concerns, we have identified several themes that constitute the content of community messages as well as provider and patient interventions (see Table 2).

Provider-Level Intervention. Provider training involved a participatory consultation approach based on our previous work in South Asia (Nastasi, Varjas, Bernstein, & Jayasena, 2000; Nastasi, Varjas, Schensul, et al., 2000). In this approach practitioners received skills-development training in workshop format preceding the intervention implementation (initial training) with follow-up training and consultation throughout implementation on both a scheduled and ad hoc basis (ongoing consultation). Training activities included lecture, demonstration, practice, and feedback.

Table 2
Key Themes Related to Male Sexual Health Problems Derived from Formative Research and Their Link to RISHTA Intervention Program

Theme	Intervention Focus
<i>Noncontact sexual health problem</i> (early ejaculation, weakness, erection difficulty, bent penis, loss of desire, pain, wet dream, semen quality/quantity)	Culturally appropriate treatment (e.g., benign herbal preparation consistent with homeopathic, <i>unani</i> , or <i>ayurvedic</i> practice) Alternative techniques to treat sexual health problem Treatment or referral for related health concerns
<i>Contact sexual health problem</i> (pus discharge, itching, “pimples,” inflammation, STD-like symptoms)	Provide information about possible link to HIV/STDs Testing and/or referral for HIV/STDs treatment as warranted
<i>Perceived etiology of sexual health problems</i> (masturbation, wet dreams, sex with older woman, CSW, eunuch, multiple partners, heat and dirt, anxiety or fear, frequency of sex, economic, grief, physical strength, male-female roles, blame others)	Disconfirm “misperceptions” about etiology Confirm risk factors for HIV/STDs Discuss male-female roles in sexual performance/satisfaction Anxiety reduction techniques Discuss the relationship between anxiety and performance Referral for economic, marital, psychological concerns as warranted
<i>Definition of manliness/masculinity</i> (causes pain, initiate/perform sex on demand, control masturbation/ejaculation, male children, satisfy many women, raise children well, last long in sex, penis size, force wife to have sex, dominate wife, value of semen)	Question sources of perceptions Redefine “manliness” Redefine male-female roles and responsibilities Reexamine and redefine sense of personal worth Explore perceptions of the link between concerns about masculinity and sexual health problems; challenge misperceptions
<i>Impact of sexual health problems</i> (marital problems, wife’s sexual dissatisfaction, wife has sexual health problems, forcible sex)	Referral for wife’s sexual health problems as warranted Strategies for addressing sexual relationship difficulties Referral for marital counseling as warranted

Table 2 (continued)

Theme	Intervention Focus
<i>Marital relationship</i> (husband/wife rights and responsibilities, privacy, sexual satisfaction, expectations about sex, "wedding night" scenario, sexual patterns/practices)	Explore links of marital beliefs, attitudes, emotions, behaviors to sexual health problems Reframe attitudes and beliefs toward promotion of sexual and psychological health and satisfactory marital relations Referral to appropriate social service agencies as warranted
<i>Forcible sex in marriage</i> (man's right, normative, alcohol-related)	Explore links of forced sex to "manliness" and sexual problems Question sources of perceptions Strategies for improving sexual relationship Referral for marital counseling as warranted
<i>Marital [domestic] conflict and violence</i> (expectations not met, alcohol-related, mutual abuse, dissatisfaction with sex, dominance)	Explore links between violence and sexual difficulties, "manliness," and personal difficulties/frustrations Alternative strategies for conflict resolution Referral for psychological/marital counseling as warranted
<i>HIV/STDs</i> (sex with CSW; condom protection)	Confirm and extend knowledge about HIV/STD transmission/prevention
<i>Emotions related to sexual health problems</i> (guilt, anger, worry, anxiety, tension)	Link emotions to sexual difficulties Emotional support for "disturbance" about sexual health problems Anxiety-reduction or alternative strategies Referral for psychological services as warranted
<i>Risky lifestyle</i> (extramarital sex, perceived norms, sex with CSWs, condom attitudes)	Link beliefs, attitudes, emotions, behaviors to sexual health problem Question sources of perceptions and attitudes Reframe attitudes and beliefs about sexual/psychological health Alternative strategies for personal and interpersonal problems Referral for psychological concerns as warranted Referral or treatment for HIV/STDs as warranted

Ongoing consultation involved periodic visits by the project's intervention coordinator and monthly training/discussion sessions to address challenges in implementation. In addition, evaluation staff visited doctors weekly to monitor implementation and gather information about challenges presented by NIM.

Both the allopathic staff of the male health clinic in the first experimental community and the 23 AYUSH providers who chose to be involved in the second experimental community participated in a 12-hour initial training workshop conducted by RISHTA over four consecutive days in October 2003. The curriculum of the program focused on the following elements:

1. an introduction to the RISHTA project;
2. increasing the knowledge on the part of the allopathic providers concerning types and prevalence of *gupt rog* symptoms as reported by the men in both the qualitative and quantitative interviews;
3. examination of the link between contact and noncontact problems;
4. increasing the knowledge about the factors that contribute to, co-occur with, and result from *gupt rog*;
5. expansion of the treatment of contact and noncontact problems, through the use of the Narrative Intervention Model (NIM), to include attention to factors reflected in Table 2 including:
 - a. biological, psychological, and sociocultural factors;
 - b. links among biological, psychological, and sociocultural factors as influences on etiology, treatment seeking, treatment, and prevention of *gupt rog*;
 - c. education and counseling for prevention of sexual risks;
 - d. appropriate testing and treatment of STDs;
 - e. referrals for medical, psychological, and social services as needed;
6. creation of a support system for providers in implementing the NIM, consisting of RISHTA intervention staff;
8. information about RISHTA evaluation procedures and providers' role in evaluation.

After the initial training, formal three-hour refresher training sessions were provided quarterly. The sessions conducted to date have focused on enhancing provider knowledge of syndromic management of STIs (presentation by national Indian experts), addressing sexual dysfunction (presentation by local psychiatrist and sexologist), and implementing the assessment and intervention phases of NIM (conducted by RISHTA team). In response to provider requests, monthly training meetings began in October 2004. These meetings are conducted by local RISHTA staff and focus on challenges that the providers face in implementing NIM. RISHTA field staff visit each provider on a weekly basis to identify informational needs and to assess the integration of the NIM into patient treatment.

Patient-Level Intervention. The treatment objectives of the staff of the male health clinic and the nonallopathic providers in the experimental communities are to foster knowledge, attitudes/beliefs, and behavioral changes in the individual clients that lead to appropriate culture-specific care-seeking behaviors and STD/HIV risk-reduc-

tion behaviors. The one to two sessions, brief intervention (fitting into the standard provider-patient contacts) combines assessment, education, counseling, and treatment to (a) address the medical/physical (symptoms), psychological (self-esteem, masculinity, assessment as a husband), and social relationship (gender equity, gender violence, extended family conflicts) issues related to male sexual health concerns (contact and noncontact); (b) provide accurate information about STDs, particularly HIV/STD transmission, risk reduction, and prevention; (c) determine the presence of STD symptoms and make referrals for STD testing and treatment as warranted; and (d) determine the need for social services related to economic, family, and individual psychological concerns and make referrals as warranted.

The Narrative Intervention Model (NIM) for HIV/STDs prevention and risk reduction provides a culture-specific program of healthcare and risk reduction that addresses medical, sociocultural, and psychological components of male sexual health problems and STD/HIV risk. The unique feature of the intervention is the use of personal narrative (story) to facilitate the assessment-intervention process and to insure that the intervention session(s) address emotional, cognitive, and behavioral components that are both individually and culturally relevant to the experiences of clients. The focus of the intervention is primarily affective and cognitive. The assumption, based on formative research, is that the primary barriers to risk reduction and prevention are found in the personal, community, and culturally based beliefs that guide the men's behavior. The brief nature of the intervention and provider capacity precluded the provision of specific skills training beyond the encouragement and refinement of existing skills or treatment of psychological or marital problems. For this reason, the project called for the development of a referral network for clients who need additional skills training, psychological counseling for individual or marital problems, or more intensive medical treatment for STIs.

The steps in the model involve assessment, support, reframing, retelling, and referral in the context of the client's individual story about sexual health concerns. Although presented in a sequential manner, the specific steps are recursive. That is, the health provider revisits earlier steps during the course of the session. In addition, the sequence of the steps may vary across provider and client. The key criterion is that all the steps are covered in the context of the client's narrative.

- Step 1. Assessment* is focused on (a) eliciting the narrative that includes client's current knowledge, attitudes, beliefs, emotions, and behaviors relevant to sexual health, sexual health problems, and HIV/STDs; and (b) testing for HIV/STDs.
- Step 2. Support* is designed to provide (a) emotional support to allay anxiety and foster optimism; and (b) instrumental support with suggestions for seeking related services.
- Step 3. Reframing* is focused on facilitating (a) acquisition of accurate information about sexual health, sexual health problems, and HIV/STDs; (b) awareness of the links between sexual health and psychological, interpersonal, and sociocultural factors; (c) awareness of the links between emotions, cognitions (attitudes, beliefs), and behaviors; (d) reframing of attitudes and beliefs consistent with health promotion and risk reduction; and (e) a mini-

mal level of behavioral skills training related to anxiety reduction, health promotion, and risk reduction.

Step 4. Retelling facilitates narration of the reconstructed story incorporating changes in knowledge, attitudes, and behavioral intentions consistent with health promotion and risk reduction.

Step 5. Referral involves referring clients to relevant community agencies for additional services related to medical, psychological, or social concerns that are beyond the scope of the intervention.

Acknowledging the challenges of introducing NIM into the daily medical practice, we proposed to work closely with the providers on adapting the model to meet time limitations and providing ongoing support and training to facilitate modification of their approach to treatment. The modification of provider practice became an important component of the intervention. Our ongoing consultation with the providers alerted us to specific gaps in knowledge and challenges in modifying practice.

We have worked with the providers in training sessions to identify ways to integrate the five steps outlined above into their preexisting approach to history taking, diagnosis, and treatment. Step 1 (assessment) has been reframed as an extension of history taking and diagnosis to include gathering information about the patient's attitudes, beliefs, feelings, and behaviors that may influence sexual risk and integrating that information into their "diagnosis" of the problem. Over the course of the first year of implementation, the providers have reported success in using the NIM to achieve a more extensive history taking of the psychological and sociocultural factors related to patients' sexual health concerns and sexual risk. Step 2 (support) is consistent with current provider practices and has presented minimal challenges. At present, we are working closely with the providers on more effectively integrating Steps 3 and 4 (reframing and retelling) into the treatment phase of their treatment. Implementing Step 5 represents a major challenge for our project staff, primarily because of the lack of adequate resources in the target communities. For example, individual and marital counseling services are nonexistent in the study communities and are not easily accessed in the metropolitan area of Mumbai because of financial and transportation restrictions. It has been necessary to build these services into the capabilities of local community-based organizations rather than seek these referrals in the wider city.

Issues related to hypermasculinity, gender equity, and the marital relationship are particularly challenging to the intervention team at community, provider, and patient levels. Changing deeply rooted cultural beliefs about masculinity and gender require intensive, consistent, long-term intervention. Efforts to challenge and modify these beliefs are targeted at all three intervention levels. As we have worked with men and providers, the need for work with women, marital couples, and youth has become clear, and we are currently in the process of extending our work to these sectors.

EVALUATION

The major hypotheses of the intervention study include the following:

- All communities will show an improvement in a reduction in the prevalence of

STDs, in men's sexual risk behavior, and in knowledge and attitudes with regard to sexually transmitted diseases as a result of community education.

- The experimental communities will show a significantly greater improvement than the control community.
- The trained providers will integrate the NIM into their practices.
- Patients provided treatment by the trained (AYUSH and allopathic) providers will show a greater reduction in risky sexual behavior than patients seen by untrained providers.
- It is difficult to predict whether the AYUSH-focused community and the patients treated by the AYUSH providers will show greater improvement than the allopathic-focused community and patients treated by the male health clinic. We have proposed that, given the traditional involvement of AYUSH providers in men's sexual health issues, their outcomes may be superior to those of the allopathic providers.

The methods utilized for evaluation are designed to assess the intervention from the perspective of the community, the provider, and the patient. Community-level impact is assessed through a baseline (already completed) and end-line survey (2½ years after initiation of the intervention) of 2,400 men in the two experimental (intervention) communities and one control community. Provider-level impact, acceptability, and integrity are assessed through in-depth interviews with patients and providers, and collection and analysis of patient case records. Patient-level impact is assessed through pre-treatment, immediate post-treatment, and six-month follow-up for a random sample of 640 patients visiting the male health clinic and the trained AYUSH providers in the experimental community and untrained allopathic and nonallopathic providers in the control community. The pre-treatment, post-treatment, and follow-up instruments assess patient sociodemographics, presenting problems and perceived causes and consequences, the prior relationship with the doctor, activities with friends, substance use, exposure to pornographic materials, self-assessment as a husband and sexual partner, administration of a masculinity scale (hypermasculinity to positive masculinity), global life assessment, quality of the marital relationship, the nature of marital sex, spousal abuse, involvement in extra-marital sex, and STD knowledge.

Preliminary results of trained provider capacities indicate that the intervention model at both the community and provider levels is being well implemented. The data from the patient records of the male health clinic show a steady flow of male patients into what has been an almost exclusive female health clinic since its opening in December 2003. The clinic is opened from 4:40 p.m. to 8:30 p.m. on two weeknights and from 10 a.m. to 1 p.m. on Sundays. From December to May, 68 clinic sessions were held, involving 834 patient visits representing 373 new cases for an average of 14 patients for each clinic session. Of 373 patients, 210 people (56.3%) presented with sexual health problems, of which 27 (12.9%) presented with syndromically defined *contact* problems. Out of the 210 patients who presented with sexual health problems, the specific presenting complaints mirror those in the baseline survey: 40.5% (85) had premature ejaculation; 21.9% (46) had issues with the quality and quantity of semen; 18.1% (38) impotency; and 15.2% (32) nocturnal

emission. Of those with sexual health problems, 57.9% (216) of the patients are in the 21-40 age group, and 74.0% (276) are married. The six-month results indicate that a male health clinic in a government urban health clinic is capable of attracting men, of which a significant percentage will present a sexual health problem.

Reports from the AYUSH providers indicate that the training was very positively received, as evidenced by pre-post evaluation and by calls for monthly refresher training. An interim assessment of the impact of the training on the AYUSH providers indicated that there was a significant increase in the number of men being seen for sexual health problems, the willingness of men to discuss their sexual health problems, and referrals by AYUSH providers to other services within the healthcare system. AYUSH providers also reported that the frequent trainings provided them with an opportunity to network among their fellow providers and to seek out assistance from them after the training. Prior to the intervention, AYUSH providers served in the role of "family doctor," dealing with common complaints that included cold, fever, and diarrhea. After the training the AYUSH providers reported that they felt more comfortable dealing with their patients with sexual health problems and that their patients felt more comfortable in raising these problems. Further, AYUSH providers reported that men presented sexual health problems at shorter intervals after onset (a mean of five months) rather than delaying treatment (a mean of 20 months) as was the case prior to intervention.

At the community level, the RISHTA program and its field staff have become well known in the three study communities. Team members are now regularly contacted by men in the community for advice on their sexual health problems; community-based organizations request education sessions; and official and unofficial community leaders provide advice and input into programmatic decisions.

CONCLUSION

The major theoretical frameworks and AIDS behavior change models provide important guidance in developing interventions on the ground in the local study communities. This study shows that it is essential, however, to generate concepts and methodologies that emerge from the local context, which can provide the structural and cultural links for these exogenously derived intervention approaches. The delineation of the concepts and beliefs surrounding *gupt rog*, the identification of the role of AYUSH providers in treating these problems, and the opportunities provided by the urban health center to implement a male health clinic represent an ethnographically generated approach to ground-up planning and implementation of intervention. Further, these ground-up intervention approaches increase the sustainability of the interventions. The male health clinic is being implemented at a low cost and can be continued by the Mumbai Municipal Corporation, should the data show it to be a successful intervention. Further, periodic training of the nonallopathic providers also represents a low-cost approach to the upgrading of the key resource for men seeking treatment for their sexual problems. Finally, the strength of the RISHTA program lies in its capacity to have a multi-level impact on the community, the provider, and the individual male resident/patient with a message that sexual health problems are linked to all aspects of men's lives. This ecological approach is consis-

tent with Indian cultural and healing traditions and is central to the intervention being implemented in the study communities. In the next two years, the RISHTA program will have the data to fully test the impact of this intervention model on the community, provider, and patient levels. In its first year, the model shows promise of reaching and involving men in a comprehensive and responsible approach to their sexual health and the health of their families.

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Peer Advocates for Health: A Community-Based Program to Improve Reproductive Health Knowledge and Lifestyle Choices among Adolescent Males

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Peer Advocates for Health is a community-based program to increase reproductive health knowledge and improve lifestyle choices among African American adolescent males. This study examines program impact on knowledge, clinic utilization, communication, and condom use among participants. PAH provided training, support, and employment experience to 75 African American males from 15 Chicago high schools, who reached 4,000 adolescents in their own communities, providing information and condoms. Mean age at intake was 15.9; all were in school, unmarried, and living at home. One-third reported never having sex; only one had fathered a child. After one year, knowledge, utilization of clinic services, and communication with partners and peers increased significantly. Condom use remained high, and condom self-efficacy increased. Results suggest that, to impact behaviors and lifestyles of high-risk adolescents, programs must provide not only education but also long-term follow-up and support in the context of everyday lives.

Keywords: adolescent males, community-based programs for males, reproductive health, condom use

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The 1990s brought a renewed awareness of reproductive health issues for males and an increased recognition of the roles and responsibilities of the male partner (Schulte & Sonnenstein, 1995). The globalization of HIV and AIDS during the past two decades has highlighted the importance of male sexual behavior and condom use in relation to the health of both partners (AVSC, 1999). The impact of male attitudes and behavior upon the reproductive health of both partners is especially critical among adolescent populations, particularly those adolescents who live in worlds with little structure and few resources. Increasingly, empirical research suggests that men who are informed and educated about reproductive health issues are more likely to support their partners' decisions about family planning and contraceptive methods (Grady, Tanfer, & Lincoln-Hanson, 1996; Fee & Youssef, 1993), yet access to reproductive health information and services is limited for many young men growing up in low-income, inner-city neighborhoods in the U.S. (Guttmacher Institute, 2002; Male Advocacy Network, 2002; Shultze & Sonenstein, 1995; Shirk, 1997). Unlike female adolescents, who generally access information and enter the health system with menstruation or pregnancy, adolescent males living in underserved neighborhoods may have contact with a healthcare provider once a year for a school physical or in a hospital emergency room (Male Advocacy Network, 2002). African American adolescent boys have been shown to be less knowledgeable about sexual health and have less positive attitudes about condoms than their female counterparts (St. Lawrence, 1993). Their source of reproductive information and gender norms is often the "street," where females tend to be viewed as "sexual targets" rather than partners in a healthy relationship.

THE PEER ADVOCATES FOR HEALTH PROGRAM

This paper describes "Peer Advocates for Health" (PAH), a community-based program designed to increase reproductive health knowledge and improve lifestyle choices among adolescent males recruited from inner-city neighborhoods in Chicago. Between 2000 and 2004, 75 African American males, ages 14-17, from 15 high schools on the south side of Chicago were enrolled in the program. This study examines the impact of PAH program participation on knowledge, clinic utilization, communication, and condom use among adolescent male participants. Peer Advocates for Health is a five-year demonstration project supported by the U.S. Department of Health and Human Services, Region V, Office of Family Planning. Broad goals of this pilot effort are, first, to determine if adolescent males from the south side of Chicago could be recruited to join a program that required a long-term commitment and group participation and, second, to design a program that meets the needs of these young men. The long-term goal is to utilize well-trained Peer Advocates as a mechanism for change, providing information and condoms to the broader community.

PAH is being implemented at a community health center that provides primary healthcare to families living in low-income communities on the south side of Chicago. The Peer Advocates program targeted two neighborhoods adjacent to the health center, Englewood and Woodlawn, where 40% of the families live in poverty, a majority of households (61%) are female-headed, only 63% of the people over 25

graduated from high school, and nearly one-quarter of the residents are unemployed (CDPH, 2004). Each of these factors—poverty, education, and employment—can directly impact access to healthcare (Sandman, Simantov, & An, 2000). Being a minority, being poor, and living in a female-headed household are all factors associated with risky behaviors and poor reproductive health outcomes for adolescent males (Blum, Beuhring, Shew, Bearinger, Sieving, & Resnick, 2000; Jemmott & Jemmott, 1992; Lindberg, Boggess, Porter, & Williams, 2000).

Current health status indices, coupled with limited access to healthcare, paint a bleak picture for adolescent males growing up in these neighborhoods. Life expectancy in Englewood (which is 98% African American) is 57 years, compared to 70 for the city of Chicago and 65 for the nation as a whole (CDPH, 1997). Non-Hispanic Blacks accounted for nearly 57% of HIV infections diagnosed in adults and adolescents in Chicago in 2001-2002 (Simpson & Benbow, 2003), and the rate of death from HIV infection is 21.4 for Blacks vs. 6.6 among non-Hispanic whites (Benbow, 2003). In 2001, HIV was the seventh leading cause of death for Black males in Chicago (Simpson & Benbow, 2003). The rates of AIDS cases in the two target communities are approximately twice the rates for the city of Chicago, while rates of other STDs are even higher in comparison (Kouvelis & Thomas, 2003; see Table 1).

At the community level, contraceptive behavior among adolescent couples is reflected in levels of teenage childbearing. In the Englewood and Woodlawn communities, 30% and 27%, respectively, of the live births are born to women under the age of 20 (Kouvelis & Thomas, 2003); 18% and 19%, respectively, are low-birthweight; and infant mortality rates are double those of the city of Chicago (20 and 25 per 1,000 live births, see Table 1; Kouvelis & Thomas, 2003). Such indices suggest that changes in reproductive health behavior among adolescent males could have significant impacts upon the health of young people in these inner-city neighborhoods.

To date, 75 African American adolescent males have participated in Peer Advocates for Health program activities. After six months of training, Peer Advocates are paid to make presentations to school and neighborhood groups or talk one-on-one with peers about issues related to male health. The current analysis examines the impact of PAH program participation on the reproductive health knowledge and lifestyle choices of young men who joined the program between June 2000 and June 2004. Given the intense training and follow-up provided by the Peer Advocates model, we hypothesized that reproductive health knowledge would increase among young men participating in the program and that utilization of clinic services, communication, and condom use would increase during the program year.

METHODS

PROGRAM MODEL

Design of the Peer Advocates program model and the implementation strategies for adolescent males were guided by a number of different theoretical frameworks. Rational behavior models and subsequent refinements of these models suggest that changes in knowledge are necessary, but not sufficient, for behavior change (Glanz,

Table 1
Demographic and Health Characteristics of Communities in the Program Area, 1999-2000

Variable	Englewood	Hyde Park	Woodlawn	All Chicago
Demographics				
Total population*	40,222	29,920	27,086	2,896,016
Males	18,207	14,479	12,084	1,405,107
Females	22,015	15,441	15,002	1,490,909
Ethnicity*				
Non Hispanic Black	97.84%	37.73%	94.21%	36.39%
Non Hispanic White	0.44%	43.52%	2.81%	31.32%
Hispanic	0.86%	4.11%	1.06%	26.02%
Other	0.24%	11.84%	0.99%	4.63%
Socioeconomic status				
Median household income‡	\$18,955	\$35,991	\$18,266	\$38,625
Below poverty line*	43.8%	16.5%	39.4%	19.4%
Below twice poverty line*	67.5%	31.5%	63.9%	39.3%
Poverty rate, children < 18 yrs‡	54.1%	14.0%	48.7%	28.1%
Public assistance income (% households)‡	21.6%	2.3%	16.4%	6.9%
High school graduates or higher (% population ≥ 25 yrs)‡	59.3%	92.7%	67.7%	71.8%
Unemployment rate (% civil labor force)‡	25.8%	7.3%	19.8%	10.1%
Female-headed households‡	60.6%	25.8%	61.3%	31.8%
Health				
Causes of death (per 100,000 pop)#				
All cancers	292	157	236	223
Homicide (Assault)	65	12	56	21
HIV infection	31	4	18	13
Heart disease	413	223	446	330
STD cases (per 100,000 pop)#				
AIDS	55	30	52	27
Gonorrhea	1,343	211	897	402
Syphilis	15	0	18	10
Chlamydia	990	231	761	491
Maternal and child health#				
Teen births (< 20yrs)	29.7%	10.0%	27.4%	17.1%
Low birth weight (< 2.5 kg)	17.5%	10.3%	18.6%	10.1%
No prenatal care	6.2%	2.1%	5.5%	3.5%
Infant mortality rate (per 1000 live births)	20.3	10.3	24.7	11.5%

*Source: Chicago Department of Public Health (CDPH, 2004). Chicago Community Health Profiles (Englewood, Hyde Park, and Woodlawn). Chicago Health and Health Systems Project (Year 2000 data).

#Source: Kouvelis & Thomas, 2003. Community Area Health Inventory 1989-1999 Volume II. City of Chicago Department of Public Health, Epidemiology Program Report (Year 1999 data).

‡Source: Data spreadsheets compiled by the Northeastern Illinois Planning Commission (NIPC, 2004) using data from U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 1: June 2001 and Summary File 3: August 2002.

Note: Chicago has 77 community areas.

Lewis, & Rimer, 1997). These frameworks suggest that changes in attitudes, skill levels, and self-efficacy must also occur (Bandura, 1977). Both Life Transition and Stages of Change Models provided useful frameworks for designing reproductive health training for groups of young men who differ in age, learning ability, physical and emotional maturity, and sexual experience (Forrest, 1993; Prochaska, Redding, & Evers, 1997). The work of Jemmott and Jemmott (1990, 1992, 1996), among others, highlights the necessity of combining theory-based research with practice when developing innovative community-based interventions designed to reduce high-risk behaviors among African American male adolescents.

These frameworks, and more than 10 years of community-based program experience working with young people in Chicago, suggest that, to impact the behavior and lifestyles of inner-city adolescents, programs must provide not only information but also the long-term follow-up and support necessary to process and utilize this information for decision-making within the context of their own lives. This philosophy underlies training and support strategies utilized within the Peer Advocates program model.

Primary objectives of the Peer Advocates for Health program are:

- to increase reproductive health knowledge among adolescent male participants during the program year;
- to increase access and utilization of reproductive health clinic services among young men participating in the program; and
- to improve healthy lifestyle choices among program participants, especially communication and condom use.

The three major components of the Peer Advocates Program Model are (1) reproductive health training, (2) individual support, and (3) employment. PAH provides intense, long-term training through group participation and one-on-one support through a personal relationship with the Project Coordinator. After six months of training, participants are employed to work as Peer Advocates providing information, distributing condoms, and serving as role models in their own schools and communities.

TRAINING

Basic Training. Peer Advocates training begins with an initial eight-week basic training session held three days per week during the summer. Participants meet three afternoons per week for three hours for training that is supplemented by homework and field trips to a male clinic and Planned Parenthood. Participants are paid \$6 per hour to attend training. At the end of Basic Training, each participant makes a formal presentation on one of the curriculum topics to an audience of participants, parents, and friends. Although difficult for some young men, making these formal presentations instills confidence and marks a transition to the next phase of Peer Advocates training.

Continued Training. Beginning in the fall, PAH Continued Training is carried out through weekly group meetings for the remainder of the program year. In addition to reproductive health issues, this Continued Training focuses upon building communication and decision-making skills and upon understanding the consequences of decisions in everyday life.

The Peer Advocates for Health Curriculum topics include *Communication; Reproductive Anatomy and Physiology; Puberty/Home Clinic Partnership; Healthy Relationships; Conception/Contraception/Teenage Parenthood; Avoiding and Handling STDs, HIV/AIDS in Our Community; Real World Education and Employment, and Domestic Violence.* The Peer Advocates curriculum built upon a reproductive health curriculum for adolescents developed working with community providers over the past 10 years. PAH participants have provided continual feedback regarding choice of curriculum topics and method of presentation. Over the past two years, more time and emphasis has been placed upon domestic violence and HIV/AIDS in the community—two very real issues in the lives of these young men. A variety of training techniques is used during the group sessions, including group discussion, role playing, scenarios, videos, and professional guest speakers. Because group membership is closed in June (no new members after the first week of training), these young men get to know each other intimately, and group participation becomes an important source of support for each participant.

INDIVIDUAL SUPPORT

Each young man who joins the Peer Advocates program receives ongoing, individual support through a personal relationship with the project coordinator.

The coordinator is an African American male who has devoted his career to working with young people, primarily in social service agencies and the Chicago public schools. The coordinator, a seven-foot African American former college basketball player who grew up on the south side of Chicago, relates directly to the young men and the issues they face with school, family, and the street. He serves as friend, mentor, confidant, and role model. The coordinator attends and participates in all weekly training sessions. In addition, he meets with the group two Saturdays per month for follow-up discussion of curriculum topics, field trips, and community outreach activities. The coordinator meets individually with each participant at least once a month and maintains close contact with his family through home visits and telephone calls. He monitors school performance and grades, finds tutors (or acts as a tutor himself), and advocates for these young men with school faculty and administrators. As illustrated by one participant's comment, "Mr. S., I spent more time with you in the six months I been in this program than I have with my dad in my whole life," the coordinator becomes an important support in each young man's life.

EMPLOYMENT

Employment and job skills training are important components of the Peer Advocates program model. PAH program participants are paid an hourly stipend to attend training sessions and for doing community outreach activities in their own schools and

communities. After six months of formal training and certification as a Peer Advocate for Health (based upon knowledge, participation, and attendance), participants are paid an hourly stipend (\$7 per hour) to work in their own neighborhoods, making group presentations or talking one-one-one with their peers about adolescent health issues, including pregnancy and disease prevention, abstinence, contraceptive methods, condom use, STDs, and HIV/AIDS. Formal community presentations are planned and rehearsed during weekly meetings or on Saturdays. The trainer or the project coordinator accompanies Peer Advocates when they do group presentations and often facilitates discussion or answers audience questions following the presentation.

In order to be paid, PAH participants must become temporary employees of the health center where the program is being implemented and must go through the formal hiring procedures for clinic employment, including application forms and drug testing. After the first year of training and program participation, the young men are eligible for summer employment at the health center. Over the past four years, 20 young men have been employed at the health center in a number of different departments, including administration, data entry, medical records, and storeroom. (Not all PAH participants were available for summer employment due to summer school or other jobs). A full week of job skills training is provided to each of these young men prior to beginning his clinic employment. Supervisors in each department worked with and assessed the performance of each young man who worked in the clinic through written evaluations of job performance. Employment in the clinic provides income but also a familiarity and personal relationship with a healthcare facility in the community and with the professional staff who work there.

In addition to providing a needed source of information and referral, Peer Advocates provide an important mechanism for condom distribution. Within the Peer Advocates program, condom distribution occurs at two levels: individual program participants and the broader south side community. Program participants receive condoms at each group meeting. Peer Advocates distribute condoms using "condom wallets," which are velour wallets holding two condoms and instructions. All Peer Advocates carry a supply of condom wallets that they distribute at school and in their neighborhoods. Condom distribution is generally done one-on-one with few formal distribution requirements other than discussion of correct usage.

RECRUITMENT AND RETENTION

In order to provide the level of support that staff feel is necessary for these adolescents, the number of participants is kept small, with a maximum of 25 young men accepted into the program each year. The initial challenge was to inform people about the project and to recruit 25 young men, ages 14-17, who were in school and living on the south side of Chicago. During the first year, the project coordinator made personal visits to 20 local high schools to talk with counselors and principals, posted flyers in the clinic waiting rooms, and asked for referrals from adolescents' physicians. These recruitment channels have been supplemented by word of mouth from former participants and their parents, and last year 75 young men applied for the 25 participant positions. To insure that both the young man and his parents understand the Peer Advocates for Health program, the project coordinator carries

out a personal interview with the young man and his parent(s) prior to his joining the program.

PAH retention strategy includes an initial effort to explain the intensity of the training and the hard work and commitment that group participation and becoming a Peer Advocate requires, the rationale being that those young men who joined PAH for the money and who are not committed or willing to work will not contribute to the group or become effective health advocates in their own communities. The summer Basic Training “boot camp” is rigorous with intense training sessions, attendance and participation requirements, and homework. A dress code including no braids, no heavy gold crosses, no pants’ crotches at the knee, and shirt and tie for formal presentations, is firmly enforced. Behavior that is disruptive to the group or training process entails specific consequences such as a “no excuse card,” which translates to a pay dock or, if severe, expulsion from the program. Every year, about one-third of the new recruits either drop out due to the intensity of the training or scheduling conflicts or are asked to leave because of behavior problems or lack of group participation. However, those young men who remain in the program are serious about learning and about sharing their knowledge with their community.

MEASURES

Evaluation has been an integral and ongoing part of Peer Advocates program activity since the beginning. The participant level record-keeping system currently used for Peer Advocates was adapted from a system previously developed to evaluate a multi-state adolescent male health initiative (Mosenen & Ruch-Ross, 1998). Pre- and post-tests were developed in conjunction with curriculum development; both were based on training materials previously used by the PAH team in another program for adolescents in Chicago.

Three existing scales were added to the PAH data systems in the second year of program effort. These included *An Adolescent and Young Adult Condom Perception Scale* (Hanna, 1999), a 15-item scale with an alpha coefficient of .82, and a 10-item reproductive health knowledge scale used in the *National Longitudinal Survey of Adolescent Health* (ADD Health) surveys. An eight-item contraceptive self-efficacy scale developed for use with a high-risk American Indian adolescent population (Chewning, 2001) and previously used by the PAH team in a program for adolescent mothers was also added. All scale scores are derived by summing items once coded in the appropriate direction.

DATA COLLECTION

Data collection activities carried out each year include written participant questionnaires completed at program intake, three months, six months, and 12 months (year-end). Attendance logs are used to document participant attendance at training sessions. Community outreach logs are completed by all Peer Advocates to record their work in the community and to document the number of people reached, the topic, and duration of each presentation or individual contact made. Employment records and supervisor assessment forms are used to document and evaluate Peer Advocate clinic employ-

ment. In addition to program impacts, these data provide process variables and a means of documenting stages of program development and implementation over time.

To supplement quantitative documentation of program activity and impact, every effort has been made to obtain qualitative feedback from both adolescent program participants and their parents. Parental Advisory groups meet quarterly for discussion and feedback and provide written evaluations at the end of each program year. Semi-structured group discussions are carried out with each group of young men at the end of summer training and after one year of program participation to determine “what they liked best and least about the program, what they would change, and what type of young man they thought should join the program.” Because the number of participants each year is quite small, every effort is made to utilize both qualitative and quantitative data and to look at impacts across program years. Results of these data collection efforts and analyses of these program data are used for modification and refinement of the Peer Advocates program model and are not intended for generalization to other populations of adolescent males.

RESULTS

PARTICIPANT OUTCOMES

Changes in key outcome variables among PAH program participants will be reported. They include (1) reproductive health knowledge, (2) clinic utilization, (3) communication with partners, peers, and parents, and (4) condom use and attitude. Given the small number of new participants recruited into the program each year ($n = 11$ to 24), and due to program attrition and nonattendance of sessions when outcome assessments were collected, all four years of PAH groups are aggregated for the current analysis. Preliminary analyses supported this decision in that there were few meaningful differences among the participant groups across the four years. The sample size used for analyses differs with each outcome because questionnaires were distributed at different time points during the program year.

Changes in reproductive health knowledge among program participants were measured using percentage of correct responses on three sets of pre- and post-tests by curriculum topic. Post-tests were administered within one to two weeks after a topic was taught in a training session; thus there are 48-58 participants for this outcome. Improvements in healthy lifestyle choices are measured using participant responses to questions on clinic utilization, communication, and condom use, asked at intake and after six or 12 months of program participation. For communication about birth control with peers and partners, there are 12 months of completed questionnaires for 20 of the 75 young men. For condom use, there are three, six, or 12-month follow-up data for 68% ($n = 51$) of the young men. The three-to-12-month data for this variable were aggregated since noncondom use was extremely low at all time points.

CHARACTERISTICS

During the first four years of the program, a total of 75 young African American men from 15 high schools in the Chicago south side area were initially enrolled into

PAH. Mean age of all participants was 15.9 years; all were in school, grades 8-12; 52% lived in single-parent households; and two-thirds (65 %) reported they had already had sexual intercourse at the time they entered the program (see Table 2). Most of the sexually active participants reported use of a condom at last intercourse, but only a small proportion, 15%, ($N = 12$) had ever been to a clinic for condoms, STDs, or birth control information.

Table 2
Participant Characteristics at Intake (n = 75)

Mean age	15.87 years ($SD = 1.20$)	
Single parent household	39	52%
Number with children	1	
Grades obtained school ^a		
Mostly A's	5	7%
Mostly B's	22	30%
Mostly C's	37	50%
Mostly Below C's	9	12%
Ever had sex	48	65%
Age of sexual debut	13.5 years ($SD = 1.9$)	
Used condom at last sexual activity	42	88%
Ever been to a clinic for condoms/STD/ birth control information	12	15%

^a Missing = 2

ATTRITION ANALYSES

Among the 75 young men who joined the Peer Advocates program during the past four years, more than half, 61%, remained in the program for 12 months or more. Although year-end data were collected on only 20 participants, attendance records show that 46 young men actually completed the program year. Due to the high attrition of participants and nonattendance at data collection sessions, analyses were conducted to compare key demographic and health variables by number of sessions attended. Results showed that those who attended fewer training sessions were not more likely to be from single-parent households, $\chi^2(6, N = 75) = 1.66, p = .948$. Number of sessions attended was also not related to condom attitudes and self-efficacy at baseline. However, young men who dropped out or were asked to leave the program during the first three months were older than those who remained in the program for six months or more, $t(70) = 2.46, p = .016$. They were also more likely to be sexually active than those who participated for a longer period, $\chi^2(3, N = 74) = 12.14, p = .003$, but they were as likely to have used condoms at their last sexual activity.

REPRODUCTIVE HEALTH KNOWLEDGE

During the first three months of PAH basic training, pre- and post-tests were administered for three curriculum topics, Puberty/Anatomy and Physiology, Contraception and HIV/AIDS/STDs. Pre-and post-tests consisted of 10-15 true/false questions for each topic. As expected, knowledge of reproductive health increases among young men exposed to PAH curriculum and training. As seen in Figure 1, paired-sample *t*-tests showed significant increases in pre- and post-instruction knowledge for each reproductive health topic: Puberty/Anatomy/ Physiology, $t(57) = -14.16, p = .000$, Contraception, $t(55) = -19.30, p = .000$, and HIV/AIDS/STDs, $t(47) = -12.48, p = .000$.

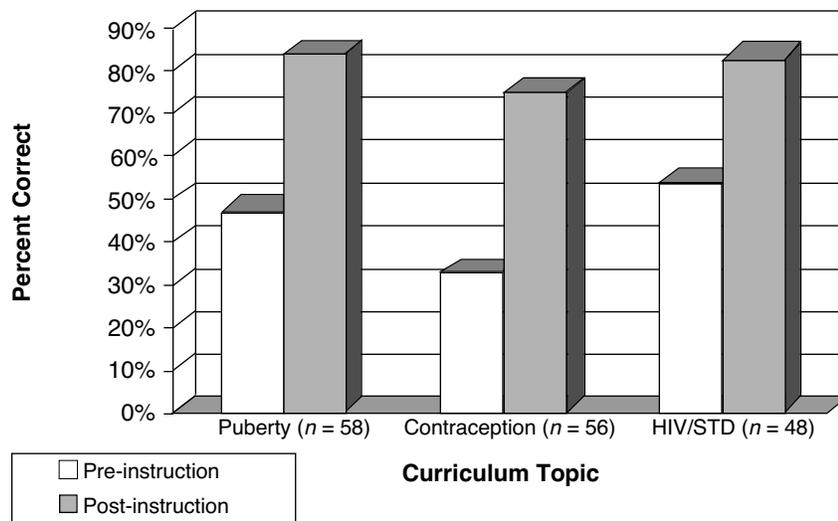


Figure 1. Pre- and post-instruction reproductive health knowledge.

CLINIC UTILIZATION

At baseline and six months, young men were asked if they had been to a clinic for condoms, STD information, birth control information, or “with girlfriend.” As shown in Figure 2, paired-sample *t*-tests showed that visits to a clinic for reproductive health purposes (not physical exam) increased between baseline and six months, $t(21) = -2.11, p = .047$.

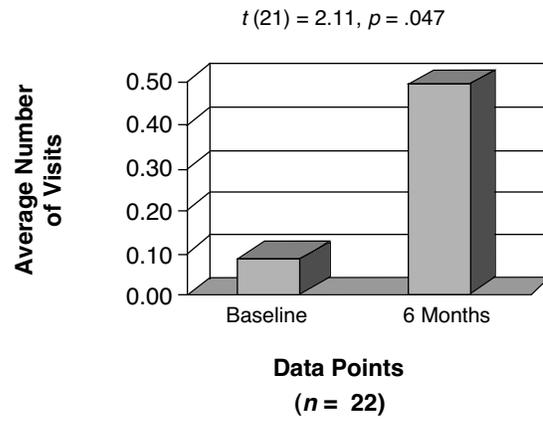


Figure 2. Reproductive health clinic visits over time.

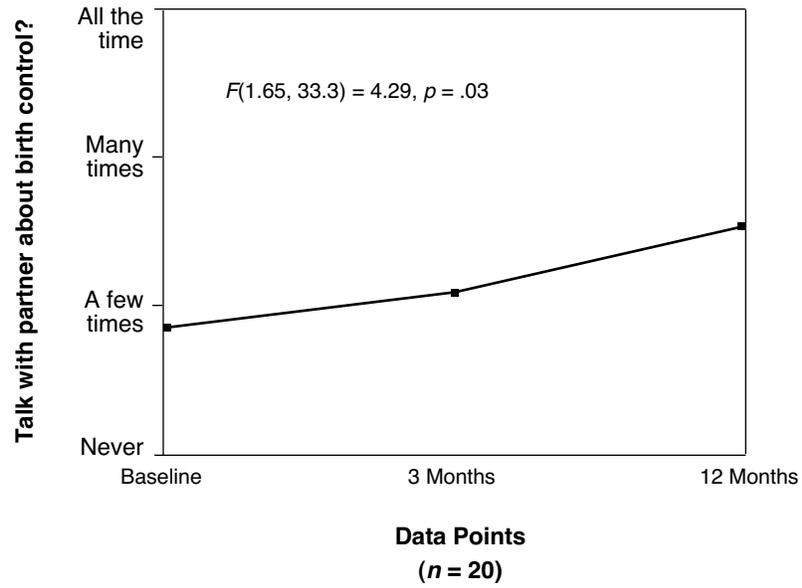


Figure 3. Change in frequency of conversation about birth control with partner.

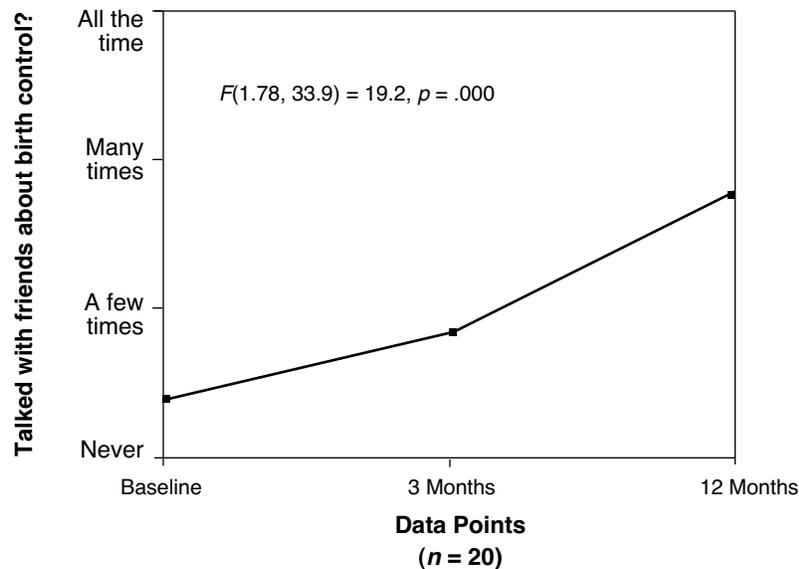


Figure 4. Change in frequency of conversation about birth control with friends.

COMMUNICATION ABOUT BIRTH CONTROL

A series of ANOVAs with time of measurement (baseline, three-month, and 12-month) as a within-subjects factor were conducted based on 20 young men for whom 12-month follow-up data were available. Results show that frequency of talking with girlfriend or partner about birth control increased significantly, $F(1.65, 33.3) = 4.29, p = .03$ (see Figure 3). Frequency of talking with friends about birth control also increased, $F(1.78, 33.9) = 19.2, p = .000$ (see Figure 4). Interestingly, the frequency of conversation with parents about birth control did *not* change $F(1.67, 30.1) = 1.59, p = .22$.

CONDOM USE AND ATTITUDE

Among PAH participants, condom use was very high at intake, and analyses did not show a significant change during the 12 months of program participation. We have three-, six-, or 12-month follow-up data for 68% ($n = 51$) of the young men. For this analysis, we used the last available follow-up time point. Among these participants, 58.8% ($n = 30$) started or continued to use condoms at follow-up; 3.9% ($n = 2$) of the sexually active young men went from not using to using; and 7.8% ($n = 4$) reported not using a condom; 29.4% ($n = 15$) remained abstinent at follow-up.

Results also showed that attitude towards condom use did not change throughout the study period. However, the young men generally expressed positive attitudes toward condom use at all data points. Mean attitude was 4.2 ($SD = .46$ to $.55$) for all data points on a five-point scale with "5" as most positive. Finally, the main effect of

time of measurement was significant for reproductive health self-efficacy, $F(1.96, 37.3) = 5.02, p = .012$. Reproductive health self-efficacy increased for our participants between baseline and 12 months of program participation (See Figure 5).

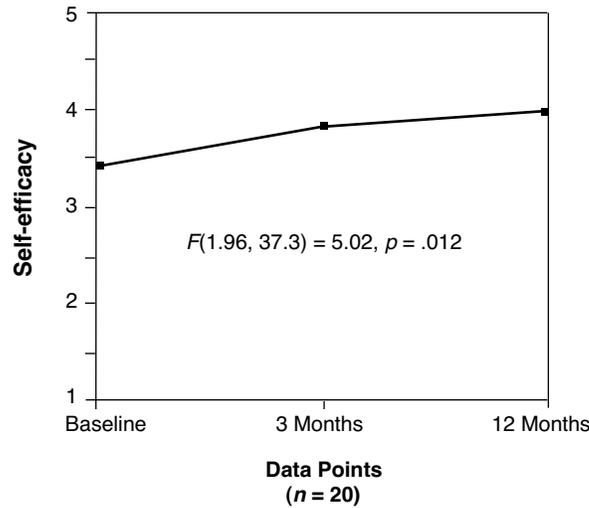


Figure 5. Change of reproductive health self-efficacy during 12-month study period.

COMMUNITY OUTREACH

Peer Advocates for Health program activity is designed to impact not only the young men who are being trained but also the broader community in which they live. However, adequate assessment of community-level impact is beyond the scope and budget of this community-based pilot program. At the current level of program development, assessment of Peer Advocates community outreach activity is limited to documentation of the number, age, and gender of community residents reached and number of condoms distributed. Over the past 30 months, from late 2001 to early 2004, Peer Advocates documented talking about reproductive health issues with 4,419 individuals, both adolescents and adults, individually and in groups.

Both the type and level of Peer Advocates community outreach activity has increased in response to felt needs in the larger south side community. Initially, community outreach efforts centered upon Peer Advocate presentations to school classes and one-on-one discussion with peers. Peer Advocates now make presentations to a variety of groups including after-school programs, church groups, health fairs, youth conferences, and most recently a prom expo and a women's shelter. Beginning in 2002, monthly *Let's Talk About It* sessions were begun in which male Peer Advocates work directly with female Peer Educators and make coed presentations to middle school students and their parents. Over two years, these young men and women have worked together to make 19 co-ed presentations to 199 middle school children and 61 adults attending these monthly sessions.

An important part of Peer Advocates community outreach activity is condom distribution. Each year, Peer Advocates distribute between 2,000 and 3,000 condoms at their schools or in the neighborhoods. Last year, one Peer Advocate was the regular distributor for his football team, and another young man distributed 33 “condom wallets” on prom night at his local Catholic high school. In the past four years, Peer Advocates have distributed more than 10,000 condoms in their own communities.

DISCUSSION

Community-based program experience working intensely with adolescent males in inner-city Chicago strongly suggests that these young men will join the program, will come to group, and need and want information. When asked what they liked best about being in the Peer Advocates program, participants responded: “learning new things,” “learning to be safe and communicating,” and “the things we were learning can be applied to everyday life.” Once these young men are trained as Peer Advocates, their willingness and level of enthusiasm for sharing their reproductive health knowledge with friends and family has surprised even the project staff. Each year only 12 to 15 Peer Advocates are active in their communities, but these young men have reached more than 4,000 other adolescents and adults living in a broad geographic area on the south side of Chicago. Along with information, Peer Advocates also provide a mechanism for distributing condoms to their communities—at school, in the locker room, at the prom, or wherever the need arises.

Analyses of four years of program data support the hypothesized outcomes among PAH program participants with significant changes in reproductive health knowledge reported among adolescent males in and across all four participant groups. After six months in the program, more than half of the young men had been to a clinic for reproductive health services, as compared to 15% at intake. Although year-end data are available for a very small number of participants, these participants report increased communication with partners and peers after 12 months of program participation. Condom self-efficacy increases, and use of condom at last intercourse remains high throughout the program year.

The small number of respondents for whom 12-month data are available is a serious limitation to the current study and results from both participant attrition, due to dropout or expulsion, and poor timing of data collection efforts that conflicted with sports and high school graduation. The intense training and strict rules for participation are both a strength and a weakness of the Peer Advocates program model. Each year, a large number of participants leave the program because they are not willing to meet these requirements. However, those young men who remain in the program are both committed and well prepared to become Peer Advocates and to represent the program in their own communities. Overall, during the four years of program activity, more than 60% of all PAH participants remained in the program for a year or more, and the impact of their participation in the Peer Advocates for Health program appears to be very positive both in terms of knowledge gained and willingness to share this knowledge with the broader community.

These impacts of Peer Advocates program participation on adolescent African American males in Chicago are similar to those reported for adolescents in Africa,

where peer education programs are reported to be effective at improving knowledge and perceived self-efficacy and promoting attitudinal and behavior change among program participants (Brieger, Delano, Lane, Oladepo, & Oyedrian, 2001; Speizer, Tambashe, & Tegang, 2001; Lane, 1997). Likewise, the long-term goal of utilizing Peer Advocates as change agents in their own communities is supported by several studies reporting that outreach programs, especially involving condom distribution and STD/HIV prevention, have been successful in reaching other males and making valuable contacts in the community and, when attached to clinic services, have resulted in increased contraceptive compliance among teen clients (Herz, Olsen, & Reis, 1988; UNFPA; Mellanby, Newcombe, Rees, & Tripp, 2001).

Given the nature and characteristics of these south side neighborhoods, providing a mechanism for information and condom distribution that reaches adolescent males could have a significant impact on the young people and on the health of these communities. Peer Advocates is currently a small community-based demonstration project, and the ability to assess program impacts at the broader community level is very limited. A rigorous evaluation of both individual and community level impacts of Peer Advocates program activity should be the next phase of program development but will require substantially more resources and a longer time frame.

LESSONS LEARNED

A number of lessons have been learned in developing and refining the Peer Advocates program model. Four years of PAH program experience demonstrates that improving levels of reproductive health knowledge is relatively easy compared to changing attitudes and the normative context in which these young men live. Despite significant gains in reproductive health knowledge and six months of training and group participation, a large majority of the participants continue to report that “their friends would respect them if they got someone pregnant.” Such responses suggest the normative influence of peers and the negative influence this context can have on decision-making and reproductive health behaviors. These responses strongly support our recommendation that, in addition to reproductive health education and training, adolescent programs must also provide the time and support necessary to process this new information and to incorporate reproductive health knowledge into the belief system and lifestyle choices of each adolescent.

Because project staff were developing a new program model and implementing this model for the first time in a community health center, they faced a number of obstacles at various stages of program development. Initially, recruitment of young men to participate in the program was a challenge, but this challenge was overcome by using several channels of recruitment and personal contacts. Continual changes in administration and clinic staff (five Executive Directors and four Medical Directors in four years) resulted in a constant need to explain the program and to advocate for training space and payment to the Peer Advocates at the health center. Initially, the per capita cost of training a small number of Peer Advocates was high, but when program costs are spread across the number of community residents reached by the Peer Advocates program, the cost per participant becomes less than a clinic visit and certainly less than the cost of a teen pregnancy. More accurate estimates of the

cost-effectiveness of Peer Advocates program effort cannot be determined until more rigorous evaluation of community impacts is carried out. Financial support by DHHS, Region V, Office of Family Planning, made this type of local community-based project possible, but funding was not always sufficient to pay the Peer Advocates for all the hours they wished to work. Having too many trained adolescent males who want to work in their own communities as Peer Advocates for Health is a “positive problem” and speaks to both the need for and effectiveness of this demonstration effort.

Finally, a number of factors contributed to the effectiveness of this pilot effort and should provide guidelines for replication and expansion of the Peer Advocates program model. The project coordinator and the individual support he provides to each young man are critical because he spends the time necessary to know and meet the needs of each young man. Both the program’s coordinator and the trainer, who is an African American female, possess high levels of expertise, an in-depth knowledge of the challenges faced by minority adolescents growing up in inner-city neighborhoods, and a deep commitment to providing the knowledge, skills, and support necessary to optimize the potential of each young man in the program. Parental support is also important, both in terms of supporting program goals and providing transportation to weekly meetings. In her year-end evaluation, one parent wrote:

“The focus is on the *entire* male and not just sex. Mr. S. [the project coordinator] is an excellent role model who supports these young men in their character, choices, and integrity as they become young men who can be a positive influence in their communities.”

To date, the Peer Advocates for Health Program has directly served a relatively small number of participants. Nevertheless, both quantitative and qualitative analyses point to positive program impacts in the areas of knowledge gains and healthy lifestyle choices for these young men. Moreover, participants reach a substantial number of their peers in an intentional effort to have an impact in their own communities. Based upon the first four years of Peer Advocates program experience, the long-term potential for individual and community impacts is strong. Results of this study add to the growing body of literature that suggests that, to improve behavior and lifestyle choices among high-risk adolescent males, programs must provide not only reproductive health education but also the long-term follow-up and support necessary to utilize this information in the context of everyday lives.

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Book Reviews

Vital Man: Natural Health Care for Men at Mid-Life by Stephan Harrod Buhner. Wayne, NJ: Avery Publishing Group, 352 pp.

Having been in practice for almost 20 years as a naturopathic physician, I have come to the conclusion that all human beings possess an innate knowingness at a core level that allows them to understand, with the right presentation, what it is they need in order to foster their own healing, growth, and development. That we often do not listen to this and continue to cover the same ground time and time again is what makes our lives interesting and challenging. What it seems we need is a good kick in the pants or, better yet, a way of viewing the aging process in ways that allow us to step back and take a deep breath as we put things in perspective. Stephen Buhner accomplishes this in *Vital Man* by providing the reader with a down-to-earth perspective on aging, its challenges, the transformations encountered, the opportunities it presents, and ultimately its rewards.

One of the things that caught my attention immediately was the author's mixing of philosophy, psychology, common sense, humor, and a profound respect for the intertwining of them all. I'm a middle-aged man myself as well as being expected to possess the wisdom and knowledge that physicians and healers are expected to have. *Vital Man* quite adroitly places things in perspective in a manner that any man can understand and relate to.

The author presents an excellent overview of a complex subject—that is, aging and the changes encountered—educating the reader in easily understandable terms. The reader also benefits from his training as an herbalist because of the nutritional and herbal supplement suggestions he has so painstakingly researched. I particularly enjoyed the section on prostate cancer and the challenges the author presents to so-called “conventional wisdom” on the subject. Additionally, his views on coronary artery disease and the role cholesterol plays certainly are controversial but may prove ultimately to be correct. These and other statements throughout the book provide grist for the thought mill and help to make *Vital Man* an enjoyable read.

This is a book I wish I had written but haven't, but I am certainly glad someone has. In an era of the pursuit of the chemical, surgical, and psychological fountain of youth, it is long overdue.

Permission to reprint a book review printed in this section may be obtained from the reviewer.

BOOK REVIEWS

Vital Man is a book I will recommend to my male and female patients—the men because, well, this book provides a needed perspective and a few alternatives that are largely missing in our fast paced culture, and to my female patients so they can gain an understanding of what their spouses may be experiencing but do not speak of. (It's that Y-chromosome, you know.) I strongly recommend *Vital Man* to anyone who has a vested interest in his or her own or loved one's health and well-being.

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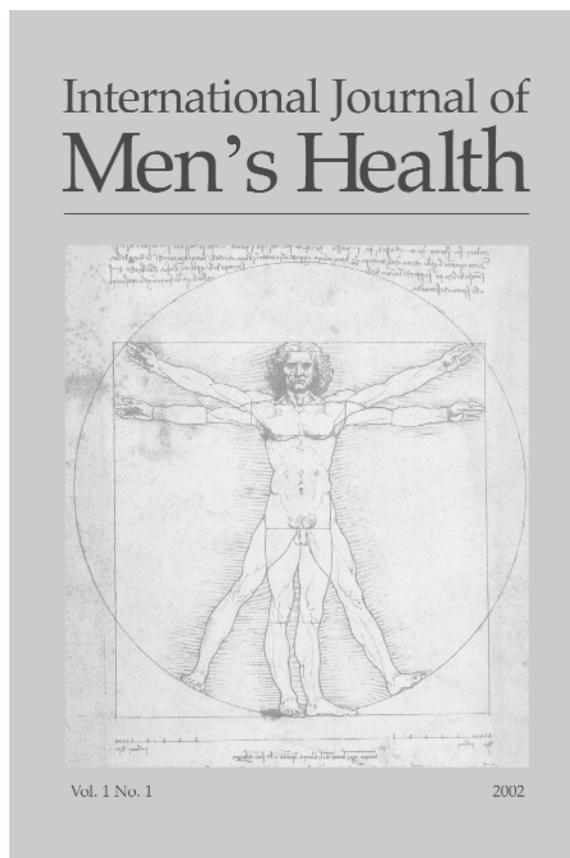
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