Sex and youth:

*contextual factors affecting risk
for HIV/AIDS*

Sex and youth: contextual factors affecting risk for HIV/AIDS
A comparative analysis of multi-site studies in developing countries

UNAIDS BEST PRACTICE COLLECTION

Young people and risk-taking in sexual relations

Community responses to AIDS

Use of the female condom: genders relations and sexual negotiation

Young people and risk-taking in sexual relations

This set of studies presents a comparative analysis of data collected in interviews and discussions with nearly 3000 young people in 7 countries in Africa, Asia and the Americas. Strikingly similar themes and issues emerge, including concepts of youth, the challenge to traditional cultures, modernization and urbanization – revealing a complex and heterogeneous situation for young people and no one HIV/STD prevention strategy. Future prevention efforts must take into account the impact of dominant sexuality frameworks, the onset of sexual activity, the importance of the body for young people, mass media, risk assessment and safer sex.

Community responses to AIDS

A comparative analysis of the resulting data from 5 countries identified local beliefs about HIV/AIDS, the community and household responses and the inter-relations between the two. Key factors influencing the responses include the existing economic situation, prevailing relations between men and women in the communities and households, local beliefs in health and health care and local levels of stigmatization. Recommendations are made for policy and programme development.

Use of the female condom: genders relations and sexual negotiation

This third set of studies first collected data in 4 countries on gender relations, sexual communication and negotiation followed by an intervention to strengthen women's capacity in these latter areas. The comparative analysis clearly identified economic dependence on men and gender stereotypes as the two major factors constraining women in their sexual behaviour. The report finishes with specific recommendations.

This bare summary of these 3 pioneering sets of studies investigations into the determinants of HIV-related vulnerability cannot convey the extraordinary wealth of data and the richness of experiences and feelings reported by the participants with striking frankness. The volume will be read and re-read by national authorities, programme designers and managers, researchers and intervention specialists. In addition it will be of great interest and value to all those who are interested in the issues surrounding young people and HIV/AIDS, sexual behaviour, communication and negotiation, the improvement and strengthening of responses for the benefit of people living with HIV/AIDS, their carers and their communities, gender roles and the options for women who want to protect themselves against HIV and other STDs as well as pregnancy.

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Part 3
Use of the female condom: gender relations and sexual negotiation

INTRODUCTION

Since early in the epidemic, enquiry into the factors influencing HIV-related vulnerability has been recognized as essential for prevention efforts. While much early work focused on the individual determinants of sexual and drug-related risk-taking, increasingly the contextual factors which render some groups more vulnerable than others has come to be recognized. Factors as diverse as age, gender, social position, economic status, cultural norms, beliefs and expectations determine the risks faced, and enable and constrain individuals in their actions.

It is now widely recognized that both individual persuasion and social enablement are essential for programme success, and increasing numbers of prevention programmes and activities are designed on this assumption. The recent UNAIDS report *Expanding the global response to HIV/AIDS through focused action* recognizes the importance of such an approach and seeks to encourage its application in countries across the world. Yet knowing how to develop and fine-tune programmes requires insight into the often complex determinants of behaviour in specific cultural settings and contexts. Good quality social enquiry has a key role to play in providing this information and in supporting the development of work that is attuned to the needs of particular groups.

The three sets of studies described here were begun at a time when the importance of contextual enquiry into the determinants of HIV-related vulnerability was first being recognized. All were commissioned by the World Health Organization's Global Programme on AIDS (WHO/GPA), were supported by the GPA Steering Committee on Social and Behavioural Research, and were completed with the active support of UNAIDS. They vary in their focus from investigations examining the contextual factors affecting risk-related sexual behaviour among young people, through enquiry into the manner in which households and communities respond to HIV and AIDS, to studies of gender relations, sexual negotiation and the female condom.

WHO Regional Offices, WHO representatives and WHO/GPA in-country staff played an important role in identifying the principal investigators and research teams which conducted the studies. Each investigation was conducted by local researchers who were encouraged to work closely with national HIV/AIDS programmes and nongovernmental organizations to maximise the potential usefulness of their findings. Technical assistance and support was provided to the studies both by the staff of UNAIDS and by advisers. The preparation of the comparative analyses of findings was undertaken by Peter Aggleton and colleagues at the Thomas Coram Research Unit in London working closely with the consultants and authors named in each individual report.

The reports identify the principal findings from each of the three sets of studies along with policy and practice implications. They highlight the value of close focus research that remains sensitive to the intentions, beliefs, life

projects and experiences of individuals, families, households and communities. They provide stimulus for further work in each of the fields described using complementary methods and approaches. We hope that national authorities and programmes, researchers, programme developers and intervention specialists find them interesting, and that they act as an important source of impetus for future work.

Michel Caraël
Team leader : Prevention
UNAIDS

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Part 1

Young people and risk-taking in sexual relations

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INTRODUCTION

Those attending any major international or national conference on HIV/AIDS cannot help but notice the concern about, and emphasis on, young people. The XI International Conference on AIDS in Vancouver saw abstracts for no less than 319 posters and papers about aspects of young people's risk of HIV infection, or responses to it. As a major sector in almost every country's population seen as at enhanced risk in this pandemic, young people are viewed as a 'problem' — a problem for prevention education, and a problem for potential HIV transmission.

This problem is captured by the very words so often used to describe young people — youth, youngsters, teenagers, juveniles, minors, adolescents. However, the term 'young people' is itself ambiguous. The term is often used to refer to those between the ages of 12 and 26, although in many cultures the upper level of this cohort should properly be regarded as fully mature adults. Were the age of onset of sexual activity to be used as a starting point for the lower limit, then we would have to recognize that in some parts of Africa about 40% of 15-year-old young men have experienced intercourse, whereas in some parts of south-east Asia, over 80% of 20 year-olds are virgins, still waiting to transform themselves from 'children' into 'young people' (Cleland & Ferry 1995). It is this difference between the cultural experiences and understandings of different groups of young people that makes direct comparisons between countries and cultures so difficult.

The category 'young people' is a recent one. Like its predecessors, the term attempts to distinguish between childhood and full adulthood, and historically the gap between these two has widened. In the West, and particularly since World War II, increased retention rates in secondary schooling and rising enrolments in postschool educational institutions have increased young people's dependency on their families, communities and the state. In contrast, more than half of all 14–16-year-olds (depending on the country) were likely to be in the workforce only a few generations ago, contributing to family incomes or working for family businesses, farms and/or in domestic labour in the home. This last point also highlights the fact that gender differences in relation to paid and unpaid work, and in relation to school retention and further workforce training, have changed rapidly in the West in the last 50 years.

In developing countries, ambiguity concerning young people is even more pronounced. The process of Westernization occurring in many developing countries brings with it new ideas, new influences and novel ways of understanding. It is important that Western concepts of young people, as an age cohort dependent on family, community and/or the state in an extended process of preparation for adult and productive life, are not applied uncritically to developing countries. It is important too that young people are not seen globally as some artificial homogeneity. This is especially important in the formulation of public health strategies to limit the effects of HIV. Local specificity in public health responses indicates a recognition that different epidemics of HIV

(and sexually transmissible diseases [STDs]) exist and that there is a need for cultural appropriateness.

It was the awareness, both of the widely acknowledged vulnerability of young people to HIV infection globally, and the need for better informed understandings of cultural differences and forms, that led to the development of the multi-site study described here. The title of the research programme — *Studies of contextual factors affecting risk-related sexual behaviour among young people in developing countries* — hereafter the Contextual Factors study, brings this concern with cross-cultural difference to the fore, and the seven research teams who carried out these studies successfully document such differences. Yet as we will see there are striking similarities too, the most apparent being the situation of young women when it comes to attempting to 'negotiate' sexual relations with men. The value, then, of this cross-cultural comparison lies both in its capacity to reveal differences and similarities, and in its ability to draw lessons and ideas from these seven countries that might apply elsewhere.

Existing research frameworks

Research on young people and HIV/AIDS has changed little throughout the pandemic. The global literature on this topic (which is reviewed briefly in Chapter 2) is familiar in two respects. First, a large number of surveys have been undertaken in many countries to examine young people's knowledge, attitudes, practices and behaviours. These have usually been conducted among accessible populations of young people such as school or university students. Second, there is a distinct absence of young people themselves in most research. Young people constitute a population most usually *researched upon*, a population seen as being 'at-risk', almost by definition. They are a group regarded in most societies as yet to become real persons, full citizens and to be accorded full human rights. They are a group whose behaviour, particularly sexual behaviour, is often regarded as premature if not immature, immoral or at least unfortunate, and whose own ideas, experiences and concerns about sexuality are mostly neglected by society at large.

The studies described here aim to contribute to new thinking about young people and sexual health. They demand that we grapple with the changing situation for young people in Cameroon, for example, as continuing urbanization radically transforms the rules for sexual conduct. They encourage a recognition that some middle-class young women in Costa Rica are competently handling significant changes in gender roles, while less affluent young men are struggling to maintain their sense of self through sexual success. They suggest we should take very seriously the fact that young women experience considerable coercion in sex in Papua New Guinea, yet these same women claim the right to physical sexual pleasure, following their Western counterparts, and distancing themselves from their mothers' and grandmothers' experiences and understandings of sex. And they encourage us to stop ignoring the same-sex pursuit of sexual pleasure reported by young people in *every* country in this study, thereby recognizing the very real diversity of sexual experience among young people across the world.

Health promotion successes in HIV prevention share certain common characteristics, and a central one of these is the notion of community inclusion in processes of intervention development and deployment. A key message from the seven countries that participated in this multi-site study is that young people themselves must be included in the development of health promotion programmes if prevention approaches are to be relevant. Young people's sexual conduct, the meanings they generate concerning sex, and the individual and shared investment they have in sexual exploration, pleasure and activity, must be represented in a plausible and respectful manner if we are to convince young people everywhere that HIV/AIDS is a real danger to them.

To achieve this accurate and fitting representation of young people's sexual conduct in health promotion material and programmes, it is important to know more than their specific sexual practices, the frequency of coitus, the age of sexual initiation, or the extent of sexual experimentation of various kinds. While this kind of information is important in gauging the size of the 'problem', rarely does it help us know *how* to educate, *what* curricula to use and *how* to teach.

It is in relation to those broader concerns that the studies reported here were intended to make their mark.

The material reported from each country is rich. Similar methodologies assured that certain issues were well covered by all seven studies, and these will be discussed in detail in Chapter 3. Differences in approach between countries, however, also enabled the studies to provide quite specific insights into young people's sexual culture in particular contexts. Although we cannot generalize these findings to all young people, they are valuable in helping us rethink notions of sexuality. They enable us to think about sexual expression as a set of meaningful acts, not just as a biological urge. In this way, sex can be seen as a deeply inscribed process of self-construction, pursued in the context of changing social expectations and often rapid economic change.

The report has been written for a wide range of people working on issues relating to young people and HIV/AIDS. It describes work initiated by the World Health Organization's former Global Programme on AIDS (WHO/GPA) and completed with the support of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

BACKGROUND

The Contextual Factors study was conceived of as a multi-site comparative study guided by a *General Research Protocol* that outlined the overall research questions, objectives and methodology.

Preliminary literature review

Before this *General Research Protocol* was developed, a literature review was commissioned to provide an up-to-date picture of young people's sexuality at that time, in relation to risks associated with HIV infection and AIDS.[3] In this review, various methodological approaches to investigating young people's sexuality were discussed, and their comparative strengths assessed. Issues such as cultural appropriateness, flexibility in use, terminology, sequencing of questions and issues, implied values, and the divergence between medical/scientific and lay persons' understandings of HIV/AIDS were examined.

Four main theoretical frameworks regularly used in investigating young people's sexuality were identified: the individual differences approach; the behavioural modelling approach; the sexual 'scripts' and discourses approach; and structural explanations. The review concluded that, while each of these had particular strengths, the first generally 'contributed little to recent attempts to plan and introduce appropriate interventions to encourage risk-reducing behaviours'[3]. As for the others, the major weakness was their lack of, and need for, deeper understandings of social and cultural contexts as the basis for the development of perceived normative attitudes and behaviours.

In reviewing this literature on young people's sexuality, a number of emphases in existing social and behavioural research were identified. Much previous research had focused on:

(1) measuring patterns of sexual behaviour (e.g., age at first intercourse; levels of sexual activity; experience of anal intercourse);

(2) ascertaining the meanings of sexual activity for young people (e.g., familiarity with sexual partners before intercourse; characteristics of first sexual partner, such as age, level of experience; category of first sexual partners, such as sex work client, peer, spouse; reasons for, and reactions to, first sexual intercourse; reported condom use);

(3) describing community understandings of sexual activity (e.g., generational differences; traditional values; understandings of sex work);

(4) identifying reported sources of information about sex and HIV/AIDS (e.g., families; overseas influences; peer groups; schools; family planning programmes; mass media);

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3   *Ingham R (1992) Personal and contextual aspects of young people's sexual behaviour: A brief methodological and theoretical overview. Unpublished paper prepared for WHO/GPA/SSB, Geneva.*

(5) exploring the impact of HIV/AIDS on young people's sexual activities (e.g., knowledge of HIV transmission; issues of personal vulnerability; dynamics of condom use);

(6) analysing the structural and contextual aspects of sexual behaviour (e.g. gender, socio-economic issues).

The review concluded by identifying future research priorities in relation to young people and HIV/AIDS. First, the cultural bases of normative attitudes and behaviour were regarded as needing further investigation, with particular focus on socioeconomic issues and the relationship between the individual and society. A second priority was the need to look closely at how to make interventions sensitive to local situations and conditions. Third, the sociopolitical context of research was identified as important to the construction of longer-term research planning.

Subsequent literature review

A subsequent review of the literature on young people and HIV/AIDS was undertaken after the studies themselves and prior to the preparation of this report. This revealed few significant shifts in the type of research being undertaken, although there were some indications of a growing concern for contextual and cultural issues. This supplementary review involved examining abstracts from the Berlin, Yokohama and Vancouver International HIV/AIDS Conferences, and conducting searches on the Medline, Popline, Sociofile and Psychlit CD ROM data bases for the years 1992-96. The aim was not to conduct an exhaustive review of the current literature on young people and HIV/AIDS, but to identify the overall direction of social research and any more recent concerns.

One of the enduring types of research on young people, particularly among school and college students, was found to be the standard and now very familiar *Knowledge, attitudes, beliefs and practices* (KAPB) survey. These studies generally and consistently reveal the well-known disparity between levels of knowledge about AIDS and HIV transmission (usually good) and changes in risk-taking practices in response (usually less good). Recent studies in Ethiopia (Mulatu & Haile, 1996; Teka, 1993), Zaire (Bindaki Muaka, Ndonda-Kumba & Lufua-Mananga, 1993), Zimbabwe (Campbell & Mbizvo, 1994), Nicaragua (Egger et al., 1993), Namibia (Zimba, 1995), Kenya (Pattullo et al., 1994), and Mexico (*JOICEFP*, 1994) offer examples of the continuing deployment of this type of research. The findings of such surveys are remarkably consistent and encourage some judicious rethinking of the need to sponsor more of this kind of enquiry. While local data may be useful to confirm local specificities, the reliance on college students in particular, and the substantial sampling bias this produces in developing countries, must call into question the validity and usefulness of this type of enquiry.

A second issue in the more recent literature concerns children living on the streets. While recent studies have reported on the prevalence of STDs, poor knowledge levels about HIV/AIDS and the part played by sex in exchange for favours, goods and money (Richens, 1994), there has

been a notable shift in emphasis toward a more cultural and contextual understanding of the circumstances in which street children pursue and engage in sex. In South Africa, for example, Richter and Swart-Kruger (1996) have highlighted the inadequacy of rational choice models of risk assessment and decision making in the face of coercive sexual contexts, pointing to social conditions of risk-taking beyond the individual. Ruiz (1994) has stressed the importance of understanding street life as a culture that contextualizes risk-taking behaviour in Colombia. Raffaelli et al. (1993), using a combination of qualitative and quantitative methods, have described the integrated nature of sex in exchange for goods, services and (important and often neglected) pleasure in street life in a study of the early and diverse sexual experiences of street children in Belo Horizonte, Brazil. Together, these studies underline the importance of understanding sexual behaviour among street children not as isolated and individual risk-taking but as aspects of collective behaviour deeply embedded in a sexual culture.

Other work concerning the meanings of sex builds on this idea of sexual culture. Domingo (1995), for example, has stressed the importance of motivation in assessing sexual activity among young Philippinos in order to develop prevention interventions. There has also emerged a concern with tensions in social life as a result of HIV/AIDS, notably in relation to religious attitudes and teachings on condom use (e.g., in Zaire - Haworth et al., 1996; in Mexico - Castaneda, Allen & Castaneda, 1996). This points to structural sources of conflict for young people in determining decisions about sexual conduct.

An added dimension to these reports on cultural context and sources of meaning for young people has been the documentation of significant gender differences. Bhende (1993) has highlighted the effects of gender inequalities on young women in Bombay, India, arguing that women's unequal status is an important factor to be taken into account in health promotion. Ford and Kittisuksathit (1994) have noted the gendered nature of sexuality and sexual expression among young Thai factory workers. Castaneda, Allen and Castaneda (1996) have pointed to the contrast between young women's and young men's expectations of sex and the tension between cultural approval for sexual experience among young men, despite demands for sexual abstinence among young women. These are important findings since they suggest that gender differences are deeply structured and culturally inscribed sets of meanings and understandings.

A number of other studies have expanded our understanding of the cultural factors affecting young people's sexual conduct, arguing for the extended use of a range of qualitative research methodologies. Focus groups and in-depth interviews feature strongly in a 13 country study of young women's sexuality described by Weiss and Rao Gupta (1996) at the XI International AIDS Conference in Vancouver. Similar work on young men's use of condoms in Zambia employed in-depth interviews (Feldman et al., 1993). Paiva (1993) used action-research methods among Brazilian young people, finding that traditional sexual culture was an important factor influencing expectations about sex. A combination of

quantitative and qualitative methods in Thailand allowed a more complex and culturally contextualized picture to emerge of young people's communication and interpersonal concerns (Pattaravanich, 1993).

This brief overview of the more recent literature on young people, HIV/AIDS and sexuality therefore reveals a growing focus on *sexual culture* and the *social contexts* within which different kinds of sexual conduct occurs. It reinforces a sense of the timeliness and focus of the Contextual Factors studies described here, and encourages an appreciation of the value of in-depth qualitative enquiry in the pursuit of a better understanding of young people's perceptions, beliefs and needs.

Conceptual framework

Taken together, findings from the two reviews identify a number of principles that informed the conceptualization and development of the Contextual Factors study and its qualitative methodology, using individual and group interviews. Theoretically, the study was based on the belief that, in order to intervene effectively in a moment of sex-related risk to prevent HIV infection, it is essential to understand how those participating view what is happening — in particular their intentions, their interests and the possible outcomes of the event. For many young people, sexual motivations are complex and may even be unclear or largely unformulated. The pursuit of sex may be bound up in confusing expectations and fears. These expectations and fears are likely to be couched in identifiable ideas, terms and frameworks and formed in local or immediate cultural contexts.

In order to develop better educational interventions to prevent HIV infection, greater emphasis needs to be given to the ways in which young people understand their social and physical worlds, and to the social and cultural processes that help them make sense of sexual desires, feelings and interests. This theoretical approach emphasizes the social and cultural rules and expectations that operate in particular societies. It focuses on the processes through which identities (including sexual identities) are acquired, developed and maintained, and on the way in which meanings about sexual behaviour and sexuality are communicated and learned.

A central theoretical assumption here is that sexual activity is, to a large extent, *socially constructed*, in addition to having its biological components, and that all societies mould basic sexual urges for their own social or cultural purposes. A good example of this direct social moulding of sexuality can be seen in the marked differences between countries in their legal ages of consent. It was important, therefore, that the research methods used were sensitive to the processes through which various societies actively construct ideas about what is sexually appropriate (or not) for young people. It was also important that all the relevant 'players' or participants in determining the appropriateness or otherwise of young people's sex lives were involved in the studies.

Attention was also directed toward other factors that may affect sexual understandings and conduct (such as historical and economic conditions), as well as to the influence of particular institutions such as legal and reli-

gious systems. Wherever possible, efforts were to be made to link with other studies that had already collected data on young people's sexual conduct using other methods (e.g., existing KAPB and Partner Relations surveys).

The overall objectives of the research programme, therefore, were to:

- examine the personal and social contexts in which sexual activity among young people takes place and the ways in which such activities are explained and justified;
- analyse the range and shaping of meanings of sexual activity among samples of young people in particular contexts and cultures;
- identify the different sources and contexts from which young people acquire their knowledge and understanding of sexual issues;
- explore the dynamic processes through which young people learn about sexual issues and appropriate sexual meanings, and how alternative meanings develop and change; and
- work toward developing culturally relevant explanatory models of sexual behaviour among young people, and assess the implications of these models for the design of appropriate preventive interventions.

The key research questions were outlined in the *General Research Protocol* and formulated to ensure that findings from the different countries undertaking the study had some common points of reference. Research questions were of two types: principal research questions, and additional research questions. The former were grouped into three areas (although there is considerable overlap between these): questions relating to the meanings of sexual activity and sexuality (ies), including the discourses of sex; questions concerning the contexts of sexual activity; and questions about specific sexual behaviours and activities.

In terms of the meanings of sexual activity and sexuality(ies), the central questions were:

- how do young people learn, and what do they learn about sex and sexuality;
- what are the sources from which they acquire knowledge, values and attitudes, and what is the relative importance of each of these;
- how are feelings and thoughts about sexual activity shaped and formed, and how do the meanings of sex and sexuality alter in different age groups over time; and
- what do young people expect from or seek in their sexual relations?

Potential sources of information included the mass media, parents and other kin, and schools and peers, as well as less direct influences such as religion, legal systems or other cultural traditions. Examples of meanings regarding sexual conduct might include general ideas about sex and procreation. Other sexual meanings might be revealed by answers to the following questions; is sex always associated with physical pleasure? Are sexual desires publicly acknowledged or hidden? How does each society understand and recognize gender identity for males and females? Are transsexuals and transvestites recognized cultural categories? Are there

recognized rituals for sexual initiation, or for achieving sexual maturity? What are each society's ideas about sex and love, power, rebellion, curiosity, and so on?

In addition to obtaining answers to these questions, data were also to be collected on the way sex is talked about, the hierarchy of meanings, the sources of alternative meanings, the resolution of conflict between meanings (at individual and relational levels), and the development of meanings over time. In seeking to identify and explore the contexts of sex, researchers' attention was directed toward:

- the social, emotional and physical contexts in which sexual activity occurs (e.g., the extent to which early sexual contacts take place with relatively long-term partners, or with sex workers);
- respondents' expectations of particular contexts (e.g., the implication that drinking and socializing at particular places implies that one might be looking for a sexual partner, or being bought presents by an older person implies that sexual favours should be given in return);
- perceived 'rules', such as reported obligations and expectations of self and others (e.g., that all will marry);
- the integration of alternative meanings into different contexts (e.g., there may be conflicting definitions and pressures from parents, the media, peers and others);
- differing perceptions of vulnerability (e.g., how perceptions of risk of HIV infection and/or pregnancy alter with age, gender, ethnicity); and

- socially approved or disapproved sexual activities, and their relation to gender, age, sexual preference, and other factors.

Included in these considerations were to be the actual or potential impact of aspects of specific cultures, such as legal constraints (e.g., the laws that govern sexual conduct and their enforcement or contravention) and economic factors (e.g., the effects of poverty on sexual conduct). The term contexts encompassed general norms and regulations within societies, those in specific locations, and those affecting interpersonal behaviour in localized settings.

Information was also to be gathered on the sexual practices of individual respondents, with particular attention being given to the details of events and contexts, and of personal explanations, interpretations and justifications. The relational aspects of sexuality were seen as particularly important. These included such things as the emotional (or affective) aspects of sexual activity, the kinds of partnerships entered into, and how these are understood, valued and talked about. Since the direct observation of sexual activity was not possible, personal accounts and explanations of sexual activity were to be sought. Social settings in which young people actively pursue the development of sexual interests and relations e.g., at discothèques or in leisure activities), were to be targeted for systematic observation by researchers.

As stated above, research teams participating in the programme were encouraged to add to the study design additional research themes

and questions that arose for their particular country, for the areas chosen as their research sites, and/or which related to the samples chosen. Possible additional themes included the migration of young men from rural to urban areas, changes in traditional sexual values and meanings as a result of economic development, and the local impact of new sex education programmes on contemporary sexual identities.

It was hoped these studies would lead to:

- a better appreciation of dominant sexual understandings, sexual meanings, sexual identities and sexual cultures in seven contrasting sites;
- a sounder understanding of the implications of such understandings, meanings, identities and cultures for self-understanding and individual sexual behaviour;
- a comparison between the ways young women and men come to understand themselves sexually, and the consequences of this for patterns of sexual behaviour;
- analyses of sexual behaviour perceived as 'risky' (in relation to HIV and STDs) within a specific culture; and

- implications for health promotion interventions to minimize risk-related sexual behaviour.

Throughout 1993, site visits were undertaken to over 12 countries to identify potential principal investigators and to assess institutional capacity to undertake studies of this complexity. Potential principal investigators were invited to attend a briefing meeting to familiarize themselves with the *General Research Protocol*, and to receive guidance on development of the country-specific local research proposals. Draft local research proposals were subsequently submitted for assessment, returned with suggestions for improvements, and were then reviewed formally by the GPA Steering Committee on Social and Behavioural Research in October 1993 and March 1994.

The local research proposals from seven countries were chosen to participate in the programme: Cambodia, Cameroon, Chile, Costa Rica, Papua New Guinea, the Philippines and Zimbabwe. These seven countries received funds from WHO/GPA/UNAIDS to undertake the studies, most of which took an average of two years to complete. The final study (that in Cambodia) finished in 1996, and this comparative analysis of findings was finalized some nine months afterwards.

CHAPTER 3

STUDY DESIGN AND METHODOLOGY

The overall research methodology employed in the studies was qualitative, with an emphasis on an in-depth comprehension of people's own experiences, rather than the use of statistical analysis for the purposes of generalization. The aim was to identify the social processes that need to be understood when thinking about HIV-related public health policies and programmes. The multi-site study aimed to theorize the relation between individuals, their immediate milieux, and broader social and cultural forces. We can understand how a society works best when we understand how its citizens interact on a daily basis with each other, with groups of people, and with others in institutions and organizations. In this kind of enquiry, therefore, individual experience is investigated, not for the purpose of accounting for majority or minority patterns of behaviours, but in order to *explain* experience and behaviour. The aim is not to produce information on population characteristics, but to provide the sometimes detailed and complex ideas needed for policy and programme development and implementation.

Generalization is possible in qualitative research, but not at the level of majority or minority experience and their correlates. Instead, it is possible to identify and characterize the social forces or cultural components underlying individual or group behaviour. Generalization can also occur when assessing the contribution of particular cultural and historical forces to patterns of behaviour, and by revealing institutional imperatives in one population (e.g., school rules, religious prohibitions and so on) that are likely to produce the same effects, actions and understandings in other similar populations. In other words, by uncovering how social forces and cultural components affect a certain population, it is often possible to generalize these findings to other populations affected by the same forces and components. As we will see, in these studies' findings there are similarities that cross national boundaries and even span continental divides, and these can judiciously be generalized to other countries. There are also country-specific practices and understandings, however, that relate directly and only to a particular country itself.

Research plan

The studies were undertaken in three stages: a rapid assessment process; a period of main fieldwork; and an analysis and write-up period.

Rapid assessment

The purposes of the rapid assessment were to enable local research teams to fine-tune their original research design, pinpoint more exactly fieldwork sites, and assess and clarify the sampling frame. This period allowed for corrections to the original proposals, designed as they had to be in abstract, and proved an important and useful step. For example, one study (Chile) added a third group of young people to its planned two-part sample after their initial rapid assessment. This enabled the inclusion of young people marginalized from mainstream society and whose sexual behaviour was found to be somewhat different.

Rapid assessments also allowed the research teams to test out both the principal research methods common to all sites (see below), their chosen additional research methods, and to undertake some initial key-informant interviewing to sharpen the focus on principal and additional research questions. Reports from the rapid assessments were sent to WHO/GPA for technical assessment and individual research teams were assisted, where necessary, in adjusting the final design for the main fieldwork period.

Main fieldwork

During the main fieldwork period, technical assistance was made available to the research teams. This included site visits by staff, consultants and temporary advisers; regular communication and information; and informal support from other interested parties. Various conferences and meetings, and later e-mail correspondence to some sites, facilitated more regular communication and provided additional opportunities for sharing ideas, discussing fieldwork problems and keeping the seven studies in touch with each other.

Analysis and write up

A meeting in Geneva in 1994 of all principal investigators provided an important first opportunity to share preliminary findings, identify major themes, explore similarities and differences in the evolving analyses, and established a common framework and process for producing individual country reports. Finally, an assessment of individual countries' draft final reports by the authors of this report provided a further oppor-

tunity to sharpen detail, clarify argument, and focus recommendations.

Principal research methods

Three principal research methods were employed in all studies: individual interviews, focus groups, and participant observation. The standardized use of these three principal research methods was intended to generate data that could be used for comparative purposes across the seven countries.

As the term *individual interviews* suggests, this research method involves interviewing people in a one-to-one situation. Such interviews were conducted primarily with young people, but also with selected 'key players' identified during the rapid assessment. In relation to young people, the intention was to explore in a confidential way issues related to sexual conduct and understanding. In general, such interviews lasted between one and two hours (although longer in some places), and the researchers explored the principal and additional research questions in a flexible manner. Wherever possible, interviews were tape-recorded with the informed consent of the interviewee.

The term *participant observation* covers a range of research techniques from 'observer as participant' to 'participant as observer', the main purpose in this case being to allow close observation of the everyday behaviour and contexts that relate to sexual activity. The extent to which an observer can become fully immersed in the activities under observation depends on many things, including the nature of the activity itself, and the

relationship between the observer and those being observed. Direct observation of sexual activity was not possible in these studies (nor is it in most HIV/AIDS research irrespective of methodology), therefore self-report is usually the source of most data. However, much can be gained from careful study of the social contexts in which potential sexual contacts are made, and which provide, shape and give meaning to sexuality in specific cultures. Suggested participant observation contexts included bars, clubs, discothèques, parks, streets and other places where young people congregated or met regularly. Such observations were intended to provide useful information on the manner in which relationships are formed, the patterns of interaction between people, the rules that govern behaviour in such contexts, and the range of 'key players' in each setting.

The basic aim of *focus groups* is to encourage a group of between five and ten people to focus on specified topics through a set of facilitated activities and to gather data through an interactive process of collective reflection.[4] The composition of the groups selected in these studies depended on the sites in which the fieldwork was undertaken, but were expected to be constituted largely of young people, although the method could in principle be used with other interested parties such as parents and youth leaders.

Additional research methods

All research teams were encouraged to add additional research methods to their design if this was thought to be useful. This was done in the recognition that country-specific research questions might require different methods of investigation, or that certain sections of samples chosen might prefer other methods. Most research teams took advantage of this opportunity to expand the scope of their research. Additional research methods chosen included the use of 'vignettes' in Papua New Guinea, an ethnographic case study of a discothèque in Chile, linguistic analysis of terms and meanings of words for sex and sexual relations in the Philippines, discourse analysis in Costa Rica, peer-led focus groups and peer participation in preliminary analysis in Cambodia, and attendance at certain ritual events in Cameroon.

Fieldwork sites and sampling

In their local research proposals, research teams were asked to nominate at least two sites in which to undertake their research. The purpose of having at least two sites in each country was to encourage possibilities for comparison or contrast, thereby preventing an artificially narrow view of young people from unwittingly emerging. Various combinations of site-selection criteria were used. Some teams chose three sites (Papua New Guinea, Zimbabwe). Some drew a rural-urban distinction (Cambodia,

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4   *Focus groups are a valuable method for obtaining a wide range of understandings, views, opinions and attitudes on particular social and cultural activities. Focus groups are not the same as group interviews, where participants in turn are asked similar questions and individual experience is reported in front of others for comment or reflection.*

Papua New Guinea, Cameroon), and two selected contrasting sectors of the same cities using social class and socioeconomic status as the distinguishing factor (Chile, Philippines). Still others chose a capital city/provincial town difference (Costa Rica, Philippines, Papua New Guinea, Zimbabwe). The attempt here at contrast and comparison was not one that argued that complete coverage of all young people could thereby be achieved. Rather, the aim was for high contrast, which would maximize the capacity for clear comparison so that social processes could be uncovered. The details of each country's site selection are contained in the final country reports, and these are summarized in the Appendix to this comparative analysis.

The *General Research Protocol* provided research teams with guidelines on the sampling frame to be employed. The studies' samples were constituted, in the main, by young people. Within these parameters, it was important to specify the involvement of particular age ranges in each country, since it was anticipated that these would vary considerably across cultures. So that national comparisons would be possible, sampling covered fairly similar ages in all of the studies. The age range for young people in each study was: Cambodia 15-26; Cameroon 15-30; Chile 18-22; Costa Rica 12-19; Papua New Guinea 12-24; Philippines 16-24; and Zimbabwe 13-24.

In order to analyse gender issues and their relation to sexual matters, it was important that young women and young men be equally selected, except in circumstances where an over-sampling of one sex or the other was necessary for a particular reason.

In cases where existing data on young people were available, such as information from surveys conducted for WHO or other agencies, research teams were asked not to replicate such data collection but to use existing data as a starting point to ensure that the relatively small numbers of young people recruited for detailed investigation in the study were reasonably typical of the larger population of young people in at least some respects. In some countries, existing data included social descriptors such as age, education level or ethnic background, and sexuality indices such as age at first intercourse, numbers of partners and patterns of contraceptive use. Similarly, the selection of members of focus group discussions was to be guided by data from these other sources where applicable.

It should be noted that representativeness was not required for this study. Instead, the aim was to develop a heterogeneous grouping of respondents in terms of their relation to the research questions. In this sense, the sample recruited at any site was constructed theoretically in relation to the principal and additional research questions. *Theoretical sampling* can be defined as a systematic process of selection developed from an understanding of the theoretical field, a recognition of the social circumstances surrounding the issue to be researched, and an initial estimation of which populations might best provide useful data on these particular research questions. As a result, who is interviewed, when, and how will be decided as the research progresses, according to one's assessment of one's current state of knowledge and one's judgement as to how it might be developed further (Hammersley & Atkinson, 1989).

Comparability across studies was to be achieved not only through the basic sampling frame involving common social descriptors and sexuality indices, heterogeneity, and sample weighting (if used), but also through the relationship between the groups of young people selected and the issues being investigated. For example, if migration between rural areas and cities were regarded as an important issue, then young people who are involved in this migration would obviously be a starting point for sample recruitment.

Sample sizes

The methodology used in this study was never intended to generate data on the relative frequencies of particular sexual or social behaviours. Rather, it was designed to explore the range of sexual meanings, identities and cultures. Each research team was expected to obtain a heterogeneous sample of young people in the particular country, community or site, developed from the theoretical sampling model. Exact sample sizes, therefore, were not specified in the *General Research Protocol*. Instead, general guidelines were developed to assist each research team in developing their sampling frame. It was planned that each study would complete between 100 and 200 individual interviews, and between 10 and 30 focus group discussions. The exact allocation of these numbers between sample categories (e.g., young people versus other 'players') was to be decided after the initial rapid assessment process.

The various studies produced differently structured samples as a result of

employing the principles of theoretical sampling. In Cambodia, 341 respondents in two sites were involved (146 young men, 135 young women, 60 others—adults, key informants or officials). In Cameroon, a total of 550 participants were interviewed, 301 men and 249 women in three sites. Of these, 108 were key informants. An additional 22 focus groups were conducted. In Costa Rica, 56 people in two sites were interviewed (25 young men and 31 young women). This study did, however, involve interviews of much greater length than the others did. An additional 48 people participated in focus group discussions, with approximately equal numbers in each site. In Chile, the sample was divided into three different socioeconomic categories investigated through the following techniques: 21 group discussions involving approximately 250 young people; 36 individual interviews on general discourses of sexuality; 26 individual interviews on selected sexuality topics; 48 individual interviews on information systems; and innumerable observations in the ethnographic study of the discothèque. The sampling in almost all categories was divided equally between the sexes. The Philippines study involved 78 young men and women in the initial rapid assessment stage, 120 in in-depth interviews and 70 in focus groups in the main fieldwork period, equally divided between the sexes, and 33 others in both phases — a total of 301 respondents in two sites, divided into two categories in each site by socioeconomic class. In Papua New Guinea, the research team held 64 focus group discussions, 174, 331 and 493 'media, 'personal' and 'secret' interviews respectively,[5] and 77 key

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5   See the Papua New Guinea research report summary in the Appendix for an explanation of these interview types.

informant interviews. Fifty-two respondents were observed. This large number of 1,191 study participants (560 males and 631 females) across three sites must be understood within the framework of the much shorter interview methods used in the study. Finally, the Zimbabwe study involved 82 young men and 91 young women in individual interviews. A further 21 focus groups and 5 key informant interviews were conducted with members of both sexes in three sites.

Time scale

The first studies were funded at the end of 1993, and a second set was funded in March 1994. All studies were under way by mid-1994. All final reports had been received by the end of 1996, although it was necessary to seek clarification on aspects of methodology and study findings throughout the early part of 1997. This comparative analysis was completed some six months later.

COMPARATIVE ANALYSIS

There are a number of levels at which the findings from this study have relevance beyond the individual countries involved. The first derives from the closeness gained to young people. Throughout the analyses, there is a clear sense of contact with, respect for, and knowledge gained from an extended engagement with young people. There were no one-off, brief and carefully distanced ('objective') moments of contact. Instead, sex is presented as an embodied, meaningful, collective act for young people. Sensation is felt, bodies matter, minds cogitate, and real young people struggle with the meaning of *their* desire. The cultures studied are clearly in conflict over young people's sexual conduct and no amount of denial or refusal will counteract that. As a number of country reports note, it is not young people who are the problem, but the way they are (mis)understood by many who seek to work with them.

This brings us to a second purpose behind this analysis — the desire to develop new thinking and better HIV/AIDS health promotion for young people in developing countries. Marked levels of sexual risk-taking are noted in all reports. This should not surprise anyone. What should surprise is the complexity of personal and cultural investment in forms of conduct that — at least in the minds of health professionals, epidemiologists and health educators — are so easily reduced to 'risk-taking'. What appears on the surface as intractable behaviour is in fact historically formed and trusted patterns of conduct, and ways of relating.

Key concepts

The concepts of sexual culture, sexual identity and sexual meaning allow us to cluster superficially different and culturally distinct experiences of sexual activity among young people into understandings that cut across the seven countries involved.

Sexual culture

Sexual culture is a concept that recognizes that there are systems of sexual behaviour among any group of people. The term suggests that sexual activity is not simply a manifestation of biological drives or 'natural' processes. As used in this study, the concept of sexual culture allows us to understand the origin and source of information about sex and specific expectations of it. It also helps us recognize the specific shaping of erotic procedures and sensations, and why one form of sexual expression may be taken for granted in one culture but eschewed in another.

In this sense, sexual cultures are to be regarded as social products, made and re-made in daily life, often locally, and therefore adaptable to changing pressures and circumstances. For example, notable findings across all countries in this study were the rapidly changing expectations and practices of sex among young people as a result of modernization and rapid urban growth. A second example might be different understandings of the importance of virginity to young women and men expressed by different groups of young people even

within a single country. And if there is a single key overall finding from these studies, it is that there are *many* sexual cultures within a particular setting, and no individual country has merely one.

Sexual identity

Sexual identity is a concept that provides a psychological (or psychic) place for situating the self in sexual activity. This recognition of the self in sex (how one behaves, what one wants, what one expects of oneself and others) is crucial to any individual's accurate assessment of risk in relation to potential HIV or STD infection.

Sexual identity is a recent and very Western term, receiving significant attention since the rise of second-wave feminism, often in relation to, and sometimes confused with, gender identity. Gay and lesbian theory has also addressed the issue of sexual identity, particularly in the personal consequences of same-sex sexual partner choice. The distinction between sexual identity and gender identity can be difficult to maintain, as gender plays a crucial part in structuring the sexual identities of young people in all countries in the study. Indeed, larger structural imbalances between the sexes have profound consequences for the expectations and experiences of young men and women in sexual matters and emotional relationships. Among the findings of this study, worrying conse-

quences of the differences between sexes included the common experience of sex exchanged for favours among young women, and the belief in the urgent 'need' for sexual experience among young men. In this analysis, sexual identities will be used solely to deal with matters of sexual activity and interests; the term gender identity will be used to refer to other issues of masculinity and femininity.

Sexual identity and gender identity are not just about personal relationships and a sense of the self, but also about finding one's place in families and communities, and in economic and cultural life. For example, in Papua New Guinea personal identity is linked traditionally with land, its use and with certain areas or homelands. This link has been weakened by migration, mobility and the undermining of traditional modes of social control related to membership of, and participation in, that traditional social and economic order — in a sense, one is what one does within the broader community. Older people in Papua New Guinea lament this weakening of traditional life, particularly in sexual matters, and see this as a source of permissiveness and sexual experimentation. In other words, they observe the shift from identity based on kin or territory to a more psychological sense of self, acted out also in sexual conduct.[6]

This shift signals a major, unnoticed impact of modernization on developing countries, one that is occurring rapidly and unsteadily. One conse-

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6   *This shift from collective to personal individualized identity, as modernization proceeds, is largely unnoticed by many identity-obsessed Westerners, but is worthy of greater attention. It registers a breaking-up of local cultures, which education programmes, particularly those charged with personal or health education, may need to tackle. These are longer-term issues that need to be taken into account in development and modernization programmes, health and education initiatives, and in HIV/AIDS and sex education.*

quence of this rapid and unsteady change was noted again in the Papua New Guinea report. There, in the somewhat lost and marginalized situation for some young people in Port Moresby, landlessness and lack of employment prospects (and therefore no cash substitute for wealth) creates *raskol* (hoodlum) activity. This is contributing to the widespread rape of young women, which as the Papua New Guinea report notes is 'seen as theft'. These shifts in identity from its historical and traditional roots were noted also in Cameroon and Zimbabwe in strikingly similar ways, and in each case were seen as a major contribution to changing sexual conduct among young people.

Although some older respondents in these studies saw this in a cause and effect way, this is *not* the important point. Rather, it is vital to recognize that sexual conduct is not uniformly regarded as 'naturally' constitutive of the self in all cultures, as it is in the West, but is becoming so as social and economic modernization proceeds. We are all now familiar with projective environmental impact studies, increasingly regarded as necessary before any economic development activity begins. It may be that future development and modernization initiatives should assess 'sexual impact' in a similar way by looking, for example, at the way in which a new mining town might produce increased prostitution. This would acknowledge the broader social and cultural consequence of development initiatives.

Sexual meaning

Sexual meaning as a concept offers a way of getting a firmer grip on the significance of sexual activity to young people. The meanings of sexual conduct and interests can vary greatly: meaning can be derived from collective and traditional rituals, or from a more modernized personal desire. Other sexual meanings can be generated in close interpersonal relationships, or are derived from more general societal expectations about sex. Meanings change, and the influence of an increasingly internationalized framework for understanding sexual activity has been greatly extended with the advent of the HIV pandemic. This has already been noted in relation to sexual identity. Beyond that issue, Western frameworks, notably the binary opposition between 'heterosexual' and 'homosexual' people, imposes an interpretative framework at times at odds with indigenous and local understandings, yet one that is increasingly pervasive. This binary opposition is barely 100 years old in its dominant position as *the* interpretative sexuality framework. It is also increasingly subject to critique in current sexuality theory in the West. Argument about its limitation as a framework for understanding sexual conduct in HIV/AIDS work has been already clearly established in earlier debates on sexuality and HIV/AIDS in Latin America, and are again pertinent in these studies.

However, mass communication is promoting a 'heterosexual'/'homosexual' conceptualization of sexuality as almost *the* single global understanding of many young people's sexual experiences and expectations. The effects of this are still partial as noted, for example, in Cambodia where young people reported themselves as indisputably 'heterosexual' but did not regard those men who engaged in same-sex activity as 'homosexual'.

Similarly, same-sex activity in Papua New Guinea is rarely regarded as homosexual (and almost never as 'gay'). Among working class and marginal youth in Costa Rica and to a lesser extent in the Philippines and Cambodia, same-sex sexual conduct was largely regarded as gender-related. The *playos* of Costa Rica, the *kteuy* of Cambodia and the *bakla* of the Philippines (all effeminate men who engage in same-sex activity) were seen mostly as products of gender inversion — in essence more transsexual than homosexual. This example offers just one obvious moment of seeing how sexual meanings are not universal or uniform, even when they describe superficially similar kinds of behaviour.

Contrasts between countries in relation to sexual meanings were most marked with respect to gender. There is no doubt that relationships are more important to most young women than they are to most young men, and that the physical sensations of sex acts dominate most young men's minds. There were, however, exceptions to this general point about differences between young men and young women, and these must be taken into account in any attempt to insert a biological or genetic explanation for such differences here. Any simplistic idea that maleness or femaleness is the fundamental source of these differences fails to take into account the powerful effects of social class, regional contrast and modernization. In other words, there is much more than biology involved here.

The importance of sexual meaning as a theme cannot be underestimated. Irrespective of somewhat different methods of investigation or techniques of analysis, the central significance of sex to young people can no longer be in dispute. Sex is not an area of conduct that does not belong to young people, even if some adult members of each society wish it were so. Clearly, the young people in these studies have their own sexuality, whatever the rules, whatever the traditions, and whatever the dangers. Any notion of young people as somehow still pre-sexual, or simply play-acting at sex, or practising a little in preparation for later, must be rejected for a framework that now recognizes young people as fully sexual beings, logically and legitimately so. Whether adults like it or not, the young people in these seven countries *own* their sexual conduct already.

This recognition profoundly affects our assessment of the importance of sex and sexual relationships for young people, and must force a reckoning with *their* meanings about sex. In other words, although there is indeed conflict and contradiction between traditional sexual mores and young people's current sexual conduct in all countries studied, any new set of meanings attached by young people to current sexual activity must be taken seriously and dealt with respectfully if we are to assist young people in coping adequately with HIV/AIDS and other sexual health issues. It is clear that young people can and do simply ride out the contradictions between their ideas and those of their parents, and conflicts between traditional and more modern values. Sometimes this might be done through cognitive strategies of 'compartmentalization', as the Costa Rica study suggests. Sometimes new sexual possibilities are opened up as a result of migration and mobility as suggested in Cameroon

and Zimbabwe, or by the creation of a new language for sex and sexual relations as noted in the Philippines and Cambodia. There are also indications of countervailing discourses of gender transformation, e.g., transsexualism, or modernization and individual pleasure, as evidenced in Chile and Papua New Guinea, which provide young people with new meanings for sex and new ideas about what sex is for.

These all become *strategies of legitimation* for new sexual ideas among young people, and can be effectively used as resources in health promotion and prevention education. All the Contextual Factors studies argue for the need for HIV/STD prevention to be couched in the terms of young people, in their own words and meanings. These strategies of legitimation provide the resources for an effective educational approach, as noted in the Philippines report:

> *The present research project shows active, discerning young adults, not necessarily well informed, but in spite of these problems, managing to negotiate with the world around them. The inquisitiveness of young adults needs to be encouraged, and a good place to start is handling this curiosity as it relates to sex and sexuality, allowing young adults to question norms, and in the process, recognizing their self worth.*

The purpose of the three concepts

These three themes, sexual culture, sexual identity and sexual meaning, in their distinct ways, are useful tools for examining young people's sexual conduct in other countries beyond these seven, and for doing so in a way directly related to harvesting material for developing health promotion

strategies. A few examples will illustrate the importance and subtlety of sexual meanings and their shifts, noted in all studies as vital to accurate representations of young people's sexual experience and their understanding of sexual activity and its deeper relational contexts.

> *Example one.* It is important to recognize *pror chuk* (to pump the penis), the new word that young Cambodian people have given the Khmer language to describe masturbation for men. There were many other terms noted in that study for oral and anal sex, masturbation, and so on that young people use.

> *Example two.* In this same country, it is important to understand the significant difference between *kou songsar* (a relationship without sexual activity) and *kou sne'har* (a relationship implying sexual activity). This distinction registers a shift in young people's relations with boyfriends or girlfriends to something deeper, something potentially involving sexual love. This is similar to the idea of a 'person with rights' in Costa Rica, a term which allows young women to permit young men greater exploration of their bodies.

> *Example three.* In the Philippines, the idea of *madala* implies being swept along erotically and relationally, not necessarily but often towards, sexual activity. Similarly, in Costa Rica the notion of *templado*, in both women and men, registers a kind of irrefusable body 'heat', a burgeoning sexual desire that permits, and even demands, satisfaction.

These are not just semantic differences or merely local slang. Nor is a simple argument being mounted here merely to encourage the use of local language or colloquialisms in health education. That all studies offered detailed accounts of the subtle shifts in terms used by young people for sex acts and sexual relations, indicates the importance of such detail to young people themselves. In all the countries studied, young people employ specific and finely graded terms and shades of meanings both to understand what is happening to themselves and their bodies, and to locate themselves within their culture and age group. These terms and meanings help young people to measure themselves against adults and their immediate milieux. They verify sexual progress and assuage fear, doubt, guilt and any sense of being lost to an incomprehensible sexual desire. In the adult world's deafening silence that surrounds young people's sexual conduct in all countries studied, and in the face of the appalling lack of information with which young people in every country in the study seek to understand sex, these terms and the culturally specific concepts they embody enable young people to find their sexual 'feet'. The terms encode and make possible sexual interactions. Without them, confusion reigns for young people and their bodies become their only teachers.

Health promotion that either relies on clinical lists of sex practices or concepts of sexual development that universalize the specific to the point of misrecognition (e.g., theories of adolescent development) will fail to reach young people. Again, a simple example comes from one site in the Philippines. Here, the notion of first sexual experience makes no sense when there is a commonplace of five 'sexual baptisms' for a young man: sex with an *agi* (a cross-dressing homosexual man), a female sex worker, an older woman, a girlfriend, and finally his wife. Similarly, in Costa Rica among more affluent and educated young people, virginity is widely regarded more as psychological state and therefore both young women and men 'lose' their virginity. This contrasts with a more direct physical understanding of virginity (and its loss for young women alone) among working-class Costa Ricans, thereby registering also that meanings shift not just from country to country but within countries themselves.

Similarities

A set of recurrent themes and issues emerge from the seven countries. These are: concepts of youth; the challenge to traditional cultures; gender; modernization; urban, rural and provincial aspects; and other effects of larger social forces.

Concepts of youth

Not surprisingly, all countries reported a special category for young people, although the definition and boundaries changed from country to country. There is an important lesson here: undoubtedly the category 'young people' offers a way of defining this particular population, which can be generalized so as to make global comparisons among all young people. There was a remarkably uniform concept of young people in relation to age cohort and maturation, even when the onset of sexual activity and the time to marry (the parameters in many countries) differed between age

cohorts quite markedly. So, a focus on young people is understood everywhere as valid.

Yet herein lies a danger: a kind of global, essentialist category called 'young people' tends to mask quite diverse cultural definitions. What is also clear is that definitions of young people are changing in relation to sexual activity. In Zimbabwe and Cameroon, and also in Papua New Guinea and Cambodia in slightly different ways, young women were once regarded as ready for sexual activity at or not long after menarche. In the past, in some of these countries these young women were then 'traded' as wives through various methods and customs of exchange, dowry or bride price. In almost all countries in the study (though with different kinds of explanation) young men were regarded as 'needing' sexual experience once they were pubescent, and sex with sex workers, male peers or older women was sought, encouraged tacitly or facilitated directly by older males, families or peers. Although these ideas are often couched in questionable 'naturalized' terms, i.e., related to some biologistic characteristic or 'hydraulic' proclivity,[7] the important point is that these practices all register a widely held, if unstated, view of young people as sexual beings from puberty.

Undoubtedly this view is increasingly undermined by processes of delaying young people's accession of full adult status and rights, and the extension of their dependency through longer schooling or high unemployment, noted earlier. This shift in the definition of young people up to ages of 26

at times, carries with it an explicit intention to delay or prevent young people from engaging in sexual activity that, in some cases only a generation or two ago, was seen as perfectly 'natural' or understandable.

Yet it is also clear that young people in all seven countries (and likely everywhere else) are contesting such creeping 'infantilization' with their bodies and in their sexual pursuits. Indeed, the Costa Rica report notes that delayed marriage and extended educational training, mainly at universities, among middle-class young people has actually enabled premarital sex to be more permissible among those young people, as they increasingly regard the delay as unacceptable. All seven country reports argue that exhortations to abstinence or delayed sexual activity are resisted by many young people and seen for what they are — moral agendas dressed up as health promotion.

Second, the age ranges chosen by the various studies reported here are sufficiently different to force a recognition that 'young people' is a category that must be culturally defined first and foremost, even if it is under increasing international pressure to be all-inclusive and consistent for the sake of programmatic and bureaucratic neatness. The very notion of young people as being that cohort, for example, from 12 to 26 should be regarded as a dubious fiction, and the recent broader acceptance of the definition of the 'child' as having an upper age limit of 18 is similarly questionable in this regard. In the Philippines, where 18 is regarded as the minimum age for marriage, such a definition may seem

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7   *Notions of biological or hormonal 'pressures' that build up and demand 'release'.*

appropriate for a country where the average age at first sexual activity was reported as being between 18 and 19 for young men and between 21 and 22 for young women. But this age marker is irrelevant in Papua New Guinea where the period between the appearance of secondary sex characteristics and marriage is relatively short, in direct contrast to its lengthening in the West. Elsewhere, the onset of sexual activity was reported as sometimes being as early as 9 in Zimbabwe, and in Chile 32% of young people reported having had sex before age 15.

Third, there is certainly some evidence that extended schooling and increased retention rates in some countries in this study are prolonging the period in which young people remain in this category as a cohort before being regarded finally as adults. Indeed, there were accounts from more affluent young women in Zimbabwe who are consciously delaying sexual intercourse (but pursuing other sex practices such as 'fingering' and 'smooching') so as not to affect their schooling. Similarly, young women in Papua New Guinea argued that were there more schooling on offer, they would delay sexual activity if they were likely to obtain better job prospects as a result.

This effect, however, may only apply to young women. Young men in those parts of the various samples where the most change was happening to young women's prospects, as noted in Costa Rica, Chile and to a lesser extent the Philippines, seem to accept certain changes in gender role, but this seems scarcely to affect their pursuit of penetrative sex when and wherever possible. This is an important issue for sexual

health education. In a sense there is an increasing tension between changing gender roles, and the potential sexual consequences of them, that young men are handling less well than women.

In contrast, some reports note that young people are also becoming sexually active earlier (e.g., in Cambodia), and are engaging in sex with a larger number of partners (e.g., in Chile), and a wider repertoire of practices (e.g, anal and oral sex in Costa Rica and Cambodia). All reports note same-sex activity and use of prostitutes among young men. The reports from Zimbabwe, Papua New Guinea and Cameroon note a significant and actively pursued (sometimes encouraged) culture of sex for favours, goods or cash among young women. The prospect is slim for this progressive 'infantilization' of young people producing a significant delay in onset of sexual activity, or a widespread shift to monogamy.

Indeed, the only prospect for such a delay would appear to lie with comprehensive sex education, noted in the research literature as definitely not producing earlier onset of sexual activity, and in some places achieving delayed onset. This determination of young people to have a sexual life of their own would seem to reinforce the finding in all countries in this study that sex education is wanted and much needed by young people. These seven countries report sex education as woefully inadequate everywhere, as do their young people.

The challenge to traditional sexual culture

There is no doubt that all countries are experiencing a waning of 'traditional'

sexual values and cultures coinciding with this growing pressure to identify young people as a special category. In some countries where sexual activity among this cohort was less problematic in traditional cultures, young people are using aspects of traditional culture to fashion a new one. The increase in a culturally transformed group male circumcision in Papua New Guinea, using far from hygienic means, represents a determination to create, anew, sexual meaning where it once was. Similarly, the use of sex workers by young Cambodian men receives a perverse kind of approval from the still-dominant traditional value placed on the virginity of its brides. No doubt, traditions of dry sex in Cameroon, for example, also create current problems in relation to condom use and damage to genitals, countering claims that it is the loss of sexual traditions that has led to increases in STDs. Traditional sexual culture is often involved in the production of the very 'deviancies' it deplores.

More worrying is the transformation of traditional patterns of exchange, in which sex was once unproblematically a part, into a widespread cash-for-sex or goods-for-sex sexual economy noted in Zimbabwe and Papua New Guinea. Ironically, this transformation has also enabled young women to fashion for themselves a kind of sexual independence in which body pleasures have found legitimacy. These two reports also noted that families and kin are often involved in either encouraging or setting the terms of this exchange; so, again, any appeal to tradition would appear less than unsullied by its own history.

Another aspect of the challenge to traditional culture can be found in the idea that young men's sexual needs are beyond their control and demand immediate satisfaction. Held as true by men and women in every country in this study, this pervasive myth can either be read as confirmation of modern feminism's conception of a universal patriarchy, or as proof of the particular interpretation of biomedicine that sexual interests are merely genetically or hormonally driven. More telling is the confusion expressed by so many young men in these studies as to the exact meaning of the things they feel, and their ineptitude in translating those embodied feelings and experiences into any explanation other than those handed down to them by their fathers, brothers and other males. If young people are experiencing dilemmas in relation to their sexual instincts and conduct, these country reports confirm that it is largely the failure of traditional sexual cultures to offer meaningful, actionable rules for conduct and sensible guidance as to sexual relations which is at fault. Before fault is so easily found with young people themselves, it is important to note how often we ask that they grow to sexual maturity in silence, amid misrepresentation, and on their own. If they make mistakes (according to adults' terms), it is most probably because they are inexperienced, ill informed and unseasoned, not because they are, by definition, reckless.

Gender

There is a striking convergence in all seven country reports in the experiences of young women and their difficulty of handling young men's expectation and understanding of sex acts, sexuality and sexual relations. There are a number of related issues here:

- differential cultural understandings of young women's and men's sexuality;
- different expectations of young women and young men in relation to sexual conduct;
- the centrality of virginity to young women's sexuality and challenges to that centrality;
- the experience of coerced sexual activity and rape among young women (and some young men); and
- the effects of modernization on gender roles.

Individual country reports all highlight a similar differential in cultural understandings of young women's and young men's sexuality. Although there are some differences between countries (and some divergence within countries themselves), there is a marked perception that young men are sexual beings and young women ought not to be. This is recognizable at the simplest level as the 'double standard' noted by feminist writers over the last century or more.[8] The only country to report a formal traditional pattern of young men's sexual abstinence was Cambodia, where novitiates in Buddhist monasteries once paralleled young women's period of seclusion prior to (quite early) marriage. The practice of young men entering temples for a period was almost destroyed during Cambodia's tragic recent history and is only now being encouraged anew. However, parallel evidence in the Cambodia study of male-to-male eroticism in the temples questions the extent of abstinence achieved.

In the pervasive formulation of their 'needing' sexual experience, the origin or nature of the sex partners whom these young men are so energetic to find and actively penetrate remains tacit. Unless they are animals, male peers, sex workers, or older women and men (all reported in these studies), these unnamed sex partners can clearly only be young women. So this double standard also masks an underlying contradiction within understandings of femininity itself: an implicit recognition of the sexual potential of young women and of their silenced engagement in sexual activity with young men. Another result of this double standard is that sexually active young women, or those assumed to be so, are subject to derogatory classification as sluts, whores, cheap, fallen, wayward, sick or shameful.

In these studies, one example of those contradictions in action to the detriment of young women is also a Cambodian one, where the deflowering of young women is regarded as the ultimate sport by young men (although it would appear that fewer have actually experienced it than report the desire to do so), replete with mythologies about the act itself and its consequences. Any (and many) young women so 'deflowered' are dishonoured thereby, as well as by the dishonourable action of many young men in rejecting them soon afterwards

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8   The essential meaning of the double standard is that women ought not have sex outside of culturally approved boundaries, almost uniformly marriage, and that young men must 'sow their wild oats' and gain sexual experience whenever and wherever they can. There is usually a begrudging deference to some vague notion of young men remaining sexually inexperienced as well, but this carries little weight at the collective behavioural level, even if it is enforced and valued at the individual level for some or as doxy.

for their acquiescence to sex. This double bind for young women operates hand-in-hand with a high value placed on virgin brides.

The issue of women's virginity arose in all studies and remains a dominant framework within which young women are forced to understand their bodies, their sexual interests and any sexual experience. As the best marker of the double bind for young women, virginity is still held as important in two ways: as a guarantee of the value of a potential marriage partner, and as proof of the character and worthiness of each young woman in the eyes of her partner, family and community. Yet, the value placed on young women's virginity is ambiguous for many espousing it. Young women clearly find it an uncertain barrier to sexual activity, and in Costa Rica and Chile among middle-class young people it has lost its once considerable status. The Chile report argues that middle-class young women *and* men now see virginity as a largely symbolic and psychological state, a hurdle between sexual inexperience and sexual experience to be positively leapt over. In this sense, loss of virginity for both is a rite of passage not a terrible sin. But more working-class respondents in these studies still place a wavering emphasis on virginity at odds with their more middle-class, educated colleagues. This may reflect both some impact from modern feminism and a weakening of the utility of virginity in guaranteeing anything. The Philippines study noted that births out of wedlock to famous political and artistic figures were defended as being 'modern'. In Papua New Guinea, virginity is less valued in practice than in principle, and the sexual initiation of young women is pursued

vigorously by young people and their elders. Indeed there, as in Zimbabwe, young women's claims to sexual pleasure clearly help invalidate notions of abstinence and opposition to premarital sex.

This challenge to virginity is a complex one. In Cambodia most young men still demand a virgin bride, and this is the case in other country reports. But young men's avid pursuit of penetrative sex with young women almost guarantees a growing shortage of virgins. That they cannot see the paradox in the position in which they place young women, and find themselves, remains one of the great conundrums in sexual culture. Moreover, the global influence of youth culture, despite an emphasis on romantic love (which might support waiting for marriage), increasingly validates a 'surrender to love' (as the Philippines report noted), as one of the new understandings and expectations of sexual activity available to young people today. In the face of the growing, if uneven, dissolution of virginity as a criterion of value, there is a powerful cry from young people in these reports for some clearer and less hypocritical guidance on this issue.

Nevertheless, there is still a widespread framing of young women's sexuality as an absence, or at least abstinence, in all countries studied. There is considerably more attention paid to preparing young women for their (hopefully delayed) reproductive roles. Striking in the country reports is the level of energy put into explaining to young women the ins and outs of menstruation and reproduction. There were certainly findings in many country reports that this education was

often patchy and partial, delayed or deferred, and generally inadequate. Certainly, little is said about sex or sexual pleasure, and many country reports noted a breakdown in traditional methods of educating young women in these issues — from seclusion, the guardianship of various female kin, to the guarantees incorporated in bride prices or dowries. A repeated theme was the failure of the often presumed central relationship between mothers and daughters as a source of education about young women's bodies and sexuality. Some country reports (Cameroon, Zimbabwe, Papua New Guinea) noted traditional taboos operating for this issue as well as other, more modern, pressures increasing the difficulty.

Yet, even more striking was the almost complete absence of any similar, formal, educational processes for young men. Physical responses to male puberty — inexplicable body growth, unsightly secondary sex characteristics, unexpected and untimely erections, perplexing first ejaculations, the unanticipated sensations and consequences of sexual activity — were experienced by all young men in an absence of information other than from peers and siblings. The encouragement of boys to be sexually active is doubly endowed with a desperate quest for knowledge and information in the face of silence about their sexuality. This is the double bind for young men that then intersects that for young women, noted above, and produces sexual confusion and distress. Families emerge as almost peripheral to the process whereby young men obtain any information or learn to understand their bodies and sexuality. Fathers appear irrelevant to the process, passing their responsibility to

older sons, sex workers or pornography, and ultimately entrusting their son's sexual progress to happenstance, peer-based mythology and their own adventuring — a potent mix of omission and error.

There are various versions of this same story in all country reports, which indicate that neither sex is adequately prepared by its older mentors for a confident sexuality. Yet there is evidence of a growing discourse on young women's sexuality that is productive, not merely reproductive, and speaks positively of women's sexual desire in terms approaching the notion of a sexual drive not dissimilar to the more common hydraulic notion of young men's irrepressible sexual instincts. In Papua New Guinea young women talked of their body responses to sex and to pleasure (*kisim piling* or getting feelings), which contrasted with older women's sense of sex as duty or forbearance. Young Cambodian women understand the notion of *ruam lob* (sex for pleasure) and offered at times graphic accounts of their sexual arousal and desire, although sex for pleasure is less practised among young women than young men. Even young men in Cambodia recognize desire and arousal in young women in the phrase *rormuol khloun* (bend and roll like a rat). Young women from Costa Rica and Chile, particularly from the middle-class parts of those samples, reported a loosening of constraint in regard to premarital sex (Costa Rica) and casual sexual encounters (Chile), with notions of female arousal and desire informing this changing sexual order. Importantly, young people in the Philippines report a coming-together of bodies within relation-

ships that acknowledges pleasure for both before marriage.

In young people's comments there is sometimes a distinct sense that changes in these understandings of sexual pleasure are patchy and often offered in defence of sexual 'indiscretions', loss of virginity, and distance travelled from traditional practices. Yet here again, the Cameroon report noted that sex was not regarded as bad or unnatural traditionally, and in some places young women were once prepared for and initiated into sex immediately post-puberty by female kin organizing a young male partner to assess her readiness. That said, the extent of this current renovation should not be overstated, having been most noticeable among young, middle-class Costa Rican and Chilean women, responding in part to a long-standing engagement with Western feminism in their countries.

Some country reports noted a good deal of confusion among some young men as a result of the change in young women's sexual interests and expectations. This confusion appears similar to the 'crisis' in masculinity in the West. The Chile report noted a crisis in *machista* culture, premised as it is on sexual adventuring, initiation and conquest, brought about partly in response to young women's new sexual assertiveness and a rupture in the salience of virginity. The Costa Rica study found evidence of some accommodation among young men to this change in sexual roles at the level of gender roles (e.g., doing more housework, defending women's right to work), but prevailing discourses of 'good/bad' women, men's 'natural' sexual assertiveness, and women's 'natural' inclination to marriage and

child-bearing have barely been dented. A more disturbing finding from Papua New Guinea noted that the developing of young women's desire and sexual interests, in conjunction with the ascendancy of the cash economy, has left young men, many of whom are unemployed, without the cash to pay for sex in a society where sex in exchange for goods or favours has a long, traditional, if rapidly transforming, cultural pattern. One response to being cut out of this rapidly emerging sexual economy was a widespread, rationalized resort to rape.

These studies were not quantitative in nature and cannot apportion this experience of coerced sex to any percentage of young women (or men) with confidence, but that does not diminish the seriousness of the issue and the necessity for programmes and interventions to minimize this very serious threat to sexual health. The widespread experience of coerced sexual activity among young women noted in many country reports is gravely distressing. The most graphic account of the institutionalization of rape and also pack rape of young women was, undoubtedly, reported in the Papua New Guinea study. There, the suggestion of a connection between traditional definitions of gender and sexuality should not render the experiences of Papua New Guinean women as exotic. The Papua New Guinea report argues that something more profound is occurring — a change in sexual culture that is registering pressures and distresses from larger social forces, such as economic modernization.

The data in other country reports, and the upsurge in reports of sexual

assault, pack and date rape, rape in marriage, incest and sexual abuse, and rape of men in the West signify a larger, similar arena of crisis. The studies conducted here do not attempt an explanation for that larger crisis; nor can this comparative report. But, combined, the disturbing evidence of coercion in sex in these reports warrants an urgent, considered inclusion of this issue in any conception of sexual health and HIV/STD prevention.

This overview of young people's sexual culture has highlighted already a set of tensions in the gender differentiated pattering of young people's sexuality, with quite common patterns emerging in all countries, if in different ways. These tensions are influenced by longstanding or traditional gender differentials, themselves under pressure. There are both encouraging findings and disturbing consequences at the level of young people's sexual culture, of the destabilization of traditional understandings of sex and sexuality, and of the impact of gender on sexuality. It is important to note that these findings reveal processes of both *de*struction and *con*struction, not merely some descent into chaos. Change is occurring in sexual cultures in all the countries studied with uneven effects and at various paces. There is a strong sense of young people being at times somewhat rudderless, yet also active in creating new meanings and giving themselves often quite adequate directions. The glaring omission in this active response to change is young people's distinct lack of understanding beyond the personal, interpersonal and milieux levels of the impact of large-scale social change on their sexual conduct. One of the greatest dangers young people face, and one of the great disservices we do

them, is to reinforce the delusion that sexuality is an individual, freely chosen or merely interpersonal experience. Fostering an awareness of the structural, larger, socioeconomic forces that impact upon sexual conduct in all societies may prove to be a more rounded context for helping young people assess their risk in the face of HIV/AIDS. In other words, sexual and drug-related safeties may amount to knowing not just the rules of a game, but also the arena in which it is to be played.

Modernization

Social and economic development and modernization do not simply change the day-to-day conditions and circumstances in which people find themselves. They also affect personal and interpersonal life at the level of the body, the sexual development of the self, and understandings of desire and pleasure, and expectations of both. All studies reported the marked effects of economic modernization and the pressures caused, in particular, by rural transformation and increased urbanization. In addition to the changes at the personal level listed above, these pressures assist, among other things, in providing the infrastructure (bigger cities, bars and clubs, gymnasiums, etc.) for greater sexual opportunity among young people (and adults as well). Modernization brings with it new understandings and ideas to justify how life might be lived differently from traditional ways. These understandings and ideas facilitate sexual experimentation and the breaking of traditional sexual rules.

The Cameroon study in particular noted how urbanization had undone the patterns of exogamy that pre-

vailed in traditional village life. A significant increase was reported in the range and number of sexual partners now living in close proximity. Simple changes, like the arrival of a road or highway, vastly increase the sexual traffic as well. This was noted in Papua New Guinea and Zimbabwe, partly through the arrival of outsiders (truck drivers, military personnel) but also by encouraging settlement at points on the roads as well. In Zimbabwe, the growth of the dormitory town of Mbare, both as a result of previous colonial government's policies of racial separation, but also as a result of more recent migration to the economic opportunities seemingly offered by Harare, has led to a new sexual culture in its own right. Here, new patterns of sex work, an intensity in habitation leading to losses of privacy, and an expanding number of commercial entertainment venues provide increased sexual opportunity. This, at one level, may seem unproblematic, but it clearly provides a fertile ecology for increased sexual activity, increased numbers of partners and the increased likelihood of STDs.

With this kind of mobility and urbanization comes a kind of new sexual infrastructure in the form of bars, discothèques, and other venues. The Zimbabwe study also noted the development of similar infrastructure around coach terminals. This infrastructural provision not only applies to large urban centres. The Papua New Guinea study, for example, noted the existence of similar venues on a small scale at village level and suggested a direct link between such venues and pack rape. The dramatic rise of bars and similar establishments after the arrival of the United Nations Transitional Authority in Cambodia (UNTAC) in 1992 greatly increased the opportunities for young women to pursue a social life with acknowledged sexual aspects (e.g., as bar girls), beyond that previously available. In Chile, the 'party' ethnography in a discothèque pointed to the similarly important place of new social venues, in this case a sophisticated discothèque that encouraged, facilitated and legitimated seduction.

A discussion of the importance of spaces for young people is presented later, but it is important here to note the increasing size and availability of commercial infrastructure and its impact on the changing patterns of sexual engagement for young people. The significance of this escalation in commercial infrastructure has yet to be adequately recognized in HIV/STD prevention strategies.

In Papua New Guinea, modernization has produced dubious benefits as the economic gains made in the past 50 years are destabilizing just as the HIV epidemic is increasing rapidly. The net effect of the dramatic shift to a cash economy has in part transformed many traditional patterns of exchanging sex for goods (and the more enduring exchange of bride price in marriage) to the point of increased participation of women and men in a kind of commercially organized sex work. Sex can be traded for cash, and since cash is hard to come by for young people, this has led to an increase in both female and male sex work.

The impact of economic development was not confined to countries such as Zimbabwe, Papua New Guinea and Cameroon. Costa Rica reported uneven effects of economic develop-

ment in its comparative analysis of two sites, 'Villa del Mar' and 'Villa del Sol'. 'Villa del Mar' is a small, marginal, largely working-class town with a deteriorating economic base and high levels of unemployment and under-employment. 'Villa del Sol' is an inlying suburb of San José with a modern middle-class culture and brighter economic prospects for its well-educated young people. There were notable differences between young people in these two sites in relation to decision-making about sexual activity, education and prospective professional imperatives, notions of sexual rights, such as monogamy, virginity and sexual initiative, and in understandings of sexuality, which were definitely related to access to educational resources and other social and cultural capital. In Chile, similar striking differences were found between middle-class students and young workers, and that research team was even motivated to add a third sector to their sample, 'the inactives', to register the significant differences in sexual activity and understandings found among these impoverished young people on the fringes of the youth labour market, with scant education and few foreseeable life prospects. In Zimbabwe, this differential impact of economic development was noted among more affluent high-school students from a middle-class area of Harare, where there was some evidence of young women delaying vaginal intercourse based on their judgements about their social and economic prospects.

Recognizing the socially stratified effects of modernization on sexual activity and culture is not a simple or obvious task. All country reports stress — as a result of the differentiation noted, among other things, in

social and economic terms — the need to disassemble the singularity of the term 'young people'. All reports noted the significant differences among the young people in and between the various sites studied. These differences were not merely the product of the research design, for no country used the same axes of comparison except for gender. In other words, these patterns of differentiation are likely to be readily translatable from country to country. In utilizing the social class differential used in Costa Rica, the Philippines, Zimbabwe and Chile in Cameroon, Cambodia or Papua New Guinea, similar patterns of difference might be found; alternatively, employing the rural/urban site selection used in Papua New Guinea and Zimbabwe in Chile and Costa Rica would throw light on different patterns of differentiation there as well. One conclusion to be drawn from this study is that any simplistic characterization of young people as a singular homogeneous population is a serious error of judgment if it dominates the design of health promotion and HIV/STD public health programmes. The recommendation from all country reports, that single nation-wide approaches to prevention education are inappropriate, and that local, context-specific health promotion is by far the preferable strategy, is highly significant.

When the middle-class sections of the samples in these studies are set aside, a common feature for all other young people is their wretched socioeconomic situation, facing non-existent or degraded youth labour markets, poor prospects for education and training, and little social support at community level. The

Costa Rica study argues that it should come as no surprise that young people's bodies become their only resource in these circumstances, and the pursuit of sex remains one area of activity in which success, pleasure, self-worth and emotional depth are experienced. The importance of sex to young people in the face of such unyielding socioeconomic marginalization can never be overstated.

Urban, rural and provincial aspects

Migration to urban areas is not a new phenomenon, but the Zimbabwe, Cameroon, Papua New Guinea and Cambodia country reports all commented on this issue and noted the significance of urban/rural differences. Papua New Guinea in particular reported circular forms of migration with relatively frequent movements between village, town, city and back, rather than the semi-permanent form noted in Cameroon, or the seasonal movements noted in Zimbabwe, linked to harvesting, mining and other forms of seasonal work.

These different forms of migration have a number of consequences. First, there is a marked weakening of traditional ties with family, with kin and with traditional sexual cultures. A second consequence is the enhanced availability of sexual partners (noted above). The third is the expansion of various kinds of sex for favours and other types of informal exchanges, in addition to the institutionalization of various patterns of more directly commercial sex work. Cameroon in particular reported periodic sex work tied to wage payments as a feature of this form of migration, with influxes of young women to towns or other sites where men migrate in search of work.

Other effects of larger social forces

All the reports indicate the impact of larger social forces. Development and cultural tensions, immediate histories, or processes of modernization are not simply context as 'backdrop', but context as 'structure'. If we research sexuality without reference to these larger forces, but simply at the level of individual or even aggregated group behaviour, we shall fail to understand the motivation for sex. We shall also fail to see the constraints and enabling dimensions of these larger forces underlying sexual culture and its changing emphases and importance not only for young people but for all sectors of society. HIV/STD prevention cannot ignore these larger forces. They are the constituents and determinants of health as much as individual behaviour is. There is a need to move beyond a narrowly behavioural model of health and individual risk to take seriously the broader structural understanding of vulnerability (through class distinction, race, gender, age, socioeconomic opportunity, social and cultural factors) reported here.

Comparisons

We will now look at those aspects of young people's sexuality that have implications for the design of future prevention efforts. The main comparative frameworks that emerged from the country reports were as follows: the impact of dominant sexuality frameworks; onset of sexuality activity; the centrality of bodies; mass media; space; HIV risk assessment, condom use and ideas on safer sex.

The impact of dominant understandings of sexuality

All country reports recognized that dominant understandings of sexuality emanating from the churches, the state and its laws, and from medicine and public health, are still powerful in shaping sexual understandings and, sometimes, activity among young people. They do so, however, in ways that often conflict with young people's experience and expectations of sex itself. Strong concern was also expressed by a number of research teams at the apparent failure of these dominant understandings, first, to grasp the complexity of young people's sexual culture and, second, to comprehend the impact of that reality on HIV/AIDS.

Churches were singled out in Costa Rica, Papua New Guinea, the Philippines and Cameroon for their failure to endorse condom use as an HIV/STD prevention strategy in those countries. The Cambodia report noted the need for a stronger and more active role for the dominant Buddhist religion in similar terms. These are not simply anti-religious calls for action on the part of the research teams; they are grounded directly in the empirical evidence in these studies that young people's sexual lives and sexual culture have been transformed in ways that are deep and complex, and that such change will continue. Exhortations to abstinence and celibacy, fidelity or delayed sexual activity, or to return to 'traditional' sexual transactions will definitely be disregarded, ignored, brushed aside or transcended by young people under the pres-

sures of modernization, the internationalization of youth culture, and the clearly proven sense of legitimate 'ownership' of sexuality that young people claimed in all countries studied.

The Cambodia report in particular urged key adults working with young Cambodians not to continue to use myths about sexuality drawn from their own experience alone, or from a Cambodia of a near-mythical past. The dramatic and often tragic recent history of that country demands a recognition of a deep and immutable transformation in sexual life, the report argues, requiring a somewhat hard-nosed approach to present dangers rather than a reliance on a kind of romanticized Khmer history. This argument about working with the present offers advice of value beyond the boundaries of that particular country.

A third area where dominant understandings are not applicable to the current sexual conduct of young people is in relation to same-sex activity. The *General Research Protocol* of the study did not direct country research teams to explore this issue. Those research teams that pursued the issue found it relevant to their design or salient to their analysis as fieldwork progressed. The findings indicate that many young men (and some young women) in all countries are willing to try, and find pleasure in, same-sex activity. It is also clear that the definition of these activities within the Western model of 'heterosexuality'/ 'homosexuality'[9] is culturally inapplicable to most countries, and confounds prevention efforts on this issue.

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9   *Often read as 'majority'/'minority'*

In circumstances where these dominant understandings might offer adequate and accurate guidance and information about sexual matters including HIV/AIDS and STDs to young people, most notably in schools and other educational institutions, all country reports bemoan the inadequacy of available programmes. Either these are restricted to the biologistic or the moralistic, or glaring in their omissions (e.g., women's sexual pleasure and same-sex activity) or partiality (e.g., sex equals reproduction). Indeed, the Costa Rica report notes that young people are often left to survive on myth, 'magic' and muddled thinking instead of clear scientific information about human sexuality. Other countries reported similar, often wildly inaccurate, ideas about sex and the body used by young people in their efforts to make sense of what is happening in their lives. Although some of these ideas can be dressed up as alternative explanations or local traditions and understandings, many others are just myth, as a close reading of the individual country reports reveals.

Onset of sexuality activity

The great variation in ages for onset of sexual activity confirms previous findings that there can be no generalized starting point for young people's introduction to sexual activity based on the arbitrary distinction of young people as a universal category or age cohort (Cleland & Ferry, 1995). Also, the seemingly accidental initiation into sex in most young people's accounts must be interpreted as complex culturally specific moments, which will necessitate a significant rethinking of prevention education among the presexual.

For example, not only do peers, particularly male peers, provide a social arena for experimentation and encouragement for initiating sexual activities, with girlfriends or boyfriends, sex workers or in group sex, but young people also provide each other with special words, phrases and a quite sophisticated sexual discourse to employ in pursuing, enacting and understanding their sexual conduct. This discourse, documented particularly well in the Philippines study for example (and offering a strong argument for the research method employed), is in fact a powerful structuring of sexual experience, in a sense providing an already well-trodden, culturally specific path toward sex rather than away from it. Not all young people follow that path to premarital sex — there are consistent, if few, accounts of restraint in all country reports — but the prevailing sexual culture of young people in this study seems to be increasingly moving toward a wide acceptance of premarital sex. This acceptance is similar to the rapid changes in young people's sexual conduct in the West following the evocatively misnamed 'permissiveness' of the 1960s and the invention of the contraceptive pill.

Embodiment

One of the richest sets of material obtained by the country research teams concerned the body's responses to sexual activity. This is an area of sexuality research that is often ignored empirically and yet is crucial to understanding the experience of sex. Young people in most country studies talked of the experiences of their bodies, the sensations of arousal, ejaculation, orgasm, pain, pleasure, and the physicality of the partner's

body and their own in the midst of sex. There are quite honest accounts in some studies of the sensations of various practices such as masturbation, first penetration (vaginal and anal), oral sex, and group sex that are encountered by young people in a completely unprepared state. Not only are the basic knowledges about sex and reproduction quite often absent from the understandings, meanings and ideas young people bring to their growing sexual desires, but their bodies once engaged in sex reveal what they have not been told or prepared for at the level of physical actions and responses.

This should be of vital concern to sex educators and health promotion professionals. In the absence of any adequate information about the nature of the body's capacity for sexual arousal and response, simple information about the mechanics of sex becomes lost, forgotten or irrelevant when sex is actually happening. The dangers here for HIV/STD transmission are obvious. Getting 'carried away' is shorthand for the physical responses in sex overwhelming judgement, and this warrants an inclusion of explicit information on the body-in-sex in preparing young people for the sexual lives they are exploring. The absence of such information will inevitably mean that the body's sensations alone will lead young people toward pleasures that will not be denied.

Mass media

Wider social and economic forces in each country are certainly altering sexual possibilities for young people, but in ways largely invisible to daily experience. One simple example here concerns the impact of new media technologies, such as videotapes and magazines, which in a number of country reports were listed as sources of information on sex for young people. These are sources of information valued by young people. Various countries reported the impact of 'romance' literature, popular music, film and the like, and it is important to note that although pornography was more readily available through these new technologies, not all such material enjoyed by young people was pornographic. Care should be taken to record the differential impacts of new technologies and the type of messages they disseminate. Increased access to globalizing technologies is not just going to affect young people in developing countries, but everywhere, and adults will not remain untouched by these developments either.

Space

The country reports all register the importance of space to young people, not only as places where the social interaction that precedes sex occurs, but also in relation to the real possibilities for sexual activity such spaces create, and in which young people often create specifically sexual opportunities. The most dramatic example of this was offered in Chile's ethnographic account of 'parties' and 'partying'. This account focused on the significant difference between peer-organized, informal, social events that offer space in private homes for getting together, drinking, listening and dancing to music, flirting and maybe having sex, and a more formal space created by the discothèque, where young people rely less on couples and peers, where music and dancing are

erotically enhanced by a deliberately designed atmosphere, and young people are able to pursue almost anonymously a more casual kind of sexual encounter. There may even be sections of such venues that facilitate preliminary sexual activity. This is not an unfamiliar scenario in any major city in the world today, and such venues in some countries are governed by various laws on alcohol and drug use or rules of proper sexual behaviour in public. But the Chile example warns that any reading of the idea of 'sex-on-premises' venues as being simply restricted to brothels, massage parlours, bathhouses and the like, is clearly mistaken. And the idea that all such venues are 'adult-only' spaces is no longer sustainable.

Even if some of these places can be regulated in some way by laws or rules of public behaviour, not all can. In Papua New Guinea, it is clear that many dance halls and related alcohol or drug use are rarely policed or policeable. The attendant sexual activity noted in the Papua New Guinea report, including significant amounts of sex for cash or favours, group sex and rape, is directly facilitated for young people specifically in such spaces. In Cambodia, places such as Khren Sray (a recreational resort on the river outside Phnom Penh) are well known and understood to be sites of seduction and lovemaking — not just for the young at heart. There is a kind of humorous and tolerant acceptance of the existence of such spaces, for Cambodian culture is not anti-sex.

Beyond such recreation spaces there are also the specific sectors of cities and towns set aside for sex work encounters, and for young men par-

ticularly these spaces grant licence in a way not permitted with girlfriends. The Cambodia report is again instructive on this issue. It notes the possibility of more varied sexual practices with sex workers, including anal intercourse and group sex, and a very important distinction being made by young men between sex workers (most often Vietnamese women), what is permitted sexually with them, and how they are treated and regarded. The 'good/bad' ('virgin/whore', 'Madonna/Magdalen') distinction, used against sexually active women and noted in most countries, is doubly cruel when it is linked to forms of racial or ethnic distinction. The mythology in Cameroon that Pygmy women must be forced to have sex is a similar example.

The common acceptance of, and often outright support for, young men using the services of sex workers and going, often in groups, to visit the places set aside for them, create a reasonably observable sexual space. More readily observable, but less understood, is ordinary street life read as erotic space. The Costa Rica research team effectively used street observation to uncover the eroticism of the street, and their report argues that street life is crucial to young people's sexuality, particularly poorer young people. In the street, young men (who often and usually have more freedom to traverse such spaces than young women) meet peers, older men, homosexuals, sex workers and potential sex partners. They see seduction and sometimes even sex acts. Spaces for sex to occur — parks, beaches, alleys, in cars, behind fences — become inducements, enhancements, adding *frisson* (as the Costa Rica report argues) to the illicit, turn-

ing sexual adventuring into a repudiation of the private and narrowly approved kind of sex young people are expected and hoped eventually to pursue.

The central argument from this discussion of sexual space is that young people inhabit a number of differently structured spaces: spaces they create; spaces others create for them; spaces created for others but which young people traverse; spaces specifically for sex; spaces that are sexually charged. Indeed, it is clear that young people are not and cannot be quarantined from sexual spaces, unless adults are prepared to 'de-sexualise' the spaces they themselves currently enjoy — and that is highly unlikely to happen. Such spaces cannot be targeted for health promotion in uniform ways; they need thoughtful and appropriate techniques of intervention. Developing interventions for these non-institutional and informal sexual spaces will require more grounded and localized approaches than can be achieved in the formal curriculum of a sex education programme for instance, or for that matter in large-scale, mass-media campaigns. Young people themselves are vital to the development of such programmes geared to informal sexual spaces, for without their guidance and disclosure adults will be refused access to these carefully guarded secrets.

HIV risk assessment, condom use and ideas on safer sex

All reports revealed a marked convergence in actual risk-taking among young people, even in the context of significant and serious consideration by young people of safety and risk. It is clear that HIV itself is not sufficiently prioritized to override other considerations in relation to young people's sexual expression. This conclusion warrants more respectful consideration in any rethinking about the character of young people's risk assessment.

There is clearly strong evidence that many young people have dangerously poor levels of knowledge about HIV and STDs, and some countries have evidence from previous studies of high levels of risk-taking, e.g., Papua New Guinea, Costa Rica, the Philippines. These poor levels of knowledge and worrying levels of risk-taking are not uniformly spread across all samples of young people studied, demanding again that the simplistic declaration of all young people being 'at-risk' by definition, simply because they are young, be set aside for a more sophisticated recognition of the social and cultural contexts in which risk is constituted. For example, the Papua New Guinea report noted that condoms are very favourably accepted by young people there; how to access and distribute them in the context of a rapidly deteriorating public health system is the real problem. Social marketing of condoms needs a strategy in this context quite different from that employed in places where condoms are readily available but not used (Philippines), or disliked for their interference with *machista* concepts of sexuality such as in Chile.

Conclusions

The similarities between countries involved in this study provide compelling evidence of a complex and heterogeneous situation for young

people that can be generalized to many other countries on reflection and with due care. There is little to be gained in developing HIV/STD programmes among young people from homogeneous, simplistic, universalizing and deeply romanticized visions of young people as one inevitably at-risk population. *There really is no one population called 'young people' and no one strategy to be developed to provide for them.* Naïve understandings or any oversimplification of the complexities underlying terms such as 'vulnerability' or 'at-risk' can easily lead these to become catch-all clichés that distort rather than assist our understanding of the situations in which young people find themselves in relation to sexual health. It is far more useful to pursue the understanding of young people's sexual behaviour in the context of their immediate peers and surroundings. There, we must take into account local cultural forms and expectations of sex. We must also include the physical attractions and sensations of sex, and must reckon with any dispute between all of this and the dominant understandings of sexuality that would appear largely to fail to inhibit or alter young people's interest in sex and sexual relationships. But we must also not forget the larger, socioeconomic contexts implicated in the potentials in, and constraints upon, young people's daily lives. Sex becomes much more meaningful, sought-after and even legitimate in the face of a rapidly changing but uncertain world.

This rethinking of our understanding of young people's sexuality requires a shift in emphasis from the merely behavioural and descriptive, to the more sociocultural and interactionist. Young people's sexual conduct needs to be understood as directly related to the quality of their relationships with each other and the place sex has in developing those relationships. The daily social life of young people is deeply bound up with sex acts and sexual meanings. This interpretation requires that we reject notions of young people as victims, as passive, as vulnerable lost souls on the brink of self-destruction (pervasive ideas about them). We need to recognize the rich resources that young people actively draw upon, create and then bring to their own sexual pursuits and interests. It is only by recognizing young people's capacity to act on their own behalf that we will be able to develop a realistic understanding of their sexual lives. This understanding will provide the most effective and reliable stance from which to work with young people to help them develop active ownership of their health and, consequently, to take responsibility for managing their own HIV/STD risk.

CHAPTER 5

RECOMMENDATIONS

The country reports contain a number of recommendations for the specific countries that took part in the Contextual Factors study, and many of these offer useful ideas to other countries as well. These individual country recommendations will not be presented here; they are available in the full country reports and are noted in the country summaries in the Appendix to this report. Instead, we will concentrate on key themes and issues of relevance to those involved in programme development and implementation with and for young people under the following headings: conceptual leadership; programmatic responses; gender; dissemination; and research.

Conceptual leadership

The similarities and comparisons discussed in Chapter 4 offer new starting points for rethinking issues related to young people, HIV/AIDS and sexual health. They promote a more sophisticated understanding of sexuality and social relationships, which contextualizes sexual practices and relations with their meanings and intentions, their origins and foundations, and includes their capacity to transform culture. This kind of understanding of young people's sexual conduct is more immediately useful, more easily apprehended, and more directly translatable into programmatic responses than descriptive statistics of sexual practices, social epidemiological modelling of risk-taking, or standard discourses of young people's vulnerability.

In the light of this, we urgently need to shift the frame of reference from the hitherto naïve and simplistic representations of young people and HIV/AIDS toward this more sophisticated and directly useful framework. The starting point is a significant reworking of the concept of vulnerability and a prioritizing of young people in relation to risk-in-context, as distinct from merely as 'at-risk' by definition.

Programmatic responses

A marked upgrading of effort in HIV/AIDS prevention and sexual health promotion among young people is also needed. This means introducing, developing and upgrading of sex education programmes in educational institutions. This requires distinctively educational expertise, different from that of medical or health promotion professionals, and will involve including new bodies of expertise from the educational specialities (curriculum development specialists, teacher trainers, classroom materials producers, pedagogy evaluators, community and adult educationalists, those skilled in school management, and so on). The intellectual discipline and professional field of education is large and specialized, with enormous resources for enhancing countries' responses to HIV/AIDS. The formal education sector, intellectually and professionally, has mostly been ignored in the narrow definition of health that presides in most countries and in many international responses to date.

Young people in these studies value any information they have received

from their schools and university-based programmes, despite the fact that they regard it as woefully inadequate most of the time. The willingness of young people to engage in formal sex education (governmental and religious opposition notwithstanding) is a tremendous resource not to be wasted. There is important international work to be done developing generic frameworks for HIV/STD sex education at various institutional levels. These clearly need to outline the coverage of human sexuality to be addressed and the undeniable need for basic information on HIV/STD prevention, such as condom use.

Providing technical educational guidance in the development of sex education programmes will require more than a shift in expertise toward educationalists; it requires tackling those quite powerful discourses and institutions that refuse young people respectful recognition of their sexual reality. Condom use is very patchy among young people, and premarital pregnancy would appear on the rise in most countries in this study. Encouraging condom use by young people cannot be other than a first priority. Health promotion that ignores the realities of an authentic sexuality for young people and thereby denies them adequate access to condoms is condemning them to enhanced HIV/STD risk and rising rates of premarital pregnancy at younger ages.

Parents are struggling to deal adequately with the rapidly changing sexual culture of young people. Traditional forms of sexual training are often partial or no longer working, and larger socioeconomic forces are often destabilizing whatever capacity families have to deal with their sexually maturing offspring. There is a need for programmes of support for adults who work with young people, including families, to take advantage of the declared willingness of young people to learn and their desire for assistance revealed in these studies. Simply reinforcing traditional educational relationships will not work; new approaches are needed and this may require further research, but there is a valuable health promotion resource available in both the concern of adults and the willingness of young people at least to listen to and hope for information from those adults.

Many young people in developing countries are not in educational institutions and even more are not in the workforce. Out-of-school health promotion is therefore a priority. Ethnographic research methods can be of value in needs assessment, local area assessments, in the observation of local sexual cultures (spaces, processes, language and intrigues), in the rapid assessment of sexual networks, and so on. There is a need for skills training for those working with young people out-of-school to assist them to obtain efficiently, and utilize effectively, the kinds of information gained.

Gender

Renewed focus is needed on the enhanced risk many young women face with reference to HIV/STD, noted in every country report in the Contextual Factors study, and confirmed by other recent research from the International Center for Research on Women (Weiss, Whelan & Gupta, 1996). The growing practice of

exchanging sex for cash, goods or favours; the increase in intermittent sex work related to (sometimes transient) economic need and migration; an increasing recognition of women's sexual pleasure; the widespread and undeniable experience of young women of coerced sex; the impact of globalizing sexual cultures: these are as much an urgent part of the HIV/STD agenda as is condom promotion and sex education. Young women are not, by definition, merely 'vulnerable', they are actively engaged in the production of their sexual cultures, albeit with fewer culturally approved ways of controlling their own bodies and exploring their own desires than men. Yet, there is solid evidence in this study, particularly from young women in Papua New Guinea and Cambodia, which indicates that it is foolish to ignore young women's active pursuit of sexual interests and pleasures. Young women in Chile, embracing their desire for occasional or casual sexual encounters, are clearly determined that they are not to be regarded as wayward, wicked or sexually loose, or in any other terms that have previously accompanied young women's premarital sexual activity. It is important also to note, for example, that young women in the Philippines and Zimbabwe regard young men's sexual attention and activity as necessary parts of developing sexual relations; lack of such attention is often read as serious lack of interest and threatens the development of the relationship toward marriage. There are many other instances in the findings of this study that indicate that any conceptualization of young women as sexual victims, and of their sexual experiences as unfortunate and inauthentic, will be soundly resisted by young

women themselves. There is a very positive image of young women's sexuality emerging from these studies, and it must be respected.

But gender does not simply equate with women; it concerns men as well. It is clear from every country studied that young men are sadly neglected by families and societies when it comes to their sexuality and sexual development. For all their sexual activity, for all the instances of sexual distress and anguish they inflict on young women, young men pursue sex and are left to pursue sex and their understanding of it in almost total silence and the absence of support. It is not surprising therefore that they get it wrong so often. There is a clear need to demarcate a specific agenda for young men in addition to that for young women which is already established. Growing international interest in men's health, increasing evidence of poorer health outcomes for men in many countries, and evidence in these studies of marked same-sex and group-sex activity and increasing use of sex workers, argues for a speedy development of effort in this area. Young men's sexual health is not just about STDs and HIV prevention, or a focus on men as clients of sex workers; it is about recognizing the sexual needs of young men, their search for information about their desires, experiences and bodies, and the help they need in facing the impact of those same, larger, socioeconomic forces that their female counterparts have to contend with. This argument is not a claim to equal time and equal space. It is a recognition that unless attention is paid to young men's sexuality, most efforts to help young women will be largely ineffective. The interdependence of the situations for both sexes is clearly revealed in these studies.

A final caution must be issued here: the owned, authentic and pursued sexual life of young people in these studies demands that attempts to intervene and assist them are not done at the expense of one sex for the other. Representing young men as 'predators' is as counterproductive as representing young women as 'victims'. Ultimately, the importance to young people of their sexual lives and relationships with each other will lead them to reject such representations and the health promotion messages accompanying them.

Dissemination

Some of the findings of the various country reports in the Contextual Factors study are country-specific and are not generalizable in any conventional research sense. But each is instructive both methodologically and substantively. There is significant utility to be gained by disseminating these findings to ministries of health, ministries of education, national AIDS programmes, peak and local non-governmental and community-based health promotion organizations, HIV/AIDS resource centres, and to community educators themselves. Education departments responsible for sex education, personal development programmes and the like will also be a receptive audience for these findings, as are professionals and volunteers working with out-of-school young people. Researchers too will benefit from understanding the utility of the methodologies used by the various country research teams in this study.

There has been significant and ongoing criticism of HIV/AIDS research in many developed and developing countries for its lack of foresight in relation to dissemination of findings and their implementation within programmes. Within the countries involved in this study, it would be a great shame not to see the findings widely discussed and implemented.

Research

The findings from these seven countries and the comparative analysis reveal the strength of this kind of research in getting to the heart of complex social problems that compound the impact of HIV/AIDS. A simple example of this is the qualitative difference in utility and depth between survey findings on frequencies of unsafe sexual practices and the notion of sexual cultures explored in these studies. Although the former focuses attention on patterns of risk-taking and potential population targets, the latter is more able to offer people developing interventions the wherewithal to generate them. Thus, the methodologies are not (and have never been) in competition; they complement each other in very important ways and both are needed to provide proper research advice.

It might be argued that many countries, however, do not have these research capacities and few would be able to undertake research of the complexity of this study. Yet, even though the research teams who undertook this study were not all experienced in qualitative research methodology, the research process itself provided remarkable training in new skills and the consolidation of existing skills for all teams. The theoretical shifts were also significant. The findings of the country reports clearly indicate the sophistication of these

teams and the work they undertook. This argues for the development of programmes of in-country research that include components for strengthening research capacity. Close-focus research is ideally suited to this purpose and, as the findings of this study reveal, also offer rich materials for immediate use in developing programmes for the target populations.

Part of the Contextual Factors study's success is due also to the overall design of the project, from the development of the *General Research Protocol* (which held up remarkably well as the ground work for all the studies), through the technical support provided at a number of stages in-country and from Geneva, to detailed guidance for the writing of final reports. This suggests the development of social research models that combine clear research design principles, methodological innovation, and flexible research management and support techniques. It is important not to set research priorities on the basis of pressing research concerns or issues alone; there is as much to be gained by stimulating and developing social research 'processes' and relationships as there is in concentrating on 'content' and research agendas. The spin-off from this approach is considerable in terms of in-country research planning, resource allocation and capacity strengthening, and increases the focus on health promotion as a research-informed activity, both for prevention and for health management for people with HIV and AIDS.

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Part 2

Community responses to AIDS

Peter Aggleton and Ian Warwick[1] *(from an original analysis by Ian Warwick)*

INTRODUCTION

The global epidemic of HIV and AIDS has brought with it some of the greatest devastation known this century. There are few places in the world untouched by HIV and its ability to irrevocably alter the lives of individuals, families, communities and societies. But as numerous authors have pointed out (see, for example, Mann, Tarantola & Netter, 1992; Mann & Tarantola, 1996; Piot, 1997), AIDS is not simply a biomedical phenomenon, it has profound social and personal consequences. It has the potential to inflict the most terrible pain and suffering, to end all hope for the future, and to rearrange lives in ways that could never have been anticipated. It separates parents and children, husbands and wives, brothers and sisters, lovers and friends. It can destroy economic systems, and the capacity of towns, villages and communities to provide for themselves (World Bank, 1997). And it can inflict an intolerable burden on hard-stretched health services in both developing and developed countries. Yet AIDS also has the potential to trigger responses of tremendous courage. Like many catastrophes, it can bring out the best in people — the capacity to care for others, the desire to show understanding in times of crisis, and the ability to offer support in extreme adversity. And here lies the paradox, for in the midst of this damage and destruction lies the means to teach us what we are — a global community united by a common desire to deal with HIV and AIDS, and its impact on households and communities worldwide.

It is against this backcloth that the studies described in this report were undertaken. Knowing more about how households, families and communities cope with HIV disease is of great importance if we are to develop programmes and interventions to reinforce positive responses and to counter more negative reactions. Yet as the studies described here make clear, local responses to infection have their origins in often long-standing community structures and beliefs. These include how HIV and AIDS are perceived and understood locally, traditional ways of coping with illness and disease, assumptions about the responsibilities of families and neighbours in times of crisis, and stigma and discrimination in relation to diseases acquired sexually and/or through drug-related activities.

The principal aim of the research described in this report was to identify some of the ways in which households and communities in different parts of the world have responded to the AIDS epidemic, and to draw conclusions about the kinds of activities and programmes that might usefully strengthen existing responses for the benefit of people living with HIV and AIDS, their carers and their communities. Following an initial assessment of potential study sites, the countries in which the studies were conducted — the Dominican Republic, India, Mexico, Thailand and the United Republic of Tanzania— were selected by the Steering Committee for Social and Behavioural Research of the World Health Organization's former Global Programme on AIDS. In each case, and with the support of national authorities, local principal investiga-

tors and teams undertook the studies which are described, often in close collaboration with nongovernmental organizations and groups of people living with HIV and AIDS. This was a deliberate strategy since it was believed that only by being close to the ground would insights of real value emerge.

The research methods adopted in each case were largely qualitative and exploratory — the aim being to identify recurrent themes and patterns of response, perhaps as the prelude to later more quantitative enquiry. A general research protocol for the studies provided an overall framework within which the research was to be conducted, but principal investigators and their teams were invited to refine and extend this basic framework in accordance with local needs. Two contrasting sites were chosen within each country, and in each of these an initial rapid assessment process, or RAP, preceded a period of in-depth data collection. The latter most usually involved interviews with key informants, people with HIV and AIDS, affected families and households, focus group discussions, and observation. Data was analysed thematically in relation to a series of research questions outlined in the general research protocol and to identify site specific issues of relevance to the planning of future programmes and interventions. A series of individual country reports were developed and are available direct from the principal investigators (see p. 99). This comparative analysis of findings identifies the major themes and issues emerging across all five countries. In keeping with the methodological commitments of qualitative and exploratory enquiry, no effort has been made to quantify the responses given. The themes highlighted, however, are those which local investigators identified as typical and recurrent within their sites. Idiosyncratic and unusual responses are always cited as such.

The studies themselves were carried out in Santo Domingo the capital city of the Dominican Republic; in Mexico City and Netzahualcóyotl in Mexico; in the Kyela district of the United Republic of Tanzania; in Mumbai in India; and in two villages in Chiang Mai Province, Thailand. Following a description of the background to the studies (Chapter 2) and of the study design and methodology employed (Chapter 3), this report contains a comparative analysis of findings across all five sites (Chapter 4). A final chapter outlines some of the key implications for policy and practice (Chapter 5).

CHAPTER **2**

BACKGROUND

The impact of HIV and AIDS on households and communities, and the responses this gives rise to, are of considerable policy and practical interest. Knowing more about these responses may enable us to identify the reactions of individuals, families and affected communities that warrant reinforcement. It may also lead to a better understanding of the more negative consequences of the epidemic such as discrimination, stigmatization, social exclusion, and individual and household distress. In order to learn more about these positive and negative responses, and their implications for HIV prevention, care and support, a series of two-year studies was initiated in 1993/94.

These studies set out to examine household and community responses to HIV and AIDS in five different countries —the Dominican Republic, India, Mexico, Thailand and the United Republic of Tanzania. The aim was to examine the relationship between sociocultural, political, economic and demographic factors determining different responses at household and community levels. Through in-depth study in a range of different sites, it was hoped to identify policy and intervention implications of value to international and national agencies and those working at grass roots level. The majority of studies began in 1994 and ended in 1996, enabling this comparative cross-site analysis to be completed shortly afterwards.

The theoretical rationale behind the programme of work was

> '... *(that) human beings, either as individual or collective bodies, act in response to events and crises that challenge their structured patterns of existence and survival and, in the process, their lives move on and societies evolve'. (World Health Organization, 1993).*

AIDS was therefore viewed as one of a number of challenges facing households and communities, one to which they must respond if they are to continue to function well. The diversity of responses witnessed globally results from the impact of the epidemic on different communities at different stages of the epidemic as well as prevailing economic, sociocultural and institutional conditions and traditions. Numerous studies have now shown how social context influences individual and community responses to HIV and AIDS (see, for example, Dowsett & O'Brien, 1994; Leonard & Khan, 1994; Dodd, 1996; AIDS Analysis 1997). Social context includes influences due to society, community, households and the individual. Society is usually taken to refer to the broad civic, cultural and perhaps sub-cultural features of a population, whereas community describes geographical, ideological or behavioural commonalities. Households may be construed as the relationships between a number of people, but may also consist of just one person living alone. Individuals may be understood in reference to their biological nature, their emotional and social characteristics, their cognitive capabilities and/or their spiritual qualities. Responses to HIV and

AIDS depend not only on this range of societal, community, household and individual factors, but also change over time.

Societal impact and responses

Opinions differ concerning the impact of HIV and AIDS in different societies. There can be no doubt that AIDS has had a serious impact on individuals, their families and friends, and there is widespread acceptance that its effects on health care systems can be substantial (Barnett & Blaikie, 1992; Ainsworth & Over, 1994; Cohen & Trussell, 1996). It is also well established that HIV and AIDS have effects on households including, at the aggregate level, the extent and depth of poverty (World Bank, 1997). While households may attempt to compensate for the loss of economically active adults by, for example, working longer hours, selling assets and withdrawing children from school, the extent to which they can cope with the effects of HIV and AIDS varies dramatically. The economic impact of AIDS has been documented as being larger on poor households, affecting food consumption, child nutrition and school attendance among other factors (World Bank, 1997).

There is evidence to suggest that the structural adjustment programmes instituted in many African countries since the 1970s may have inadvertently contributed to the growth of the epidemic by increasing migration and urbanization, and by causing a reduction in spending on health and social services (Ankrah, 1996). Men, for example, may increasingly travel far from their partners in search of work, and women may have little option other than to sell sex (occasionally or regularly) in order to obtain income.

The development of transport systems may also have facilitated the growth of the epidemic. As Outwater (1997) has recently noted in her discussion of the social and economic impact of AIDS on women in the United Republic of Tanzania, there is often a lower incidence of HIV infection among communities furthest away from urban areas and transport routes. Indeed, the offer of a renovated road to one group of villagers was reportedly turned down for fear that it would 'bring AIDS' into the community. In some countries in south-east Asia, and prior to recent economic crises, rapid economic expansion has caused a decline in traditional forms of employment. In parts of Chiang Mai province in Thailand, for example, traditional rice farming has given way to construction labour, caddying and work in the hospitality and entertainment industries, as rice fields have been transformed into golf courses and new housing estates (Singhanetra Renard cited in World Health Organization and UNAIDS, 1998).

Paralleling these economic and infrastructural transformations have been the responses of national and local governments. Internationally, government responses to the epidemic have varied from the 'inspirational and the compassionate' to the 'ignorant and discriminatory' (Grunseit & Kippax, 1992). Punitive government responses can affect both the quality and availability of care as well as the

efficacy of prevention initiatives. They can also result in the apparent invisibility of people with HIV and AIDS, thereby reinforcing the belief that AIDS is an epidemic of 'outsiders'. The factors influencing different kinds of government response are poorly understood, and more information is needed about how to transform negative responses into more supportive ones. While the studies described here did not attempt to explore these concerns in depth, it is important to recognize that household and community responses always occur within a broader national economic and political context.

Community impact and responses

Communities can be thought of in a number of ways: geographically, in terms of the sharing of a common identity, or linked by a set of common practices. In relation to care and support, communities consist of at least three interlocking systems: the formal health care system; the voluntary care system including support provided through community based organizations (CBOs) and nongovernmental organizations (NGOs); and the informal care system consisting of the support provided by friends, families and other relatives.

Mitigating the effects of HIV and AIDS on individuals has often been given low priority by national HIV and AIDS control programmes (Cohen & Trussell, 1996; Ankrah et al., 1997). In developing countries, day-to-day care and support is usually provided by unpaid household and community members, who are usually women.

While the impact of AIDS on women is increasingly recognized and some CBOs are beginning to respond specifically to their needs (Shrestha, 1996), the self-help ethos of these organizations, and ironically their successes, can conceal deficits in more formal health care provision. Moreover, if women are cared for primarily through the voluntary and informal sectors, their needs can become further marginalized by the formal health care system.

CBOs are vital for the provision of care in communities affected by AIDS (Mercer, Mariel & Scott, 1993; Leonard & Khan, 1994; Fernandes et al., 1996; Jayaseelan, 1996). While a number of factors, including limited resources (Leonard & Khan, 1994), constrain the effectiveness of such organizations, they are important sources of support for groups as diverse as children, women, drug users and homosexually active men (Mello, 1996). The effects of their actions extend beyond support, however. Grunseit & Kippax (1992), for example, have highlighted how CBO-supported community mobilization among gay men in the Dominican Republic helped encourage safer sexual practices and provided the opportunity for significant changes in knowledge and behaviour.

Even so, community organizations and affiliations are not always successful in bringing about positive changes in people's behaviour. Even in well-funded CBOs, resources can be wasted as a result of poor management (Mannemplaven in Grunseit & Kippax, 1992). Which organizations are best placed to provide HIV- and AIDS-related services has been examined by Cohen & Trussell (1996) in their call for

further research into the optimal roles of national governments, international donors and NGOs. They argue for a closer examination of the efficacy of AIDS-specific, as opposed to non-AIDS-specific NGOs, in mitigating the impact of AIDS.

Ankrah, Schwartz and Miller (1997) have identified some of the main ways in which health care and social support systems can meet HIV- and AIDS-related needs at community level. Whereas health care systems encompass formal structures, services and activities 'designed primarily to deliver clinical management of the disease and to ensure health maintenance', support systems provide various forms of social assistance to lessen the effect of AIDS-related stresses. These might include tangible forms of aid such as money, food and psychological assistance, as well as emotional support and information.

However, these same authors also highlight the androcentric nature of much existing health care provision. Fees and the geographical location of services can make access to health care problematic for women. Furthermore, women's AIDS- and HIV-related medical problems may not be recognized and treated, so excluding them from access to services. To address such bias, existing health care systems need to be re-oriented. Ankrah, Schwartz and Miller (1997) suggest that traditional healers, who in Africa and parts of Asia treat 70-80% of the population, could be more fully utilized in AIDS-related treatment and care. Providing AIDS-related medical care through maternal and child health facilities, as well as through primary health services, could make access for women easier. However, health care staff working in

these areas are likely to require specialist training.

Whilst there is an increasing awareness of the HIV- and AIDS-related needs of women, and a recognition of the necessity of making services more gynocentric, there is little to suggest how to develop services so as to meet both women's and men's needs. Seidel (1996) has recently pointed to the importance of addressing gender as opposed to 'women's issues'. Such an approach re-focuses policy and intervention attention on'... the difference between women's and men's interests even within the household...'

Household impact and responses

HIV and AIDS impact significantly on households and families, triggering a variety of responses. Households and kinship networks have an important role to play in caring for bereaved children (Forsyth & Rau, 1996; Levine, 1996) and in providing support and care for people with AIDS (Chuaprapaisilp & Parsons, 1996; Forina et al., 1996). They may also offer a forum within which people can appraise and evaluate the information they receive about HIV prevention (Ruben, 1996). In circumstances where household members provide most of the care for people with AIDS, stress can take its toll. Family members themselves may require support in a form that takes into account their emotional, physical, financial and spiritual needs (Kadhumbula, Tibatemwa & Kalemba, 1996; Machinjili, 1996; Mawejje et al., 1996). Once again, women are often the main providers of care (Grunseit & Kippax, 1992).

The economic impact of HIV and AIDS on households varies according to the

severity and length of the illness, as well as available financial and human resources. Cohen and Trussell (1996) have identified three types of costs facing households: direct costs such as those associated with medical expenses; indirect costs such as foregone earnings; and costs to other households connected with the payment of funeral expenses or the care of bereaved children. The impact of AIDS also depends on who within the household is affected. The most severe impact occurs when the head of household becomes unwell and is unable to work.

A diagnosis of HIV can lead to the dissolution of marriages and partnerships and, through fear of this, discourage people from disclosing that they have HIV infection. For women especially, being HIV seropositive can result in being unable to find a marriage partner or, if married, in forced separation or divorce. Given the low economic status of unmarried women in many developing countries, HIV may cause not only the breakup of relationships but also the loss of the means of survival. Without adequate support, both men and women can be placed in the situation of either having to withhold information about their HIV serostatus or put their partner's health at risk (Grunseit & Kippax, 1992).

Where children living with AIDS are unwell, there may be immediate care needs associated with HIV. As with adults, the severity of illness can vary over time and differs between individuals. Unlike adults, however, chronic illness can lead to delays in physical and social development (Auer, 1997). This can create longer-term challenges, which will need to be addressed.

Where children have been bereaved through the death of their parents or carers, the reconstitution of households to provide them with care can take a number of forms. In most countries there are formal or, more often, informal arrangements within families for the care of bereaved children. However, despite the tradition of extended family members taking care of bereaved children who have lost their parents, the costs of providing care can discourage this kind of caretaking (Auer, 1997). In some non-industrialized countries, CBOs have responded by setting up foster care placements (Auer, 1997).

Where the impact of AIDS has been greatest and there are few if any appropriate adults to care for bereaved children, some households may be made up of children alone. If they have a plot of land, shelter, and at least one girl or young woman, these households seem to have a better chance of surviving than boy-only households (Auer, 1997). Again it is usually women, in this case young women or girls, who are able to provide an affected household with the means of survival by bringing food and preparing it, and by generating income through small scale trading activities. Members of boy-only households appear more likely to resort to living on the streets and gaining an income through begging.

Group homes may also have a role to play in mitigating the effect of AIDS on bereaved children. In Zambia, for example, alongside support and involvement by community leaders and extended family networks, it has been possible for adults to share the responsibility of providing for the emotional, physical and spiritual needs of rela-

tively large numbers of children (Auer, 1997).

Where parents or care takers are themselves HIV seropositive, decisions have to be made about whether or not children should be told. These decisions can be influenced by the shame sons and daughters may feel about their parents. Where children have lost their parents to HIV-related illnesses, they may feel that their parents were bad or immoral. This stigma may have a substantial impact on the child's or young person's subsequent sense of self-worth or esteem. The mothers of children infected through vertical transmission may feel a sense of guilt and find it difficult to let their children know about their common HIV status (Auer, 1997). These findings emphasize the need to develop interventions which dispel feelings of stigma, discrimination, shame and blame, of which self-blame is a significant factor (WHO/UNAIDS, 1995; Bor, 1997)

Concluding comments

Despite an increasing number of studies examining the impact of AIDS at community and household levels, recent reports often take the form of local descriptions of service provision, with a focus either on one service (such as a particular CBO), one community (such as 'orphans' or women), or one issue (such as counselling, or the use made of health information). As such, they are unlikely to offer an adequately holistic understanding of local responses to the AIDS pandemic. As Cohen and Trussell (1996) have argued, too singular a focus on interventions to support responses to AIDS and to miti-

gate its effects can obscure the multi-faceted nature of community level AIDS-related care and support. They suggest that interventions are better analysed along three dimensions: the level of social organization of the intended beneficiary (for example, a society, a community, or an individual); the type of provider (for example a government, CBO, or household members); and the kind of support offered. The latter might be tangible (such as physical resources) and/or psychological (such as emotional support), and can be either fixed or variable.

Given the issues discussed, the following factors are likely to be among those determining whether appropriate forms of support to lessen the impact of HIV and AIDS are likely to emerge locally:

- the severity of the impact of AIDS at a community and societal level;
- the level and nature of government response(s);
- the macro-economic context;
- existing practices and meanings linked to gender, sexuality, illness and disease, as well as the care of children;
- existing health care and support systems;
- opportunities for community mobilization, especially among women; and
- the social background of the affected household (including available economic and human resources).

The challenge lies in identifying how these among other variables influence local patterns of response, and the provision of HIV- and AIDS-related care and support.

CHAPTER 3

STUDY DESIGN AND METHODOLOGY

The programme of research described here was guided by a general research protocol developed by the World Health Organization (1993). The primary focus of the enquiry as outlined in this protocol, was to:

> ' ... *explore the reactions and responses of households and communities affected directly or indirectly by HIV/AIDS, and of those who are becoming increasingly aware of their vulnerability' (WHO, 1993: 6)*

Subsequent to the preparation of this general research protocol, potential principal investigators from a range of countries were invited to prepare local research proposals. These proposals were reviewed by the former WHO/GPA Steering Committee for Social and Behavioural Research and five studies — in the Dominican Republic, India, Mexico, Thailand and the United Republic of Tanzania — were recommended for funding.

Research questions

Potential principal investigators were expected to address a range of research questions in their studies. These included:

- describing household and community responses to HIV/AIDS and exploring patterns of change which affected such responses;
- relating such responses to dominant sociocultural patterns of meaning attached to HIV/AIDS, sexuality, survival, biological and social reproduction, and health and illness;
- relating these responses to socioeconomic structures and dominant formal responses (if any) to HIV/AIDS;
- identifying the most constructive response strategies and their determinants, and thus relevant modes of intervention in contending with HIV/AIDS locally;
- identifying mechanisms and principles that give rise to and sustain the strategies that enable people, individually and collectively, to prevent the transmission of HIV/AIDS, to discourage discrimination, and to care for and support those affected by the epidemic.

Study design and samples

All five projects followed the design of the general research protocol, but variations were allowed to meet local needs and contingencies. A two stage design was followed in each country. Following the preliminary identification of potential study sites, a Rapid Assessment Process (RAP) took place to select the areas and communities for later in-depth study. Methods used during the RAP included documentary and archival research, and interviews with key informants. The subsequent selection of communities took place with regard to geographical and/or social characteristics, these being defined in relation to the local study's principal aims and objectives.

In the second stage of work, households were purposively selected from within each community according to their potential to shed light on the fac-

tors influencing local responses to HIV and AIDS. Information was elicited by means of individual interviews with affected individuals, couple interviews, interviews with other household members and focus group discussions. Observation and case studies were identified as appropriate ways of obtaining additional information. These general guidelines were interpreted in each study site as follows, and a comparison between the samples characteristic of each site can be found in Table 1.

TABLE 1

Country	Site characteristics	RAP	Main data collection
Dominican Republic	One high and one low prevalence site in Santo Domingo, the capital city.	Analysis of existing records and studies, observation, key informant interviews.	Individual, household and group interviews with 43 households — comprising 12 family groups directly affected by HIV/AIDS (6 in each site); 14 family groups indirectly affected by HIV/AIDS (7 in each site); 17 occupational families in sex industry (8 low prevalence area, 9 high prevalence area).
India	High and low prevalence areas in Mumbai, plus other areas in same city.	Analysis of existing records, media reports, key informant interviews.	Individual interviews with 26 people living with HIV/AIDS (PLWA), couple interviews with 4 couples (both partners infected), interviews in 25 households. Community based focus group discussions.
Mexico	Two contrasting communities: (i) Neztahualcóyotl and (ii) Mexico City gay community	Analysis of existing records and documentary evidence, observation, key informant interviews	(i) Neztahualcóyotl: individual or group interviews with 19 PLWA, with 37 relatives, and with 14 individuals indirectly affected by HIV/AIDS. (ii) Mexico City gay community: individual or group interviews with 10 PLWA, with 25 volunteers and members of social networks, and with 8 relatives of people affected.
Thailand	One high prevalence community (HPC) and one low prevalence community (LPC) in Chiang Mai province.	Analysis of existing records and studies, observation, key informant interviews.	Individual interviews with 60 household members (HPC) and 53 household members (LPC); focus group discussions with 4 villager groups (HPC), 3 villager groups (LPC); informal interviews with 80 others (HPC), 49 others (LPC). Observation. Case studies.
United Republic of Tanzania	Two villages with high AIDS-related mortality, and two villages with low AIDS-related mortality in Kyela district.	Analysis of existing records, observation and key informant interviews.	Individual interviews with 53 people, household interviews with 40 households (10 per village), focus group discussions with 16 groups (one involving elders and health workers in each village). Observation.

Study sites

Dominican Republic (Santo Domingo)

Site selection — The capital city of Santo Domingo was chosen as the area within which study areas would be selected. Two comparable lower class communities were chosen, one with a higher than median number of AIDS-related deaths (as reported to the National STD/AIDS Programme), the other with a lower than median number of reported deaths.

Rapid assessment process — During the RAP, key informant interviews, observation and an analysis of existing records were undertaken. This enabled the identification of the demographic profile of local households; dominant forms of economic activity; leisure activities; institutional responses to AIDS; traditional rituals involving sex, partnership, marriage, death, burial; and local beliefs about health.

Main data collection — Following the RAP, focus group interviews were completed with community leaders in each study area. Household group and individual member interviews were also carried out in selected households. Together, these sought to identify:

• responses to illness, suffering and death. At a household level, this included enquiry into household composition, roles and economic activity, issues of care, support and bereavement. At a community level, it included study of ways in which support was, or was not, sought.
• issues relating to HIV transmission.

At a household level, this included an analysis of perceptions of vulnerability, sexual behaviour, gender relations. At a community level, it involved the study of perceptions of vulnerability, discrimination and stigmatization as well as sexual practices and norms.

India (Mumbai)

Site selection — Two study areas were chosen following an initial assessment of levels of HIV infection in different areas of Mumbai as assessed from public hospital records. One was an area of high reported incidence of HIV infection, the other had a proportionally lower incidence. As the research progressed, additional data were collected outside of these areas to enhance the quality of the study.

Rapid assessment process — During the RAP, information was collected and analysed from key informants and secondary sources. Key informants included public health officials and representatives of the State AIDS Cell, social workers, counsellors, medical professionals and NGO staff. The RAP aimed to:

• provide an understanding of the sociocultural context of the epidemic in Mumbai and of major institutional responses to it; and
• develop an understanding of the magnitude and sociodemographic profile of the epidemic in Mumbai.

Main data collection — The rapid assessment was followed by data collection from household and community respondents using individual and couple interviews, as well as focus group discussions. Household interviews aimed to identify:

- experiences of living with, and responses to, HIV and AIDS;
- the nature of household care in relation to AIDS; and
- problems associated with the provision of care and ways of coping with AIDS-related issues.

Mexico (Netzahualcóyotl and Mexico City)

Site selection — In Mexico, two communities were selected. The first of these — Ciudad Netzahualcóyotl, a municipality in the State of Mexico — had a distinct 'geographical and social unity' and was reported as having a very high proportion of AIDS-related deaths. The second community consisted of the 'network of specific social and cultural relations' that make up the homosexual community(ies) in Mexico City. Behaviourally homosexual and bisexual men currently constitute the largest number of those reported to be living with HIV or to have died from AIDS-related illness in Mexico.

Rapid assessment process — The RAP involved collecting and analysing information from key informant interviews, observation and documentary evidence. Key informant interviews were undertaken with community leaders and health workers in Ciudad Netzahualcóyotl, and with leaders in the gay community. The rapid assessment aimed to identify:

- the demographic, socioeconomic and cultural context of the two communities, with a particular focus on occupational structures, income (re)distribution, and institutional stability; and
- values and belief systems, particularly those pertaining to sexuality, health and illness prevention.

Main data collection —The RAP enabled potential key informants to be identified for the second phase of work. During this second phase, information was gathered from household and community members through individual and group interviews as well as focus groups. Group interviews enabled the identification of:

- household structure(s) and 'economic survival strategies';
- shared values and beliefs about AIDS, health, disease and death; and
- household problems resulting from AIDS.

Individual interviews enabled an in-depth exploration of:

- positive and negative reactions and responses to AIDS (e.g. support, solidarity, rejection, discrimination).

Thailand (Chiang Mai province)

Site selection — Chiang Mai province was chosen as the study site since it had a high reported prevalence of HIV and AIDS and because of the researchers' prior familiarity with economic and social factors affecting household and community responses. Within the province, two contrasting study areas were chosen according to reported AIDS prevalence as reported to Village Health Stations — the first had a high reported prevalence of AIDS, the second had a lower reported prevalence.

Rapid assessment process — During the RAP, information was gathered via interviews and observation, as well as from written records. Key informants included village health volunteers, traditional healers, monks, village offi-

cials, leaders of the village senior's club, 'housewives' groups' and youth groups. The RAP provided:

- information on economic and leisure activities, social groupings and support systems;
- information on the demographic profile of the community and households; and
- an overview of prevalent institutional and community responses to HIV and AIDS.

Main data collection — During the next phase of the study, households were categorized according to socioeconomic status and age of household head. Information was obtained from individual and group interviews, as well as via participant observation in community activities. Interviewees included community members living with and affected by HIV and AIDS, as well as what were termed 'vulnerable' individuals. The latter included sex workers and their clients, singers and female golf caddies, and teenage gang members. This phase of activity aimed to:

- collect information on sexuality, class, gender, and economic and family relations as they relate to responses to HIV and AIDS;
- gather information on household composition as well as family and kinship networks of households within which someone had died from an AIDS-related illness; and
- identify household and community responses to AIDS, including issues relating to the stress of caring, attitudes towards people with HIV, the influence of media campaigns, the role of traditional healers, and traditional ways of coping with illness and their impact on the

provision of care and support to people with AIDS.

United Republic of Tanzania (Kyela District)

Site selection — Kyela district in the Mbeya region of the United Republic of Tanzania was chosen as the study site. Within this district, two areas were chosen with relatively low reported AIDS-related mortality, as well as two areas with high reported AIDS-related mortality rates.

Rapid assessment process — As many local primary health care centres were reported as having no facilities for HIV antibody testing, some of those with HIV-related disease might not know the nature of their illness (or even that they were unwell). During the RAP, therefore, households were selected in consultation with village committees if they had a member who had been ill for more than three months, or if a member had died of a chronic illness in the year immediately prior to the study.

Main data collection — Individual and group interviews, as well as focus group discussions, were conducted with household and community members in two villages in each of the selected study areas. Focus group discussions were undertaken with women, young people and teachers. Data collection aimed to:

- identify beliefs about HIV and AIDS;
- examine household, clan and community responses to HIV and AIDS, including individual and community coping strategies, and clan survival strategies;
- explore issues relating to sexuality

and changing socioeconomic circumstances; and

- explore the circumstances which facilitated individuals and groups taking preventive action against HIV, which discourage discrimination, and which promoted care and support for those affected by AIDS.

Data analysis

In each local study, data from individual interviews and focus group discussions were analysed thematically in relation to the aims, objectives and research questions prioritized by the general research protocol, and the research concerns identified in each local research proposal. Thematic analysis involved an examination of prevailing patterns of positive and negative response at household and community levels, the interrelations between these, and identifiable economic, social and cultural determinants. The relationship between what people said in individual and group interviews and what could be observed locally was also explored, as were any similarities and differences between the views of particular groups.

Given the preliminary and exploratory nature of the investigations, differences in sampling frames and samples, and the qualitative nature of the data collected, it would be inappropriate to report on the frequency with which particular views were expressed or actions observed. Instead, the emphasis is on themes and issues that recurred throughout the data sets amassed at each site, as well as those prevalent across different countries. Unless otherwise stated, the views stated are those identified by the principal investigator and their team as being typical of respondents at that site. Minority views are always reported as such. In order to enhance the reliability and validity of interpretations in this comparative analysis, its contents have been reviewed by all the principal investigators involved in the multi-site study and appropriate corrections have been made.

COMPARATIVE ANALYSIS

We will begin our analysis by examining local beliefs about HIV, AIDS and transmission, since these establish the backcloth against which to make sense of the ways in which individuals, households and communities respond to the epidemic. Following this, we will look in turn at household level responses, community responses, and interrelations between the two.

Local beliefs

Beliefs about HIV and AIDS

In all countries and at all sites within them, respondents failed to draw clear distinctions between HIV and AIDS. This may have been due to the belief that there was little need to differentiate between the two or, as was the case in the Kyela district of the United Republic of Tanzania, the local unavailability of diagnostic tests. Whatever terms were used, one overarching theme was apparent. Respondents either talked of, or acted as if, AIDS was a disease of 'others'. If you lived in a village, AIDS was seen as a disease of towns if you lived in a city, AIDS was seen as affecting only certain 'hot spots'; and if you had sex, you were protected so long as you 'knew' the other person (even if she or he was a sex worker).

'Despite current reports of high HIV sero-prevalence...and the high mortality rates in the two villages selected for the study, the majority of informants were of the opinion that HIV/AIDS was not a serious problem in their localities, and that it was a disease affecting emigrants to urban settings from the village.' (Ta, p.78).[1]

Efforts to distance AIDS from the self were also apparent in respondents' accounts in Santo Domingo where interviewees from areas of low AIDS impact had difficulty in referring to AIDS *as* AIDS.[1]

'During interviews it was noticed that many participants failed to call AIDS by its name, and referred to it as "that". This was understood as an indicator of the degree to which AIDS may be invested with emotional overtones, regarded as a taboo topic, or as an open secret.' (DR, p.13).

Local beliefs about the geographical distribution of AIDS were manifest in all studies. In Kyela district, the belief that AIDS was a disease of towns seemed to have been reinforced by men's earlier migration to urban areas in search of paid work. Some had subsequently become ill and returned to their villages for care and support. This had bolstered local perceptions that AIDS was a disease of the big cities.

At this same site, respondents showed a marked reluctance to call an illness AIDS, preferring to describe it in less stigmatizing and perhaps more treatable ways. This useful imprecision was reinforced by talk of local men's inability to meet their financial obligations to elders after migrating to urban areas in search of work: not

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1   Individual site reports are cited by the name of the country followed by the page of the local report on which the relevant reference is located. The countries are identified as: DR-Dominican Republic; I-India; M-Mexico; Th-Thailand; Ta-United Republic of Tanzania

meeting such obligations was under-stood as being the cause of tradition-al illnesses treatable by local healers.

In all countries, AIDS was equated with death. Not only was it seen as incurable, but it was perceived as involving a great deal of suffering. In Mumbai, for example, AIDS was described as a 'thinning disease' in which people lost their resistance to other illnesses, became weak and died. Among gay community respon-dents in Mexico City, a diagnosis of HIV was said to be met with despair. As one respondent commented:

> ' ... at the beginning, I felt as if I lost control completely, because through the experience of friends I thought that there was nothing to do and that death was going to be very quick.' (M. p.175).

At all sites except Kyela district in the United Republic of Tanzania, it was generally known when someone, at least in the later stages of illness, had AIDS. In Kyela district, however, where a definitive diagnosis was difficult to make due to the lack of antibody detection kits, there remained much uncertainty as to whether a serious ill-ness was AIDS. While certain symp-toms were suspected as indicating the condition — including weight loss, an itchy bodily rash, recurrent fevers and chronic diarrhoea — assuming that an illness was not AIDS enabled the indi-vidual concerned (and other house-hold members) to avoid stigmatiza-tion and shame.

> 'A large proportion of informants claimed that a cultural condition called "kigune" had existed for a long time and has symptoms similar to AIDS. This condition results from not fulfill-ing ones obligations to elders or the clan ... This disease we have here is called "ngoto", when it affects children

and "kigune" when it affects adults. The illness is a traditional wasting ill-ness. People find it difficult to accept that a wasting illness may be AIDS. ... The researchers noted that "kigune" and "ngoto" are used interchangeably in some focus group discussions and individual interviews without the above distinction.' (Ta. p. 55-56).

Beliefs about transmission

Respondents subscribed to a range of beliefs about how HIV and AIDS were transmitted. These beliefs about trans-mission accounted for how infection occurred, the types of people affected, how people were affected, and the special vulnerability of some children. The main way in which HIV and AIDS were said to be transmitted was through sex. Where mentioned, infec-tion through injecting drug use, and transmission from an infected mother to foetus or through blood-to-blood contact appeared to be of more minor concern.

Beliefs about sexual transmission were influenced by local ideas about what was, and was not, appropriate conduct for men and women. In all study sites, expectations of appropri-ate sexual conduct differed for men and women. Men were generally per-ceived as having a greater degree of sexual freedom and, although sex was often expected to be limited to within marriage, young men were encouraged to visit sex workers as part of the process of becoming adult. As adults, men's perceived need for sex was seen as greater than that of women. Men were generally expected to have sex outside mar-riage — sex being seen as a pleasure and a way of satisfying their desires. As the father of a man with HIV in Mumbai put it:

'It is possible that he would have done something like that (visited sex workers). Who wouldn't have done it at that age? ... this is a thing (that) no one can resist. Who is such a perfect person?' (I, p.29).

A similar theme was highlighted in the report from Chiang Mai province,

'The community's socialization of gender inequality and values ... results in villagers believing that males should have sexual experience before marriage. By engaging in pre-marital sex, neither his reputation, nor his virginity is affected ... For sons, norms are inculcated less rigidly than daughters. Sons, for example, are normally free to go out at night, which often involves drinking or even visiting sex workers, whilst daughters are not.' (Th, p.69).

Women, on the other hand, were perceived as needing to confine their sexual activity to marriage, and their status was dependent on complying with such prescriptions. A woman's reputation, her physical safety and her access to a home and shelter could depend on her faithfulness to her husband. In Netzahualcóyotl, for example, respondents stated that women should be obedient to men. If not, they should expect abuse and recrimination — which could be sexually as well as physically violent. While in all sites women were reported as having extramarital sex, including occasional sex with younger unmarried men, such women tended to be in a minority.

These views about men and women impacted upon their freedom of movement. Women's movement was traditionally restricted to undertaking tasks in and immediately around the home. Men on the other hand were able, and indeed expected, to travel greater distances in order to provide financially for the household — migrating from villages to urban areas, and from one urban area to another, in search of work. But with many households being in a state of permanent economic need, and with traditional work patterns changing, these geographic and employment patterns were in transition. To provide for family members, women were increasingly involved in trading (such as selling commodities at markets) or in various service industries (including bar work, entertainment and sex work).

Beliefs about transmission were linked to beliefs about those people most likely to be infected. Generally three kinds of people were identified as particularly likely to be infected: women who earned money through selling sex, men and women who had sex outside of marriage, and 'homosexuals'. In many cases such images seemed to have been reinforced by national and local HIV prevention campaigns. In Chiang Mai province, for example, it was reported that attempts had been made to educate female sex workers about the risks associated with AIDS, almost to the exclusion of interventions with other groups. Because of this, sex workers were said to be very aware of the risk of AIDS and encouraged clients to use condoms. In Santo Domingo, it was said that most sex workers abstained from unprotected sex, and sought to negotiate condom use with clients.

Men, it appeared, seemed almost compelled to have sex outside marriage. In Mumbai, for example, men

were seen as having a 'natural' need for sex. This, along with a lack of privacy in which to have sex with their wife and the wife's possible exhaustion after carrying out her routine chores, meant that men used sex workers as a source of 'relief'. As one married woman put it,

> *'Lovemaking is for a husband's pleasure. It's a duty for his happiness.' (I, p.49).*

There was evidence, however, that men were beginning to take notice of safer sex messages, at least in the context of sex work. In Chiang Mai province and in Santo Domingo, for example, they were reported as more likely to use condoms when having sex with sex workers than with other partners, unless they had a particularly close relationship with the sex worker when the use of protection diminished. Where the emphasis in public information campaigns had been on the risks associated with sex with sex workers, men reported routinely using condoms with sex workers, but rarely with other extramarital partners.

> *' ... evidence from focus group discussions revealed that condom use was practised by men when visiting sex workers (albeit not all the time), but not with (other) women whom they believed did not have HIV/AIDS. This irregular and selective use often has led to false confidence.' (Th, p.78).*

Among respondents from families affected by AIDS in Santo Domingo, there was pessimism about the extent to which men would change their sexual behaviour — even regarding condom use.

Respondents from families unaffected by AIDS were rather more optimistic, however, suggesting men could change through self-control and indeed *had* changed by having fewer extramarital affairs and, when doing so, using condoms.

Women's ability to negotiate condom use, particularly with husbands, was particularly problematic. As already indicated, women were generally expected to have sex in accordance with their husband's wishes. In Mumbai, although preferring their husbands not to do so, wives felt that if a husband were to visit a sex worker he should be responsible and use condoms. Men in this same site, however, reported feeling that it was the sex worker's responsibility to ensure that a condom was used. Moreover, the belief that condoms were only for use outside marriage was reported as having led to husbands infecting their wives.

> *'My husband knew of his condition and how it affects others. Even then he put me into danger. Every one of us is surprised that he was educated and yet he didn't tell. He was asking me to take out the Copper T [an IUD], he said it hurt him. He wanted another child!' (I, p.36).*

Respondents in Santo Domingo stated that wives should be entitled to protect themselves if their husbands had sex with other women.

Nonetheless, this remained problematic since while women might be expected to demand condom use of men, they were reported as being powerless to do so — with their fate (and health) being entrusted to God instead.

'Women married to (unfaithful men) felt powerless to avoid infection and put their fate in God's hands.' (DR, p.14).

Similar concerns were expressed by respondents in Chiang Mai province who felt that not enough attention had been given to the negotiation of condom use by women. Respondents at this same site also noted that a wife was more able to negotiate condom use within marriage if she was educated about the need for protection and had money of her own with which to engender a degree of bargaining power. Access to information about HIV and AIDS was also seen as a prerequisite for women's empowerment.

' ...women who can convince their husbands or sexual partners to take blood tests or use condoms are those who either have better socioeconomic backgrounds, are better educated, or have had some training and access to information about HIV/AIDS...' (Th, p.28).

The influence of earning power on changing relationships between men and women was noted in respondents' accounts in the Kyela district of the United Republic of Tanzania. Money was seen as affording women greater independence, and this needed to be taken into account when developing prevention work.

' ...amongst women, strong links (were) made between increased economic power of women and increased social freedom. If one is to think of (HIV) risk reduction strategies in this population, it is clear that much caution will be needed for such approaches not to impact negatively on the income generating activities women perform outside the home.' (Ta, p.80).

Other beliefs

In Netzahualcóyotl and Santo Domingo, AIDS was said to be caused by fate or the wishes of a deity. Some

sex workers in Santo Domingo, for example, reported predestination as one of the reasons why people might get AIDS.

'A few sex workers in (the low impact area) did not know that sperm was infective, ignored the length of the incubation period, and attributed infection to predestination or bad luck.' (DR, p.12).

Similarly, a number of respondents in Netzahualcóyotl felt that AIDS had a supernatural cause. Whether or not a person got AIDS was said to be in God's hands, and could be a form of divine punishment. In Mumbai (and in line with eastern philosophies of life it was said), those with 'weak minds' were believed most likely to fear becoming infected by AIDS. In Kyela district, those who had not fulfilled their obligations to elders were seen as especially vulnerable.

In Chiang Mai province, respondents suggested there was less of a need to use condoms when partners appeared 'clean' and 'healthy'.

'Only in the past four decades have rural Thai people become familiar with "germs" (as causes of disease) in addition to the belief in former causes such as spirits or imbalance of body constituents of the body and the mind. In the case of HIV/AIDS, many men said they did not use condoms with sex workers or with non-sex workers, if, in their judgement, their partners appeared clean and healthy. In other words, unless the germs of viruses manifested themselves through their partner's physical abnormality or illness, men felt they were having safe sex.' (Th, p.54).

'Knowing' (or not knowing) a potential sexual partner helped people make

judgements, albeit not necessarily accurately, about risk. In Chiang Mai province, it was reported that safer sex was equated with 'knowing' your partner. There was less of a need to use a condom when having sex with someone in your own village than with a stranger. Similarly, and according to gay community respondents in Mexico City, men had unprotected sex because they cared for each other and did not want to have a condom 'in the way'.

> ' ... if love is real, it isn't needed (a condom), no matter what happens. If (the other) lives with the virus, maybe I'll say: "I live with the virus, maybe I'm going to die, but... well..." ' (M, p.171).

Fears about transmission through everyday contact continued to affect people's responses. In Chiang Mai province, for example, workers on building sites were said to be so concerned about infection being transmitted from one person to another that they used their own drinking cups. Among respondents in Mumbai, a majority felt that AIDS was not spread by physical touch, yet some were still concerned enough to suggest that mosquito bites, AIDS microorganisms in the air, talking to infected persons, and gases created through the mixing of urine in public urinals could spread infection. While it was said that education campaigns had helped allay these fears, confusions and anxieties still persisted. In Mumbai, for example, respondents noted a tension between the messages in mass media campaigns (such as AIDS is not contagious) and the behaviour of medical professionals who did not want to touch people with AIDS. Such contradictions led respondents to question the veracity of media messages.

> 'Advertisements say that it is not a contagious disease then why do doctors and nurses not touch them...?'

> 'If it is not a contagious disease then why was ... (somebody's) wife asked to wear gloves and mask when entering his room?' (I, p.52-53).

Connections were often made between other serious illnesses and concerns about HIV and AIDS. For example, community interviews in Mumbai revealed that links were made with local beliefs about tuberculosis, and in Santo Domingo local beliefs about the transmission of tuberculosis and syphilis were generalized to AIDS.

Reference was also made to people with AIDS who were seen as the potential 'agents' of transmission. Among respondents in the lower impact area in Santo Domingo, for example, it was believed that some infected people did not develop AIDS. Instead, they became carriers and it was only the 'victims' with whom they had sex who got AIDS. This image of infected people as active 'agents' of transmission could also be found in respondents' accounts in Mumbai where it was felt that sex workers could pass on HIV without themselves becoming ill. As one man explained:

> ' ... it does not spread so easily among women, it stays like that only ... like you said the prostitute is like an agent ... she remains an agent, she does not have the trouble, but ... because of her, those who go to her get the trouble.' (I, p.51).

Husbands were often implicated in accounts of people with HIV knowing-

ly having sex with others. While in Mumbai, as in other sites, most husbands with HIV were reported as being too unwell to have sex with their spouses, one particular husband was described who 'knew of his condition' and who still had unprotected sex with his wife. Respondents in Netzahualcóyotl suggested that women were expected to have sex with their husbands regardless of whether the latter was infected. A good wife had to comply with her husband's wishes.

> ' ... women find it difficult or impossible to resist having sex with their HIV positive husbands: their subordinate condition forces them to keep from showing their fear of being infected by them, and to suppress the suspicion that they may even try to infect them willingly (deliberately).'

> 'He used to tell me: "C'mon, I'm not going to infect you!" But he, I think he did it, I don't know, that fact that he took the condom off to ... he maybe did it because he didn't want me to remarry or if he died and then I was left by myself, well, that I couldn't go with another man ...' (M, p.113)

HIV transmission: children and young people

In all five countries there were strongly held local beliefs about the ways in which children could get AIDS. In Santo Domingo, for example, where there was little mention of prenatal and perinatal transmission, it was suggested that 'weaker' children might become infected through 'casual' or everyday contact.

> 'No participant referred to mother to child transfer of the virus as a mode of transmission. Nevertheless, they believed that "weaker" children could become infected by casual contact.' (DR, p.12).

Perhaps in consequence, children at this same site were usually segregated from adult household members with AIDS. Here, as in Mumbai, beliefs about young people's special vulnerability were more strongly felt when the person with AIDS was symptomatic.

> 'He coughs a lot and keeps spitting here and there. I hate all this. For children things should be OK, right? ... people say that you should not touch him, give him injections or come in contact with his blood.
> And I feel that my problem, (HIV infection) which is "little" now, would aggravate all of this. That hanky of his, towel, I don't let the children use them, and keep it separate ... then his plate is also kept separate.' (I, p.35).

The real and imagined risks facing young people were also of concern to respondents. Interviewees in Kyela district observed that parental roles in relation to young people were undergoing change. Rules about young people's behaviour were said to be more lax owing to changes in schooling and because young people's potential to earn money was seen as providing them with a greater degree of freedom. In both Kyela and Chiang Mai districts, an increase in leisure time was said to put young people at special risk because of associated increases in alcohol consumption and sexual activity.

'Related to alcohol use was the problem of promiscuity which appeared to be particularly common amongst youth, leaving them vulnerable to not only premarital pregnancy, but also sexually transmitted diseases including HIV/AIDS.' (Ta, p.84).

Household responses

Becoming aware of AIDS

The perceived culpability of individuals was an important determinant of household and community responses. While in all sites a distinction was drawn between those who were felt to be 'innocent' and those who were seen as 'guilty' for their illness, stigma was generally attached to individuals and households with AIDS. Even when it was recognized that AIDS had been acquired through no fault of people's own, and faithful wives infected by their husbands were often described in this way, the latter could be blamed for their husband's unfaithfulness in the first place (through not satisfying them sexually), or by failing to persuade their husband to use a condom during sex.

The news that someone had AIDS, or had been diagnosed as being HIV seropositive, generally brought great shame. This shame was related to the stigma associated with sexual wrongdoing as well as likely death. Beliefs about sexual transgression had an impact on responses to the disclosure of HIV status.

Relatively little was said in reports about why people would seek an HIV antibody test except in Mumbai where recurrent illness, mandatory testing for work in the Gulf countries and voluntary blood donations were cited as reasons, and in Mexico City, where gay community respondents suggested that for gay men, the death of a close friend or ex-lover, persuasion by friends, the influence of activist groups, or a requirement by an employer, were all factors leading an individual to take an HIV test.

The way in which test results were provided by medical professionals was much criticized. As this was often the first contact with medical services, it would seem important that these situations are handled well. Gay community respondents in Mexico City reported that test results were provided with a lack of sensitivity and support. Other Mexican respondents and some interviewees in Mumbai stated that positive test results were disclosed to family members without the individual's consent.

> *'You see, they ordered me to take the ELISA and unfortunately in the laboratory, when they delivered the paper to my wife, it wasn't sealed, the envelope was just like that, and my wife thought if it was easy to open it, and since my sister-in-law is a nurse, she went (to see her) and asked her, and there it was, they were both crying ... Then she took it to the doctor. My oldest daughter goes in and the doctor, without any preparation or anything tells them: "He has, he has the disease". Then my wife went out crying and (my son) saw her and asked her what was the matter, and my wife lacking judgement told him ... This is how I found out, I who am the patient, the day the doctor told me I felt everything sank around me. Now imagine my family.' (M, p.101).*

Once a test result had been received, decisions had to be made about whom if anyone would be told. Respondents from Mumbai indicated that within households, disclosure tended to be selective. Where certain household members were seen as outsiders, as happened with daughters-in-law in that city, such members might not be informed. How household members felt about the news of an HIV diagnosis related to how the infection was believed to have been

acquired. High levels of shame and embarrassment were said to be felt by respondents in Mumbai where disclosure of an HIV positive serostatus was tantamount to admitting to having had premarital or extramarital sex.

Gay community respondents in Mexico City reported that family responses to HIV were similar to those that took place when it was found out that a son was gay. If this latter kind of news had triggered a negative response then it was likely that the former would do so too. Given high levels of stigmatization towards homosexuality and AIDS, there often occurred a joint 'revelation' of HIV status and of homosexuality. In these situations, family members were said to be particularly distressed.

In every site there were reported instances of people with HIV trying to conceal their serostatus. In Mumbai, this was said to be easier for unmarried men. Because their behaviour was less closely monitored than that of women, hospital visits could more easily go undetected. In study villages in Chiang Mai province, it was reported that people with HIV tried to conceal their serostatus until symptoms showed.

> 'Some PLWH/A in both the high prevalence community and low prevalence community concealed their HIV status until the opportunistic diseases deteriorated their health and were observable by family members ... Stigma largely accounted for such denial and concealment'. (Th, p.40)

Family support

Despite widely held negative perceptions of people with HIV, what was striking across all five study contexts was the care and support provided for and by household members. The kinds of support provided included physical care, emotional support and information (such as news about treatments), as well as accompanying people with HIV to medical centres where these existed, and when medical care could be afforded.

From respondents' accounts in Mumbai, it was clear that households responded fairly positively to a family member with HIV, seeking to provide physical, emotional and medical care when needed. In Chiang Mai province, families were reported as generally accepting of caring for a family member with HIV, even though the quality of the care offered was said to vary greatly. Responses to family members with AIDS in Netzachualcóyotl were part of a more general set of responses to ongoing crises and became stronger when symptoms appeared.

> '[At first], there is the difficulty of recognizing that one is HIV positive ... This is due, partially, to the asymptomatic characteristic of HIV infection at its early stages; and, on the other hand, to the tendency that inhabitants of Netza have of normalizing all the problems they face'. (M, p.101).

> However, when the disease starts to be visible ... the disease makes itself brutally present ... '. (M, p.100).

> ' ... Many homes see that one of their members is affected by HIV, and only when the disease aggravates does the issue then become of great interest to the family.' (M, p.213).

In Santo Domingo, data suggested that families in the higher impact areas were the most positive in their responses. In the Kyela district of the United Republic of Tanzania, care was

provided to those with chronic illness, with such provision being more often given in recent years by household rather than clan members. This was said to be due to households, rather than the clan, having become the focus of consumption and production.

Women were central to the provision of care, and husbands and sons generally expected to be cared for by their wife or mother. Even among gay community respondents in Mexico City, where support was also provided by social networks, gay men with HIV not infrequently returned to their mother's home for care. Respondents from the non-gay community sample in Mexico also suggested that when people were diagnosed as HIV seropositive, they tended to return home. Although care was often provided by kinship networks, it was usually women within these networks who provided the bulk of the support.

It was generally perceived as more shameful for a woman to have acquired HIV than for a man. In Mumbai, men were often not asked how they had been infected, it being assumed that transmission had been through sex, and that sex outside marriage was 'natural' for men. This 'non-probing' helped to sustain the generally supportive atmosphere within which care took place.

> '*In most households the infected male member was protected from shame and embarrassment in answering questions about mode of infection. Generally no questions were asked, or if asked, answers were not pressed for*'. (I, p.28).

For women, things were very different. They were often questioned and, after perhaps admitting to sex outside marriage, were reprimanded, or worse, for doing so.

> '*But women were not as fortunate. The sexual mode of infection in the case of a 17-year-old unmarried girl invited the severest criticism from the father who has ever since severed his relationship from the family.*' (I, p.29).

In both sites in Mexico and in Santo Domingo, the quantity and quality of care was influenced by perceptions of innocence and guilt. Respondents in Neztahualcóyotl suggested that if HIV was seen as having been acquired by 'accident' (the acquisition of HIV by a 'faithful' wife from her husband was construed in this way), household members were likely to respond with greater solidarity than if the person with HIV was seen as culpable. Men who were seen as blameworthy for their illness were nonetheless cared for, a response which women in this same site felt to be unfair.

While women were customarily expected to care, and more often than not did so 'with love' for their husbands and sons, there were circumstances where they cared dutifully while feeling trapped within the relationship. This could happen, for example, when a relationship between a wife and husband had already broken down, and where the husband had subsequently become infected.

Women were reported as receiving little support in providing care and hesitated to ask for help, this being seen as likely to annoy those they were helping. When women themselves needed HIV-related care, they were generally unable to expect, and often did not get, the same level of

support as men. Moreover, their own psychosocial needs tended not to be addressed when providing care for others.

> 'The needs of PLWHIV/AIDS differed along gender lines ... Men's needs largely centred around the "self" - the problems in sharing HIV status with others and their health, emotional, and financial situation and counselling needs; women's needs extended beyond the "self" to include the "family" - namely, needs of the spouse, welfare of children, shelter, economic support and so on. Their own health needs and emotional needs were low on [the] priority list.' (I, p.46).

Care for women was often lacking within the household of marriage. Unless other women in the community were able to provide care, a woman might return to her parents' home to receive additional support if ties with her own biological family remained. However, women were also reported as having to put up with stigmatization and even abuse in order to access care for themselves.

> 'HIV positive women whose husbands have already died because of AIDS, besides having to solve by themselves financial and emotional problems ... also have to struggle with the image of the "single" (unaccompanied) woman, that for many men is equivalent to 'available':

> '... I don't like him (my brother-in-law) to fondle me around, because he is not even taking charge of me (financially), and beats me.' (M, p.116-117).

Although women were the most frequent providers of care, men were also reported to offer some forms of support (often of a less personal kind), especially if they were closely related

to the person with HIV. Nonetheless, other respondents' accounts suggested that care by men was often limited, since it went against generally held notions of what men should do.

> 'There are indications that perhaps male heads of households would wish to do more when their partners fall ill but are curtailed by cultural definitions of maleness and the roles defined which determine masculinity'. (Ta, p.68).

Income and household care

In all five studies, financial resources within the household influenced the level and quality of care provided. Expenses associated with caring included payment for travel to and from hospital, purchase of medicines and other treatments, special diets, and time away from paid work (for the person affected as well as those caring for him or her). In poorer households, adults and children suffered most.

In the study villages in Chiang Mai province, for example, distress caused by the lack of money to pay for AIDS-related care, and not that caused by stigma or physical symptoms associated with the disease, was said to have led to the few known instances of suicide. In Mumbai also, it was recognized that the 'moods' of family members were exacerbated by worries about money.

Households hardest hit were those which were already poor and those where the main earner became unable to work due to AIDS-related illnesses. In Mumbai, such households were said to need to borrow from friends and take out loans in order to pay for expenses. In Santo Domingo, very poor families in the

higher impact area were reported as relying on money provided by relatives living abroad. When a wage earner was affected, other family members not only had to provide care and support, but also had to find ways to bring in extra income. Both spouses and children took on this responsibility.

> *'When the ill [person] is the main household provider, the spouse and children usually have to do some menial job to help generate an income for regular and extraordinary expenses. Several affected families had invested all their resources in the disease.' (DR, p.23).*

Care for children was severely compromised by lack of money in affected households. Children might not have enough food to eat and their education might suffer through the need to work to earn money for the household. Women, as wives and mothers, could again find themselves providing for others, doing what they could to look after both their husband and their children.

> *'Faced with limited resources and multiple demands, households exercised choice in spending money. A substantial amount of money was spent on the infected person's special foods and nutrition and if symptomatic, on medical care ... The worst affected were the children with regard to their nutrition, education and psychological well-being ... In some households, there was sometimes no food and children went hungry. Their nutrition and health were a major source of worry to their mothers ... In sum, it was the economy of the lower income, single earner households which was most severely affected and the women bore the major burden of the decline in economic standard.' (I, p.45).*

Illness progression

The progression of illness, and in particular the visibility of symptoms, affected household responses in all sites. Visible signs of illness were also reported as influencing community members' labelling of disease, the care provided, and perceptions of the likelihood of HIV transmission. Where people with HIV had tried to hide their diagnosis, visible symptoms could force disclosure to other family members. Respondents in Santo Domingo indicated that relatives would be asked for help only when symptoms became impossible to conceal, and that people with HIV were sometimes offered little support until they were in the terminal stages of illness. Otherwise, people with HIV remained largely 'hidden'. In Mumbai, it was only when symptoms became 'very visible' that people with HIV and AIDS were encouraged to go to hospital.

Caring for people with HIV who had visible symptoms appeared to be more difficult than caring for those who were asymptomatic. As one respondent in Netzahualcóyotl explained,

> *'He was all bones, believe me, it was horrible bathing someone like that. It was like crying, as if you wanted to scream out because of what you feel, of what you see; then, I used to take a drink or two in order to have the courage to take him, undress him, bathe him and shave him'. (M, p.84-85).*

People often believed that HIV was more infectious when symptoms were visible, and were especially worried if there were also children in the household. In Chiang Mai province, respondents suggested that condoms were more likely to be used when one of the partners had visible signs of illness.

Community responses

Being diagnosed as having HIV or AIDS had important consequences for community responses of support and rejection. Four sets of people were identified as providing care for people with HIV and AIDS: visiting relatives, community members known to the household (sometimes talked of as 'neighbours'), community members not known to household members, and volunteers (also described as 'activists' by gay community respondents in Mexico City). Other than in the case of gay men in Mexico City, it was mainly women who provided community support.

Relatives

In Santo Domingo, where households prided themselves on their ability to cope, relatives tended only to become involved at the later stages of a person's illness. In Mumbai, relatives were often not as fully involved in AIDS-related care as might have been the case with other illnesses, there being a tendency for family members to keep an AIDS diagnosis secret wherever possible.

> *'Relatives who are normally sources of support during crises in India, are deliberately kept out of the scene in the HIV epidemic because of the fear that they may tarnish the HIV person's character, or isolate the family'. (I, p.28).*

As one mother of a person with HIV feared:

> *'I don't go to my sister's house because there are many doctors in her family. I'm constantly worried that they may guess (about my son). If the doctors in Mumbai, after being aware, treat you like this (do not touch the patient) then what will they do in Gujerat?' (I, p.28).*

In Kyela district, relatives were sometimes said to help out by moving into the affected household. This kind of support was especially beneficial during periods of lengthy illness when assistance from other community members might be less forthcoming.

Neighbours and other community members

HIV-related stigma not only affected relationships within the home but also relationships between households. In all sites, households were said to be under a degree of surveillance by neighbours, and special interest was taken whenever a person became ill. Such interest might turn to suspicion about AIDS when it was believed that someone in the household might be at 'high risk'. In Mumbai also, particular symptoms, the manner in which bodies were disposed of, and (in a somewhat all-encompassing manner) long-term illness as well as quick deaths, could cause community members to think that AIDS had affected a household.

Less positively, and in those areas of Santo Domingo where AIDS had had greatest impact, there were occasional calls for people with AIDS to be stamped, marked, or in some way publicly identified.

> *'In the higher impact area ... some members of unaffected families proposed sexual abstinence, public identification, stamping or marking, isolating, or putting HIV positive individuals in jail ... Strong fear of infection persists in the community.' (DR, p.16).*

The quality of care provided by neighbours and other community members

varied across study sites. In Kyela district, community members were reported to be the least equivocal about providing care: visits to affected households were made, material assistance offered and help provided when visits to hospital were needed.

> '*Families with sick members were visited by members of the community not only to provide emotional support, and to contribute views on action to be taken, but also to provide material assistance ... When a household could not afford to take the patient to hospital ... members of the community either physically carried the person to the chosen health facility, or contributed towards both the fare and sometimes the medical bills'. (Ta, p.35).*

In Chiang Mai province on the other hand, neighbours and other community members were said to be unsure about visiting affected households, worried that they might be unwelcome, or fearful about transmission. In Netzahualcóyotl, there was said to be little support from neighbours, although this was linked to the fact that because of their recent arrival in this newly developing district, community members tended not to know one another. Responses in Santo Domingo were said to differ according the impact that AIDS had had. In higher impact areas, and despite occasional demands that people with HIV should be publicly identified, community members visited and provided support to affected households. In lower impact areas, people with AIDS were said to be pitied and treated as pariahs, being offered little neighbourly support. Greater local impact, therefore, was said to have created a more positive overall response. From respondents' accounts in Mumbai, it appeared that

where households successfully managed the illness of a person with HIV so that he or she was not seen by community members to pose a threat, then neighbours were on the whole able to respond positively.

Volunteers

Volunteer responses and the role of NGOs were highlighted to varying degrees in country reports. In Kyela district and Mumbai, NGOs barely figured in local responses and had little visibility. The NGO response in Santo Domingo was said to be related to the impact of AIDS. Where the impact had been lower, and where poverty (and its alleviation) was household members' main concern, few NGOs were involved in the provision of AIDS-related care. In the higher impact area, however, a well-organized network of NGO and grass roots support was in place, albeit one which was said not to be responsive to the needs of younger people.

Lack of resources was said to affect the effectiveness of AIDS-related NGOs in Netzahualcóyotl and the Village Health Volunteers in Chiang Mai province. In both cases, volunteers had become unwelcome visitors to affected households: since they brought no money, they were not seen as being able to offer useful support.

> '*The sick household also treats the house visits by Village Health Volunteers with suspicion. These visits are seen to be without purpose or desire to alleviate the problems households face. "They are just stopping by", said a member of one affected household. However, the health volunteers said they were aware of the family's uncertainty over their intentions. In addition, said the volunteers, not only*

were they not given any rewards or incentives to make visits, they were expected to bring a gift paid for by themselves to show their sympathy. For other duties such as checking dogs for rabies vaccinations, the health volunteers were given a small reward'. (Th, p.57).

Lack of understanding was also said to constrain the effectiveness of community-based organizations in Netzahualcóyotl and in Chiang Mai province. NGOs in the Thai sites were said to have failed to involve people with HIV, limiting the impact of their work and its effectiveness. This lack of involvement was said to be related to NGO's requirement that people disclose their HIV status. Integrating HIV and AIDS-related care with more general kinds of community support (such as the Village Health Volunteer System, the Health Card and the Funeral Associations) was felt to hold the potential to contribute to more sustainable forms of community care.

In Netzahualcóyotl, however, where support was provided by non-AIDS specific organizations (such as volunteers from religious organizations and Alcoholics Anonymous), questions were raised about the quality of care provided. Attempts to apply an understanding of other health issues to HIV and AIDS had acted as a barrier to the provision of effective care. Sisters from a Roman Catholic order, for example, were reported as having found it inappropriate to provide condoms.

' ... what happens is that any Sister will say that homosexuality is unnatural and the Bible [talks about] Sodom and Gomorrah ... they have already worked it out for me ... For example, one day I asked a sister to take a box of condoms

to Marcelino. She replied "No, what do you think? It's one thing to work with this (AIDS), and another to distribute condoms" ... and so she didn't'. (M, p.132).

A further barrier to the development of community-based initiatives was highlighted in Chiang Mai province. Where there was an understanding amongst community members that professionals had expertise in relation to HIV and AIDS, and where there were accompanying beliefs that care should be provided in a 'top down' way, there tended to be a lack of community initiative. This left the provision of care to households alone without significant support from wider community members.

Care by friends and community members

Aspects of community-related care among respondents in Mexico City's gay community differed from those already noted. While support by household members (particularly mothers) remained important, gay men's social networks also had an important role to play in providing care. This was particularly true for those gay men who no longer lived near to their biological families. While social networks varied in their size and complexity, they usually included partners, friends and volunteers from 'activist organizations'. While community support for a person with AIDS was influenced by broader understandings of gay solidarity, not all friends provided care and a few became emotionally and physically more distant.

There was reported to be a 'dynamic relationship' between partners, gay social networks, and family members

involved in care. Partners, in particular, not infrequently found themselves negotiating over the type of care provided when it was offered by both biological family members and themselves. The kind of care provided to a gay person with HIV depended on the numbers of people involved in different social networks, their levels of altruism, their access to material resources and their general awareness of health service provision. While friends rather than family members more often provided care at times of crisis, there were limits to such provision and both 'stress' and 'burn-out' were said to limit people's ability to provide care.

The household and the community

Death and mourning

In all sites, funerals were seen as occasions when community members could offer support to the members of bereaved households. Nevertheless, the presence of large numbers of community members at such events could sometimes signal curiosity about, rather than solidarity with, households affected by AIDS. Alternatively, as was noted in Chiang Mai province, funerals could be an opportunity for drinking and gambling.

In Santo Domingo, Kyela district and Chiang Mai province, it was reported that fewer community members expressed support to the members of bereaved households than before, especially in places where the impact of AIDS had been greatest. Although in Santo Domingo this was said to be related to fears of infection at funeral ceremonies, in Kyela district it was linked to the costs of providing food and drink at an increasing number of such events. Despite a strong desire by community members to attend funerals and to support bereaved households, traditional mourning practices involving the slaughter of cattle and the consequent feeding of mourners were now less common due to the cost and the belief that they might exacerbate poverty. Consequently, a part rather than the whole of a village tended to be involved in funeral and mourning rituals.

> '...despite the fact that the whole village is required to participate in support during the mourning period, in reality, much of the material support is offered by villagers living within the hamlet, rather then the whole village as was the case in the past. Obviously as the death toll increases, which is likely going to be the case in a few years time, even the duration of staying with the bereaved family and the nature of other support currently provided would drastically change. In one village an elder noted: "We had just come back from burying one person, when we were told that someone else had died ... and the body had just arrived in the village. It was already dusk, and we were tired. We told the household members not to start mourning until the morning as we were too tired to respond."' (Ta, p.44)

In the two villages in Chiang Mai province, funeral ceremonies had changed to accommodate local fears of infection.

The economic impact of AIDS on households was often greatest on the death of the head of a household. Due to the high cost of medical treatment, there might be particular worries when there were unpaid medical bills.

Following death, the economic impact of AIDS on households could lead both younger and older household members (who may not otherwise have done so) to seek work. While there were opportunities for carers to re-enter the labour force when the person being cared for died, such households were likely to be comparatively worse off than those unaffected by AIDS, as newly bereaved households were more likely to be headed by women whose employment position was less strong.

'Since the majority of early HIV/AIDS deceased were male this situation has increased the number of female-headed households and single-parent families. This has, in turn, increased the burden on the communities' poor. To a substantial extent, the AIDS epidemic has brought about the "feminization of poverty" since these female headed households usually have few skills and earn much less than their ex-husbands'. (Th, p.58-59).

The death of a household member could also lead to physical abuse. In Mumbai, for example, respondents suggested that in better-off families, a bereaved wife might be physically supported, but in lower-income families a woman might find her access to shelter threatened. She might be required to leave her in-laws' home which was previously shared with her husband, and might have the added disadvantage of being unable to return to her own family if they never fully approved of her marriage. Added to this was the possibility of sexual abuse when bereaved wives were seen as being newly sexually available.

Care of bereaved children

When women are bereaved, they still have to provide care for others, par-

ticularly children. In Kyela district, there were reported to be clan rules to guide the ways in which bereaved children should be looked after. Respondents, in both higher and lower impact areas in Santo Domingo, also noted that where immediate family members could not look after them, children tended to be cared for by extended family members. Children's care by extended family members depended to a great extent on the ability of households to afford such support. Children from one family, for example, might be split up and looked after by different relatives.

In Kyela district, the cost of childcare influenced with whom children were placed. With adequate resources and where HIV had not had a high level of impact, children were usually looked after within extended families. Where this was not possible due to financial difficulties, clan members would provide care. Although clan members were required to look after children belonging to their clan, and desired so to do, lack of resources could make this problematic. In Kyela district, more general poverty alleviation programmes rather than HIV and AIDS 'orphan' projects were believed to be better able to address the care and social support needs of children who had lost one or both parents.

' ... it may be more difficult for the traditional coping strategies which allow for household reconstitution, to occur, given the sociocultural and economic changes in the study area. However, in planning interventions which will assist affected and afflicted households to cope with the impact of HIV/AIDS, it is deemed wiser to find ways and means which will augment traditional coping strategies, rather than creating new structures

which may be difficult to sustain beyond foreign aid. This is particularly the case for orphans, where there exists a rich cultural system to provide for support and care of orphans. Attempts at interventions ... aimed at poverty alleviation, will be in the long run much more sustainable than focused attention on AIDS orphans.' (Ta, p.79-80).

Treatment and health care

Across all study sites, respondents noted the high costs of accessing medical care, both in relation to the time needed to travel to services (which might otherwise be spent earning income) and the financial costs of services and drugs. Respondents in Kyela district, for example, noted that medical care was no longer free, and so could not always be afforded. Respondents in Chiang Mai province indicated that the long waits involved in accessing treatment meant that people lost income by having to take time off work. In circumstances where people were paid on a daily basis and had little or no job security, this was especially difficult.

> *'Poor households ... generally ... subsist on day-to-day wage employment (and are) not covered by labour laws or social security regulations. Because (these) people have neither job security nor social welfare benefits, they have to often choose between recovery and going hungry ... In contrast, (for) members of better-off households ... their job benefits not only allow them to take sick leave, but also gives them access to proper health care'. (Th, p.35-36).*

People with HIV from higher-income households on the other hand were said to be able to spend their time 'in and out of' various hospitals and clinics, an option not available to those from poorer backgrounds.

Accessing what was perceived as 'good' medical treatment depended on the ability to pay. Public health services were often viewed more negatively than those provided privately, not only in terms of the treatment available, but also in terms of accessibility. The former might be located at some distance from where they were needed, drugs might only be available at the beginning of a month, people were not told what to expect of treatments, there might be little or no coordination between services, people with HIV were treated badly, public health professionals had little knowledge of HIV treatments or were thought of as too 'authoritarian', and people with HIV using public health services were felt to die faster than those using private services. In relation to this last point, the fact that people with HIV often accessed services at a late stage meant that they sometimes entered hospital particularly unwell. Their subsequent death not infrequently contributed to local 'rumours' that a hospital was no good.

There were, however, positive accounts of public hospitals, particularly where drugs were available free of charge. But, as noted in the report from Mexico, respondents generally had mixed experiences of health care, often reinforcing the negative experiences they had encountered when first diagnosed.

> *'The experience of receiving AIDS related health care at the health clinics can range from being a comforting experience to a completely negative one. Some informants reported solidarity behaviour in the institutions and (with) the doctors, who provided them with some drugs for free, or who at least organized events that made them feel better. But, most of the time, the*

perspective is rather bleak. If the initial impact (HIV notification) ... is not an affirmative one ... this provokes (people with HIV) to distance themselves from health institutions'. (M, p.117-118).

Respondents in Mumbai noted that hospital visits could support the care given by household members by providing the carer with information about appropriate treatments, food and nutrition, as well as affording them the opportunity to meet with counsellors. Although not often available, professional support was said to be helpful in coping with the emotional harms related to HIV such as having to put up with abuse and stigmatization.

Although the often limited resources available to affected household members were one reason why public health services might not be used, the stigma associated with HIV also impacted on people's willingness to access certain forms of health care.

'Most PLWH/A in Thailand do not live long. The delay in seeking care is an important factor (in this) ... PLWH/A ... do not enter the public health care delivery system early due to concerns about the care received as well as their stigmatization ... Many PLWH/A do not go to the hospital to avoid arousing suspicion of having HIV/AIDS'. (Th, p.38-39).

Respondents at this same site noted instances of a people with HIV paying for private treatment rather than using less expensive public health care, for fear of being identified as having AIDS. Reports of people with HIV being treated badly in hospital in this country and in others were also said to be due to medical professionals being overly influenced by the stigma surrounding HIV disease.

Traditional and complementary therapies

The use of traditional and complementary therapies was reported by respondents in Mumbai, Kyela district and Chiang Mai province. Such treatments were often used in an attempt to exert some control over health care by offering hope amid treatment uncertainty. Although media campaigns in Thailand had stressed there was no cure for AIDS, higher and lower income respondents nonetheless sought treatment from traditional healers. While it was known that traditional and complementary treatments did not cure AIDS, they were seen as being able to alleviate certain symptoms.

Respondents in Mumbai reported that complementary medicines were more likely to be used when people with HIV were asymptomatic, allopathic treatment being preferred when serious symptoms appeared. Even so, preparing special diets and foods could help household members feel they were more actively involved in the care of a household member with AIDS.

'Direct and active involvement of the family in health management could be a key to promoting positive coping strategies and possibly in delaying the onset of AIDS. The participation of the members in the treatment process, the special efforts they make in promoting wellbeing, and their general concern for the person, may help in building psychological immunity and a will to live'. (I, p.34).

Where it was problematic to medically diagnose HIV or AIDS, as in the Kyela district in the United Republic of Tanzania, and where there was stigma associated with having AIDS, traditional forms of treatment also offered a way of redefining the illness itself

(especially if the traditional treatment was seen to work). The failure of traditional treatments, an uncertain diagnosis, or the non-availability of treatment drugs could, however, cause people to 'shop around for cures'.

'Uncertainty regarding the cause of illness was evident ... where either a vague diagnosis or no diagnosis was provided by allopathic health services. Within these households, the perceived causes of illness ranged from possession by evil spirits, to being bewitched or cursed. Shopping amongst traditional healers was very prominent in these households, where divination for cause as well as treatment of the conditions was sought'. (Ta, p.60).

Where a traditional treatment was seen not to work, and where the illness was accompanied by symptoms such as weight loss, itchy bodily rash, recurrent fevers and chronic diarrhoea, household and community members tended to suspect that the illness was indeed AIDS. In these circumstances, an official diagnosis was seen as important. Even though AIDS might be more stigmatizing than other illnesses, knowing a person had the disease helped household and community members respond appropriately and use what limited resources are available to best effect.

CONCLUSIONS

Although theoretically it is possible to distinguish household from community responses, and the local enquiries described here were designed on this assumption, evidence from this multi-site study suggests that responses to AIDS cannot be so clearly differentiated in practice. Instead, household and community responses are perhaps best understood as the outcome of an interaction between factors such as poverty and gender and traditional ways of coping with illness and disease. Key influences on household and community responses to HIV and AIDS include:

- the existing economic situation of affected households and communities;
- prevailing community and household relationships between men and women;
- local health beliefs and health care practices; and
- local levels of stigmatization in relation to those living with and affected by HIV and AIDS.

Local contexts influence responses in complex and dynamic ways, and while household and community responses to HIV and AIDS are shaped by pre-existing relationships and beliefs, they in turn influence these beliefs and practices. For example, because most HIV- and AIDS-related care is performed by women, the support needs of women are increasingly being recognized and acted upon. Similarly, while there is much stigma against people with HIV and AIDS, there is growing awareness that such stigma stifles supportive responses and should be challenged. And while traditional funeral practices continue to be adhered to in many sites, the number of deaths from HIV and AIDS-related illness means that funeral practices are changing so as not to exhaust a household's or a community's financial and emotional resources.

While some household and communities have responded to HIV and AIDS with courage, determination, support and solidarity, others have done so with fear, panic, despair and stigmatization. These different kinds of response vary not only between communities but also within them. In Santo Domingo, for example, community members' views about the epidemic were reported as being more polarized in places where AIDS had had the greatest impact.

Paying your way...

Responses to HIV and AIDS at household and community levels were linked to available financial resources. Where the main wage earner (most often male) was unable to work, it was usually incumbent upon his female partner as well as the children to support the household financially. When a main wage earner died, remaining household members were often left with serious debts. For many women and their children this could mean having to vacate their home.

At community level, both the number of people requiring care and the number of deaths caused by AIDS posed serious challenges for existing health care systems and funeral practices. Even in Thailand, a country which until recently has been described as one of the 'tiger economies' of Asia (AIDS

Analysis, 1997), difficulties were reported in matching available resources to health care needs. These were perhaps linked to the benefits of economic growth failing to reach those in rural areas. For those women needing to earn income, traditional work was often unavailable, requiring some to enter a rapidly developing service sector that included sex work.

The care of bereaved children was also linked to the economic circumstances in which parents and siblings found themselves. Most often, existing household, extended household or clan relationships established the structure within which care for bereaved children was provided. But even in contexts such as the Kyela district of the United Republic of Tanzania, where rules were said to exist for the care of children, poverty may force childcare to be provided beyond preferred social networks.

... in a man's world

In each study site, there was evidence of important double standards governing expectations of men and women. Whereas men with HIV were little questioned about how they became infected and were generally cared for, women were often castigated for having had extramarital sex (whether or not this was the case), and received lower levels of support. For those wives who suspected they might be at risk of infection through their husbands, and who had been informed about the need to use condoms, bargaining power was dependent on economic power. The greater the latter, the more force a women could bring to bear in her arguments for condom use.

In every study, women most often provided care for husbands, sons, daughters, or themselves. Even among gay community respondents in Mexico City, sons who were gay regularly returned to their biological family (and particularly to their mothers) to receive care when ill. Women to a much greater extent than men had to balance the provision of care to various household members with an increasing responsibility to support their household financially. They were also reported as being physically, emotionally and sexually abused: by husbands who might insist on sex even when they themselves were seropositive; by in-laws who might demand that a daughter-in-law move out of her deceased husband's home; and by brothers-in-law or other male community members who might believe a recently bereaved wife was sexually available.

Stigma and discrimination

Each country report offered powerful evidence of the stigma, discrimination and secrecy associated with AIDS, as well as the tendency for people to understand AIDS as a disease of 'others'. Respondents made mention of ways in which the presence of AIDS might reveal itself among household or community members. Attention was paid to the forms of employment, sexuality, illness and death, which could mark out the infection, and the infectiousness of others. Sex workers, gay men, 'unfaithful' husbands, people who had lost weight for no apparent reason, and those who had died suddenly or who had been ill for lengthy periods of time were often assumed to have HIV or AIDS.

HIV- and AIDS-related discrimination was manifest in a number of forms: through loss of employment, recrimination, verbal abuse, being ousted from the family home, arguments, resentment and segregation. These responses often caused HIV to be kept secret, at least until physical symptoms made the person's condition obvious. Despite this, it was rare for care not to be provided, for men at least. Men were said to anticipate a more negative reaction than they actually received, and wives in particular usually continued to provide care for their husbands — a form of provision that often went unreciprocated.

AIDS-related discrimination was often justified by real or imagined fears of transmission. While the main routes of transmission were generally understood, there was continuing anxiety about the possibility of infection through bodily contact, bad gases, and the sharing of eating and drinking utensils. In all sites, respondents conflated the ways in which HIV might be transmitted with the manner in which illnesses such as tuberculosis were acquired. Fears were most apparent when children shared the household with a person with HIV/AIDS. When there were visible signs of illness, children, and those deemed particularly vulnerable, were often kept at a distance from the person who was unwell.

Public, private, voluntary and informal sector care

People with HIV and AIDS received care and support from those in the public, private, voluntary and informal sectors. Most reports drew attention to the severe constraints under which medical professionals operated.

Study reports also noted that services offered privately tended to be perceived as of better quality than those provided through publicly funded systems. However, such services were only available to those able or willing to pay for them — which could leave households destitute following a lengthy illness. There were also accounts of health care providers breaking confidentiality, of not being aware of the need for confidentiality, of acting in a discriminatory manner, and of failing to address the emotional needs of people with HIV and their families.

Where HIV antibody tests were not readily available as was the case in the Kyela district of the United Republic of Tanzania and in parts of Mumbai, household members tended to seek traditional cures for the illnesses they believed they had, thereby using limited household resources in an often inappropriate way. Even where medical care was more widely available, traditional forms of health care such as paying special attention to dietary needs were also practised.

The importance of voluntary sector service provision was highlighted in a number of studies. In Netzahualcóyotl, Mexico City and Chiang Mai province, advantages and disadvantages were noted in this form of support. While volunteers could provide an important service to people with HIV and their families, there were occasions when voluntary workers had little practical to offer by way of support, or addressed HIV and AIDS issues in ways which were considered inappropriate.

Despite the involvement of health care professionals, traditional healers

and volunteers, the bulk of care and support in all sites was provided through the informal sector, by partners, relatives, and friends. Without the involvement of these other groups, communities would have been unable to sustain any form of meaningful health care for their members.

Bereavement and funerals

The death of a person with AIDS had profound implications for the reconstitution of households and for funeral preparations. Household reformation often took place at a time of personal loss and mourning, and against a backcloth of impoverishment created by the costs of caring for an unwell household member. For women, the consequences could be particularly severe. If she had previously been living in the home of an in-law, for example, a woman might be asked to move following the death of her husband. Where children had also been bereaved, their emotional and physical health care requirements needed to be addressed. On the whole, however, children continued to be looked after by household members, relatives or clan members.

The high cost of funerals was referred to in both the Tanzanian and Thai studies. Due to the frequency of deaths from AIDS-related illnesses, funeral and mourning practices were in a process of transition. Increasingly, and especially among those who were poor, efforts were being made to keep funeral costs low by inviting fewer people, having fewer days of mourning and purchasing less costly victuals.

Recommendations

A number of recommendations for policy and programme development derive from the studies described in this report.

Policy development

At a policy level, it is important to recognize that:

- Contrary to what is sometimes imagined, households and communities respond to HIV and AIDS in a variety of ways. While all are likely to be negatively affected by the stress and responsibility of caring for seriously ill members, responses of tremendous support and solidarity are not uncommon.

- Existing household and community structures may require reinforcement if they are to respond effectively to the challenges posed by HIV and AIDS. This is particularly true for resource poor households where the advent of HIV and AIDS may pose the greatest challenge.

- Women most usually shoulder the burden of providing HIV- and AIDS-related care, adding to their already heavy responsibilities within the household. Households, families and communities need to be helped to understand that caring for people with HIV and AIDS is a responsibility to be shared, and that both men and women have a role to play in this respect.

- The needs of HIV–positive women in both illness and in health

require special attention if women are not to find the burden of caring for others intolerable in circumstances where they themselves may be unwell.

• While NGOs and CBOs have an important role to play in providing HIV- and AIDS-related care, their actions should not be seen as a substitute for indigenous systems of care and support. NGO involvement may sometimes be unwelcome in affected communities especially when they are seen as contributing little to existing systems of support.

Programme development

In relation to programme development, it is possible to distinguish four main fields of intervention: (i) those relating to the overall context within which household and communities must respond to HIV and AIDS; (ii) those concerning the strengthening of existing household and family responses; (iii) those contributing to the development of stronger and more positive community responses; and (iv) those seeking to establish greater synergy between the household and the community in responding to the epidemic.

(i) Contextual intervention

Local beliefs about HIV and AIDS, modes of transmission, and means of infection influence the ways in which household and communities respond to the epidemic. Where people have accurate knowledge about HIV and AIDS, responses are likely to be more positive than where erroneous beliefs exist. In many circumstances, there is a continuing need for contextual interventions to reinforce understandings of:

• HIV's major routes of transmission;

• the ways in which HIV is *not* transmitted;

• the differences between HIV transmission and the transmission of other diseases such as tuberculosis and malaria;

• the care and support needs of people with HIV and AIDS; and

• the responsibilities of both women and men in meeting these needs.

A combination of mass media and face-to-face approaches may be useful in consolidating accurate knowledge and understanding. Where some knowledge about HIV and AIDS exists, it may be more appropriate to begin by examining (and dispelling) local myths about transmission and the course of disease, than to simply provide more scientific information.

(ii) Strengthening household and family responses

Within the household, a range of interventions may be useful in strengthening positive responses to HIV and AIDS, and in seeking to reduce negative ones. These include interventions to

• promote a realistic appreciation of HIV-related risks including responsibility for safer sex and (where necessary) safer drug use;

• reduce stigma, prejudice and hostility towards people with HIV and

AIDS (e.g. by challenging the stereotypes and assumptions that underpin prejudice and stigmatization);

• promote the household's capacity to provide care and support in ways that minimize the likelihood of disease progression (e.g. through attention to diet, rest and stress reduction);

• establish and reinforce a more equitable division of labour between women and men in relation to the support and care of affected household members — this may involve a redefinition of the concept of 'family support' in circumstances where such support is understood as being women's responsibility;

• ensure that bereaved children, or children whose parents are too sick to care for them, are provided for equitably and in line with local traditions and arrangements.

A number of different strategies may need to be pursued to achieve the above goals. It is not reasonable to suppose that the provision of factual information alone will dispel anxieties about HIV transmission through everyday contact with an infected person. Instead, it may be better to provide such information alongside interventions in which care providers come into close contact with people with HIV and AIDS and suffer adverse consequences. Likewise, it is not realistic to imagine that long established gender relations between women and men can be transformed by a single AIDS-related intervention. Instead, efforts to promote a more equitable

division of labour with respect to AIDS-related care should be linked to broader programmes to improve women's overall economic and educational status.

There was strong evidence from all countries that, except in the most extreme circumstances, special projects for 'AIDS orphans' are unlikely to be of value. Instead, existing households, families and kinship structures should be reinforced in their capacity to offer care and support. This may require linking HIV-related interventions to broader programmes of poverty alleviation and health support in ways sensitive to local family structures, and in a manner which recognizes the potential of extended kin networks to cope with often difficult circumstances.

(iii) Strengthening community responses

Communities vary in their capacity to cope with HIV- and AIDS-related adversity. In some settings, systems of community support may be strong and able to accommodate the new demands triggered by AIDS. In other circumstances, especially where modernization has caused a weakening of community affiliations and ties, the capacity of communities to respond positively to HIV and AIDS may be more limited. Programmes and interventions to strengthen community responses should therefore be tailored to the contexts in which they are implemented, taking into account prevailing community norms. Among the most needed community level interventions are:

• initiatives to reduce stigma and discrimination towards affected indi-

viduals and families, emphasizing how fear, denial and social exclusion can disorient HIV- and AIDS-related prevention and care;

• actions to strengthen partnerships between communities and formal health care providers, including the provision of counselling and support, clarifying boundaries of confidentiality and responsibility, and acting to meet the specific support needs of women providing HIV-related care;

• steps to involve traditional healers and health practitioners more fully in HIV and AIDS-related work; in prevention education; in enhancing the physical and emotional well being of people living with, and affected by HIV and AIDS; and in encouraging client referral to formal health services where serious HIV-related illnesses are suspected; and

• efforts to develop and sustain appropriate systems of voluntary care and support, including those which seek to integrate voluntary care and support with that provided more informally within households and at community level. There is clear evidence from these studies that NGO and CBO effectiveness is dependent on the relationship between these organizations and affected groups and communities, and the capacity of such organizations to show they are providing a needed service or source of support.

(iv) Enhancing synergy between households and community

One of the greatest anxieties expressed by people with HIV and AIDS and their family members was apprehension about how the broader community would react should their diagnosis be known about. People feared being rejected, isolated and stigmatized in their neighbourhood and by friends and relatives. In consequence, there was a tendency to conceal an HIV positive serostatus from others and to seek care and support within the household alone. This is unfortunate since (i) communities are not helped to confront the realities of HIV and AIDS and (ii) community resources such as peer group support, advice from older members and neighbourly concern remain untapped. New programmes and interventions are therefore needed to:

• provide opportunities for communities to face up to AIDS and begin to deal realistically with the challenges it poses;
• provide opportunities for people living with HIV and AIDS to be more open about their serostatus and circumstances;
• dispel inappropriate fears and anxieties about HIV transmission; and
• enable people with HIV and AIDS to be visible as responsible, predictable and valuable members of the community — as part of the 'solution' to the epidemic and not as a 'problem'.

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Part 3
Use of the female condom: gender relations and sexual negotiation

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INTRODUCTION

Several studies have demonstrated the efficacy of the female condom as a method of birth control and as a means of protection against STDs (e.g. Sai, 1993; Soper, Soupe, Shangold et al., 1993; Fontanet et al., 1998). Despite this encouraging research, the value of the female condom for HIV/AIDS prevention remains unclear, not least because unequal power relationships between men and women impact significantly on the ability of women to control the use of any prevention technology (du Guerny & Sjorberg, 1993). One possible means of reducing HIV transmission is to increase women's control over the means of prevention, but this demands good communication as well as access to resources for protection (Mane, Gupta & Weiss, 1994). While a number of studies have focused on the acceptability of the female condom, little research has been conducted into the ways in which its introduction might affect sexual communication and negotiation between men and women (FHI/AIDSCAP, 1997). The primary question underpinning these studies, therefore, was to what extent women's capacity to negotiate safer sex with their partners could be enhanced by the introduction of the female condom.

Simply making the female condom available is unlikely to shift the balance of power between men and women in the absence of other supportive interventions. A two-phase study was therefore designed.

Assessment data were first collected over a 2 — 3-month period on prevailing patterns of gender relations, sexual communication and negotiation. Subsequently, an intervention took place to strengthen women's capacity for sexual communication and negotiation and to provide them with access to the female condom and knowledge and skills relevant to its use. Participants' experiences introducing the female condom into sexual negotiations were monitored. In each of four countries — Costa Rica, Indonesia, Mexico and Senegal — two groups of women participated in the research. One of these groups consisted of women engaged in sex work, the other consisted of women from a range of other backgrounds.

This comparative analysis of findings from these studies begins with a selective review of the literature on gender relations, heterosexual communication and negotiation, and the role of the female condom in safer sex (Chapter 1). The research methods used in each of the four sites are then described (Chapter 2) before data are analysed to highlight similarities and differences in findings across the four sites (Chapter 3). The emphasis is on the analysis of prevailing gender roles and relations, patterns of sexual communication, perceptions of risk, ways of 'negotiating' safer sex, the reactions of study participants and their partners to the female condom, and its impact on gender relations. A final chapter discusses the studies' implications for future policy and practice in HIV prevention.

The studies described were exploratory qualitative investigations and therefore exhibit the strengths

and limitations of this kind of enquiry. They provide insight into the nature of prevailing norms, relationships and processes of sexual communication and negotiation, but do not seek to measure or quantify these phenomena. No tests of statistical significance were performed on the data — such would have been inappropriate given sample sizes, the manner in which respondents were chosen, and the commitments of qualitative enquiry. This multi-site study *Use of the female condom: gender relations and sexual negotiation* seeks therefore to illuminate key issues and concerns which might be further examined, in research of perhaps a different kind.

BACKGROUND

In most countries women are at particular risk of HIV infection. Recent estimates suggest that nearly half of those infected with HIV worldwide are women, and of the estimated 2.3 million people who died from HIV-related diseases in 1997 about a half were female (UNAIDS, 1997). Women constitute more than 50% of all adults with HIV infection in sub-Saharan Africa, more than 40% in the Caribbean, around 20% in central and south America, and about 30% in south and south-east Asia (UNAIDS & WHO, 1996). There is evidence to suggest that women have increased physiological vulnerability to HIV infection, it having been estimated that the risk of transmission from man to woman per exposure can be up to 2.5 times higher than that from woman to man (European Study Group on Heterosexual Transmission of HIV, 1992). Stereotypical gender roles and unequal power relationships between men and women, as well as increased economic and social vulnerability, mean that women are less likely to control how, when and where sex takes place (Mane, Gupta & Weiss, 1994; Heise & Elias, 1995; International Center for Research on Women, 1996).

Context

Developing countries have been among those most affected by HIV and AIDS (WHO, 1994a). Although, HIV prevalence varies considerably between countries, parts of Africa, south and central America and Asia have high and often rapidly increasing rates of infection (UNAIDS, 1997). While HIV can in theory affect anyone, globally there are marked inequalities of risk dependent on cultural and structural factors that are often beyond the control of individuals (Decosas, 1996). Sweat & Denison (1995) have recently described the ways in which social, economic and political forces such as poverty, migration, urbanization, war and civil disturbance facilitate HIV transmission. Women in developing countries may be at particularly high risk of acquiring HIV, and the special vulnerability of young women is now well documented. Estimates suggest that in Uganda, for example, HIV infection among young women aged 13-19 years can be up to 20 times higher than for men of the same age group (Panos Institute, 1996). In some cities in sub-Saharan Africa HIV prevalence among young pregnant women may be higher than 30% (Mann & Tarantola, 1996).

Several factors place women in developing countries at higher risk of HIV infection. Access to education is often more limited for girls than for boys; levels of literacy for females are usually lower than for males (Sivard, 1985); and women are more likely to be living in or vulnerable to poverty (Gupta & Weiss, 1993; Ankrah, 1996). Women are also more likely than men to experience sexual coercion or rape, and are more likely to sell sex in order to survive. In Malawi, two thirds of 168 young women recently surveyed reported having sexual intercourse in exchange for gifts or money, while at the University of Calabar in Nigeria nearly 15% of women studying said that they had received payment for sex in order to finance their education

(International Center for Research on Women, 1996).

Women may be drawn into sex work as a result of poverty or in order to pay off family debts. The Chiang Mai Hill Tribes Welfare and Development Center in Thailand, for example, has estimated that one in five girls coming into contact with the project provide sexual services for payment, and some have been sold or given into prostitution by family members (WHO, 1994b). In less precarious circumstances women often lack the resources and power to negotiate effectively with men over safer sex. Women participating in focus group discussions in Mumbai, India, for example have stated that, because of economic dependence and fear of physical violence, they must submit to their husband's sexual demands without opposition (George & Jaswal, 1994).

In many parts of the world, the tendency for women to have sexual partners older than themselves also increases vulnerability to HIV infection (Heise & Elias, 1995). Since such partners are often sexually experienced, they are more likely to be infected (Panos Institute, 1996). Research also shows that women's risk of acquiring HIV increases dramatically as age at first intercourse falls (Palloni & Lee, 1992), and exposure to HIV before physical maturity greatly increases the risk of infection (United Nations Development Project, 1992).

Social attitudes towards sexual activity vary dramatically. While sexual activity may be considered acceptable and even healthy for boys and young men, this is not the case for young women (see, for example, Bezmalinovic et al.

1994). The high value afforded to virginity in girls, in conjunction with a very different set of values for boys, can also enhance vulnerability to HIV infection. Moreover, young people interviewed in several recent studies have reported that anal sex is often used as a means to protect a girl's virginity (International Center for Research on Women, 1996).

Recent work in Mexico suggests that gender stereotypes affect young men's willingness to use condoms. They also promote the idea that whereas one partner may be appropriate for women, a 'real man' must have several different partners concurrently (Lemus, 1992). Stereotypes and expectations also place women at risk in cultures where being too knowledgeable about sex is seen as evidence of promiscuity. Recent studies in Thailand, for example, have shown that here as in other countries there are pressures on young women to be ignorant about sex for fear they will be seen as being too experienced (Cash & Anasuchatkal, 1993; Cash et al., 1997).

Women have often been identified as key players in the control of HIV — a focus that has been seen by some as reinforcing their traditional responsibility for the health of the household and as guardians of morality (Bland, 1985). A major criticism of some early HIV/AIDS prevention initiatives was that they failed to give enough attention to women's economic and social subordination, and the implications of this for their ability to negotiate where, when and how sex took place (FHI/AIDSCAP, 1997). This situation has changed, however, and there is now an increasing body of literature that suggests that gender empower-

ment is key to women's ability to protect themselves from HIV infection (Preston-Whyte, 1995). Additionally, there is growing acknowledgment that structural and political changes can help both women and men in developing countries protect themselves from HIV infection. Baldo (1995), for example, has stated that responsibility for the prevention of HIV infection is not solely a matter for the individual, but that social policies are needed to inhibit the growth of the epidemic. Policies, programmes and interventions to promote greater equality between men and women, and provide greater access to education for girls, are crucial to HIV prevention (d'Cruz-Grote, 1996).

Gender, power and sexuality

The term gender emphasizes the social shaping of femininity and masculinity, and challenges the idea that relations between women and men are ordained by nature. Social differences between men and women profoundly affect women's sexual relations with men, and gender and sexuality intersect with other social divisions such as those of race and social class (Holland, Ramazanoglu, Scott et al., 1992; Jackson & Scott, 1996). In most societies, gender inequalities cause women to have less access to and control over economic resources. This in turn leads to dependence on male partners and relatives for material survival. Women's socioeconomic position in turn affects their ability to enter into sexual relationships with men as equal partners and, even where there is a measure of equality, powerful norms about sexuality and sexual behaviour construct and constrain women's behaviour.

Gender inequalities are reflected in sexual relationships between women and men. Pressure and violence may be the outcomes when male demands for sex are not met (George, 1996, 1997; du Guerny & Sjorberg, 1993). Women not infrequently have to juggle the twin expectations of being sexually available without appearing to be sexually active. They may find themselves in circumstances where men expect them to provide sexual services either privately in the context of relationships and marriage, or commercially in the context of prostitution, on terms that are not of their making — circumstances which deny women the right to sexual autonomy and sexual pleasure. Women in a diverse range of countries have reported being unable to act upon what they know about HIV and AIDS for fear of implying through requests for condom use that a partner is not loved or not trusted. Such requests may disturb the intimacy that is central to many relationships and can result in violence, abandonment or rape (Ankrah & Attika, 1997).

In most countries women's experience of sex is constructed in relation to male sexual needs and wishes in a context of dependence and, in some cases, a discourse of romantic love. This is not, however, to suggest that women are simply the passive victims of male sexual demands. Both individually and collectively, women develop strategies for gaining sexual pleasure and for resisting the pressures imposed upon them by men, but they do so from an unequal starting point.

Sexual communication and 'negotiation'

The focus of many HIV prevention programmes to date has been the

promotion of mutual monogamy and condom use, both of which require good communication and negotiation between partners. Verbal communication may, however, be one of the most problematic aspects of heterosexual encounters (Holland, Ramazanoglu and Scott, 1990), and difficulty in sexual communication appears prevalent in countries as culturally disparate as the USA, Brazil and India (Goldstein, 1994; Bang & Bang, 1992). Participants in recent focus group discussions in Mumbai suggested that unequal power relations between men and women serve as a barrier to communication about sex between husband and wife (George & Jaswal, 1994; George, 1997), and an earlier survey of spousal communication in Asian countries found that almost a third of the women interviewed *never* talked to their husbands about sexual matters (McNamara, 1991). Research suggests that overt sexual communication between husbands and wives is also rare in many countries in sub-Saharan Africa (Caldwell, Caldwell & Quiggin, 1989).

Negotiating mutual monogamy most probably entails major changes in men's understandings of themselves as sexual beings, and while this emphasizes the need to prioritize work with men, bringing about such changes is probably not a realistic short-term expectation. Women participating in research in Thailand have commented that they would tend to think that a man who does not visit sex workers is not a 'real man' (Cash & Anasuchatkul, 1993), while women in Mumbai have expressed the view that a wife must accept her husband having partners outside marriage (George & Jaswal, 1994). Women participating in focus group discussions

in Zambia have pointed out that while wives can (and possibly should) be monogamous, they cannot hope to control the number of partners had by a husband (Mushingeh, Chama & Mulikelela, 1991). While as a group women are more likely than men to be monogamous, individually they are also more likely to exchange sex for money or goods as part of a survival strategy (Heise & Elias, 1995). Promoting monogamy among women living in precarious economic circumstances may therefore be unrealistic unless alternative income-generating opportunities are also in place (Gupta, Mane & Weiss, 1996; Preston-Whyte, 1995; Benjamin, 1996).

Programmes promoting the use of condoms in HIV prevention also face difficulties caused by gender inequalities. Using condoms, for example, requires male agreement and women often have to negotiate with an unwilling partner (Heise & Elias, 1995; Elias & Coggins, 1996). Communication and negotiation about sex may be particularly difficult in cultural contexts where women are not meant to know anything about sex (Mane, Gupta & Weiss, 1994). Condoms can also carry negative associations. They may be seen as suitable for 'casual sex' but inappropriate in the context of a longer-term relationship (Cash & Anasuchatkul, 1993). Condoms may be associated with mistrust and some women fear that their partner may suspect them of unfaithfulness if they suggest condoms should be used. Others feel that suggesting the use of condoms is tantamount to accusing their husbands of infidelity (Heise & Elias, 1995; Ankrah & Attika, 1997). In order to persuade women and men to see condoms as a valuable means of protection, it is necessary to over-

come these negative associations. But it is also necessary to address inequalities of power as they influence sexual communication and negotiation for safer sex.

While the concept of sexual negotiation is problematic, since it implies a rationalism and autonomy that may not exist (Mane & Aggleton, 1996), there is evidence to suggest that in circumstances where women are able to influence the forms and contexts where sex occurs, HIV-related risks may be lowered. This may be true for some sex workers who are able to determine through the price charged the kind of sex that will take place. It may also be true for women who are in a position to withhold sex or some other service. Research has shown that some women in Nigeria, for example, are able to refuse sex without reprisal if their partner is known to have a STD, although it should be noted that the particular women surveyed enjoyed higher than usual degrees of economic independence (Orubuloye, Caldwell & Caldwell, 1992).

Central to the long-term success of HIV prevention are forms of protection over which women have more control and to which men offer less resistance (Heise & Elias, 1995; Elias & Coggins, 1996). Ideally, these might take the form of safe and undetectable microbicides over which a woman has control (Elias, 1996; Elias & Heise, 1996), but in the absence of these, barrier forms of protection such as that offered by the female condom may have an important role to play.

The female condom

The female condom was developed as a barrier method of contraception in the late 1980s by Phoenix Health Care (now Chartex International) of Chicago, Illinois. It is a cylindrical polyurethane bag about seven inches long with an integral outer ring at its wide end and a loose smaller inner ring at the closed end. This inner ring is used to guide the condom into the vagina and is then used to keep the condom in place against the cervix. The outer ring then holds the condom in place outside the vagina covering the woman's external genitalia.

Initial responses

Initial responses to the female condom were muted and there was sparse attendance at a poster presentation on its potential role in HIV prevention given by Leeper at the Vth International Conference on AIDS in Montreal in 1989. Anxieties were voiced about the likelihood of sex workers re-using the condom, a response that was in line with the view that women are 'risky' rather than at risk. For others working in HIV prevention, anticipation was tempered by concern. While some were positive about the prospect of a device that was under women's control, others were worried that it would place the task of preventing HIV transmission even more firmly in women's hands, absolving heterosexual men of responsibility for changing their behaviour and thereby reinforcing traditional gender relations (Panos Institute, 1990).

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3   The female condom received approval in the UK and some other European countries in 1991, and US Food and Drug Administration acceptance in 1992.

Acceptability

Since it became available in the early 1990s,[3] the female condom has been fairly widely assessed for its acceptability and for its effectiveness as an STD prevention measure (George & Mane, 1996). In Europe and North America it has received a mixed response from health professionals, users and potential users (Lehto, 1991; Hoffman, 1991; Ford & Mathie, 1993; Gollub, Stein & El-Dadr, 1995; Perry, Sikkema, Wagstaffe et al., 1996). Studies in a variety of African (Ray et al., 1995; Ankrah, Kalckmann & Kabira, 1996; Timyan et al., 1996; MacIntyre et al., 1996; Musaba, Morrison & Sunkutu, 1996; Ankrah & Attika, 1997), Asian (Tansathit & Cheevakej, 1990; Chan, 1994; Jenkins et al., 1995) and South American (Gindin, n.d.; Ankrah & Attika, 1997) countries have shown that some groups of women relate positively to its use. A recent review of over 40 studies of female condom acceptability conducted worldwide concluded that the overall balance of view lies in its favour (UNDP/UNFPA/WHO/World Bank Special Programme of Research on Human Reproduction, 1997).

Effectiveness

While there is evidence that the female condom can be as effective as other barrier contraceptives (FHI/AID-SCAP, 1997), its effectiveness as a means of protection against STDs including HIV has as yet been less studied. What evidence there is suggests that it may be as likely as the male condom to protect against STDs such as trichomoniasis (Soper et al., 1993). A recent field study conducted with the support of the World Health Organization and UNAIDS in Thailand suggests that the female condom has

potential to offer protection against STDs among women sex workers and their clients (Fontanet et al., 1998).

Cost

A major barrier to the use of the female condom is cost. This was found to be the main obstacle to use among women, including sex workers, in both urban and rural areas of Uganda who were in other respects overwhelmingly positive about its use (Dithan et al., 1996). The relatively high cost of the female condom compared to the male condom derives from several factors: polyurethane is more expensive than latex, more of it is used, and the manufacturing process is also expensive. Female condoms sell for between US$ 1 and US$ 3 in the USA and Europe, a price that is too high for the majority of potential users in developing countries. Expanding the range of choices is clearly important though, and research suggests that, if provided with a broader set of preventive options, women will try new and sometimes multiple methods, thereby achieving a higher proportion of protected sexual encounters (Elias & Coggins, 1996; Gollub, 1996). For this reason, a guaranteed purchase price of less than US$ 1 for public-sector agencies in developing countries has recently been negotiated between UNAIDS and the female condom's manufacturers.

Sexual communication

What remains to be ascertained is the impact of the female condom on sexual communication. Of particular importance is the extent to which the female condom may empower women in their negotiations with

men over the form and context within which sexual relations occur. Strong anecdotal evidence exists to suggest that the level of this empowerment may vary, since the impact of the female condom may depend on context (Williamson and Joanis, 1994). Learning more about the circumstances in which empowerment takes place is central to the success of future programmes and interventions involving the female condom as an HIV prevention technology.

Women's empowerment

Empowerment is a difficult concept to define and there has been much discussion as to its meaning in relation to sexual and reproductive health. For the purposes of this study, however, it is understood as implying an autonomy in sexual communication and decision making, based on an understanding of options for prevention, in the context of relevant resources for protection. Such a definition shares features with the approaches to empowerment recently offered by the 'Women's Empowerment Framework' (Longwe, n.d.) and by the Pan American Health Organization through its work on gender, health and development (Labonte, 1997).

Envisaging empowerment for women requires defining the power relations that need tackling as well as the means of changing them. In the context of sexual encounters, however, empowering women can mean a variety of things. These include not engaging in sexual activity with others, not engaging in sexual activity without informed consent, getting men to consent to safer sex practices, negotiating sexual practices which are

pleasurable to women as well as to men, exploring sexuality independently, and developing an independent sexuality (Holland, Ramazanoglu, Scott et al., 1992). Whether and to what extent any of these changes are possible are questions that depend on the circumstances in which women find themselves. There is clear evidence to show that women are more able to put their intentions regarding safer sex into practice when they have some personal experience of empowerment (Holland, Ramazanoglu, Scott et al., 1992; Holland, Ramazanoglu, Sharpe et al., 1992). Empowerment therefore offers a starting point for practical strategies to transform sexual relationships between women and men. Possibilities of empowerment are, however, influenced by divisions and differences between women including those of class, ethnicity, culture and religion (Cain & Finch, 1981).

An important study in two contrasting communities in South Africa highlighted the contextual differences affecting women's empowerment in relation to the female condom (Preston-Whyte, 1995). Findings from this study suggest that women in one of these communities — Nhlungwane — were able to begin using the female condom because existing levels of political involvement made them confident enough to negotiate its use with sexual partners. This political involvement also encouraged other women in the community to follow their example. These women, who were aware of the constraints on their lives and the threats to their health as a result of economic dependence on men, saw the female condom as a potential means of managing risk. Their shared experiences thereby

became the resources on which to draw in communicating about sex with male partners and in negotiating the use of the female condom. Other studies also point to the importance of introducing the female condom in the context of group-based interventions in which women can gain support for change both from the intervention itself and from one another (see, for example, Shervington, 1993).

Concluding comments

Much attention has been given to issues of gender, power and women's sexuality in recent work in HIV prevention. This has highlighted the importance of taking account of women's own expertise and understandings. It is important that programmes enable women by offering support, information and opportunities to develop skills that would not otherwise be available. This way of working is part of a wider movement towards building *sexual citizenship* and a more expanded understanding of sexual and reproductive health (Working Group on Sexual Behaviour Research, 1995; Scott & Freeman, 1995). The studies described in this report reflect the growing desire to promote such ideals and to work with women and men in this way. They also derive from the belief that it is crucial to conduct research in ways relevant to a particular setting, and with the desire to ensure that findings are acted upon speedily, sensitively and appropriately (Gupta & Weiss, 1993).

CHAPTER 3

STUDY DESIGN AND METHODOLOGY

In May 1993 the World Health Organization's former Global Programme on AIDS (WHO/GPA) published a general research protocol for studies of *Sexual negotiation, the empowerment of women and the female condom* (WHO, 1993). Both principal and site-specific research questions were included to enable intercountry comparisons to be made, and to ensure that data collected would be of value to those engaged in local work. Subsequent to the publication of the general research protocol, potential principal investigators from a range of countries were invited to prepare local research proposals. These proposals were reviewed by the former WHO/GPA Steering Committee on Social and Behavioural Research, and four studies — in Costa Rica, Indonesia, Mexico and Senegal — were recommended for funding.

Research questions

Studies supported under this initiative were expected to analyse: (i) prevailing gender relations, (ii) patterns and processes of sexual communication, and (iii) the possibility of empowering women in relation to sexual communication and negotiation through an intervention involving the female condom. The principal research questions to be addressed were as follows:

Gender relations

- Who exercises control in relation to sex and protection?
- Under what circumstances do established patterns of behaviour undergo change?
- How does the balance of power differ in the context of different types of sexual relationship?
- What is the effect of specific socio-cultural contexts on gender relations?
- How do gender relations respond to increased awareness of HIV/AIDS and STDs?
- How do gender relations respond to the possibility of protection?
- If there are such responses, are they favourable to women?

Communication and negotiation

- How do men and women communicate about the terms under which sex occurs?
- How does this communication vary in different kinds of relationships?
- How does this communication vary in different sociocultural contexts?
- How do women negotiate the terms of sexual encounters specifically in relation to protective behaviour?
- How do participatory peer-led discussions strengthen women's inclination and abilities to negotiate protective behaviour?

Risk awareness and protective behaviour

- What is the general level of women's awareness about HIV/AIDS and STDs?
- To what extent are women aware of the protective value of condoms?
- To what extent are women able to influence the terms of any sexual interaction?

- To what extent are women able to introduce the female condom into a sexual encounter?
- How does risk awareness vary in different types of relationship?
- How does risk awareness vary across sociocultural contexts?
- What kinds of problems do men encounter in relation to awareness and protection?
- What do men understand to be the effects of the female condom on sexual practice and negotiation?
- How do men react to any changes that occur as a result of women's raised awareness?

Study design and samples

All four projects followed the design of the general research protocol outlined above, but some variations were included to meet particular local needs and contingencies. A two-stage design was used at each site. First, an assessment of prevailing gender relations, sexual communication and negotiation, and the nature of sexual and reproductive decision making was made. Conducted over a 2—3-month period, this assessment elicited the perspectives of women and men through key informant interviews, the analysis of existing documents and reports, and observation.

Secondly, an intervention took place designed to strengthen women's capacity in sexual communication and negotiation. Two groups of women were selected in each site: women not involved in sex work (group A), and women currently working as sex workers (group B). Given the preliminary nature of the enquiry, respondents were selected so as to be typical but not representative of important subgroups of women for whom the female condom might offer an important prevention option. The numbers of women recruited to each group and their principal social characteristics varied across sites (Table 2). For example, while women in group A in Costa Rica represented a relatively affluent section of the population, this same group in Indonesia was made up of the non-working wives of poorly paid workers. Similarly, group B in Costa Rica included only literate sex workers, while in Senegal this was not the case.

Given the exploratory nature of the studies, control groups were not established except in Mexico where local investigators were confident that women already knew about the female condom and its potential benefits.

The intervention consisted of two principal elements: (i) group activities to encourage women to discuss with one another prevailing gender relations, potential barriers to communication and ways of overcoming these; (ii) the distribution of female condoms along with guidance on their use. Group activities were designed so as to be culturally appropriate and in a format suitable to local expectations and needs.[1] In addition to the female condom, participants were provided with male condoms on request.

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1   The intervention in Mexico, for example, had the following components: a first meeting to explore participant's attitudes towards gender relations and sexual communication/negotiation in general; a second meeting to help participants identify personal assumptions about gender relations and sexual communication and negotiation; a third meeting to introduce the female condom and details about how it might be used. Further details of specific local interventions can be found in individual country reports.

TABLE 2

Respondent characteristics

Country	Site charac- teristics	Initial assessment	Respondent numbers and characteristics (non-sex workers)	Respondent numbers and characteristics (sex workers)
Costa Rica	San José province	Preliminary forum involving local women's groups and potential study participants	Total = 32 Professionals (n=10), students (n=4), office workers (n=8) and housewives (n=10). Aged 20-40.	Total=32 Hotel workers n=16), bar workers (n=8), boarding house work- ers (n=6), massage parlours (n=2). Aged 20-55.
Indonesia	Jakarta area	Formal and infor- mal interviews with key informants; par- ticipant observation among truck drivers and sex workers	n=54 'Housewives'; for two thirds husbands worked in construction industry, for one third husbands were lorry drivers. Aged 20-41.	n=57 Sex workers recruited through 'rehabilitation centre'. Aged 17-32.
Mexico	Mexico DF	Key informant inter- views, observation of places where young people meet, sex work contexts, analysis of secondary sources	n=60 (30 in experimen- tal group, 30 in 'con- trol') Mixed social back- ground Aged 23-35	n=60 (30 in experi- mental group, 30 in 'control') Mixed social back- grounds Aged 23-35.
Senegal	Kaolack and Kolda	Group and individ- ual interviews, observation with focus on form and context of sexual negotiation	n=25 Mixed social back- grounds Aged 16-40	n=20 10 'registered' and 10 non registered women selling/ exchanging sex Aged 16-40

Study sites

Costa Rica

Background — The research began with a preliminary forum to which women working in the fields of health and sexuality were invited. Thirty women attended this meeting to discuss the main objectives of the study and to identify themes to be explored during data collection. This initial consultation aimed to increase confidence and broaden ownership of the project and was considered highly successful in this respect. It also established criteria for the later selection of participants.

In stage one a questionnaire was administered to all the women in each of two groups. The questionnaire was designed to elicit data on sociodemographic characteristics, daily life, health and self care, sense of identity, relationship(s) with partner(s), sexuality, STD and HIV prevention, the female condom, and experience of sex work (group B only). In stage two of the study, women were offered psychosocial support through participation in confidence-building workshops with the following objectives:

- to prompt individual and group reflection on historical and current beliefs and attitudes towards women and in particular to women's right to control their own bodies and sexuality and to determine their own health needs;

- to strengthen participants' image of themselves in order to strengthen self respect and self care;

- to affirm women as active rather than passive in relation to their own health; and

- to ascertain to what extent sharing knowledge and information about STDs, HIV and AIDS might contribute to women's success in negotiating safer sex.

Research design — Two groups of 32 women participated in the study. All the women were resident in San José province, with the majority residing within the city of San José. The first group (group A) consisted of 10 professional women, 4 students, 8 office workers and 10 housewives. These women were aged between 20 and 40. Twenty-four of them were married, a further 3 were cohabiting, and all but 1 had partners who were in employment. Twenty-three of the 32 women in this group were mothers. All were considered to have what locally would be seen as a 'comfortable' standard of living.

A second group (group B) was made up of women working as sex workers in the following settings: 16 in hotels, 8 in bars, 6 in boarding houses, and 2 in massage parlours. Members of this group ranged in age from 20 to 55, with 27 members being aged between 20 and 35. Three women were cohabiting and 13 had a regular partner. Twenty-nine members of the group were mothers. Most of the women working as sex workers had financial responsibilities for children and/or other relatives.

Research process — In the first stage of the study, data were collected on participant characteristics, prevailing gender norms and patterns of sexual communication. In stage two, 16

women from each of the two groups were selected to take part in a seven-session workshop to explore the themes that had emerged in the first stage of the research. Selection took place on the basis of the women's degree of commitment and potential for group-based work. Each group met for seven two-hour sessions held weekly with an experienced facilitator. Discussions and activities focused on issues raised in stage one of the work, as well as those suggested by the investigators.

Indonesia

Background — This study included preliminary enquiry into patterns and processes of sexual negotiation followed by the evaluation of the effects of an intervention that aimed to empower women to negotiate safer sex through the introduction of the female condom. The key aims of the study were as follows:

- to obtain more information about gender relations and sexual communication/negotiation in two samples of women: sex workers and the partners of drivers and construction workers;

- to develop materials to provide women with information about HIV/AIDS and the need to negotiate safer sex *and* to introduce the female condom as an alternative protective strategy;

- to gain a better understanding of the effect of increased knowledge about HIV/AIDS on women's willingness to negotiate safer sex *and* on their willingness to try the female condom;

- to collect data from women on how they negotiated female condom use with partners;

- to collect data on women's experiences of using the female condom over a period of time;

- to gain an understanding of how the use of the female condom may influence women's willingness to negotiate safer sex in the future; and

- to gain an understanding of differences between the two groups of women in the study and their different reactions to the intervention programme.

Research design — Study participants were drawn from the Jakarta area because this was the province with the highest incidence of HIV/AIDS. Group A comprised the partners of drivers and construction workers. These men were seen as being likely to have multiple sexual partners. Group B was made up of sex workers. The main study was preceded by a preliminary investigation using formal and informal interviews with 14 key informants and participant observation conducted among truck drivers and sex workers.

The partners of drivers and construction workers were selected from two areas of the city — Pasar Rebo and Depok — where a large proportion of such workers lives. Women in the Pasar Rebo district were contacted through the wife of a truck driver already known to the research team. Participants in Depok were contacted through a driver who was known to the research team. In-depth entry-level interviews were conducted with

11 women in Pasar Rebo and 43 women in Depok. All were Moslems aged between 20 and 41 who reported having no sex outside marriage, but who were all sexually active within marriage. All were mothers, and the majority had less than six years of formal education. Around two thirds of the women's husbands worked in the construction industry, while the rest were drivers.

The sample of sex workers was contacted through a rehabilitation centre. A meeting was held at the centre attended by about 100 women, at which the aims of the project were explained. Entry level in-depth interviews were then conducted with 63 women, and 57 women participated in the study. Study participants were Moslems aged between 17 and 32, and the majority had no more than six years of formal education. For most, their first experience of sexual intercourse had taken place after marriage and before the age of 17. Over half the women had children who were economically dependent on them and taken care of by grandparents, often in their hometown or village. In the month before the interview, the frequency of sexual contacts varied from 4 to 90 and, in the majority of cases, individuals had had more than one partner in that month.

Research process — Within each session, participants were divided into groups of 10-15, each of which was led by a facilitator and cofacilitator. In the 'housewife' sample, one set of group sessions was held in Pasar Rebo and a further three in Depok, each of which had a facilitator and a cofacilitator. The group that met in Pasar Rebo had 11 par-

ticipants who each attended every session. In the Depok groups, only one participant failed to attend all the sessions. Group sessions covered the following key areas: information about reproduction and contraception; STDs, HIV and AIDS; information and training in the use of the female condom; training in communication and negotiation relating to safer sex; and empowerment through sharing experience of female condom use. Female condoms continued to be distributed at the last two sessions and for one month after the sessions ended. Exit interviews were conducted with participants in the group sessions one month after the final session to enable individual reflection on their experiences of sexual negotiation and use of the female condom.

Mexico

Background — The study was undertaken in Mexico City through CONASIDA's AIDS Information Centres. It took the form of two parallel case studies of a group of 60 sex workers and a group of 60 women not involved in sex work. The study used qualitative methods and included in-depth interviews with individual women in each of the two groups; observations in places where young people meet; observations in massage parlours, bars and street sites where sex workers meet their clients; group discussions and focus groups. Additional background data were drawn from a questionnaire survey of sex workers attending an AIDS Information Centre to be tested for HIV and from data gathered in a focus group study conducted by the same research team in 1990.

Research design — The study had the following components:

- a rapid ethnographic study of the two groups as a result of which 30 women, aged between 23 and 35, were selected from each group to take part in the intervention;

- detailed interviews with each of the 60 participants;

- three intervention workshops at monthly intervals. Participants were provided with supplies of the female condom at the third workshop;

- focus group discussions three weeks after the distribution of female condoms at which further supplies were issued;

- detailed individual interviews two months after the second batch of condoms were distributed; and

- detailed interviews with the male partners of study participants.

Research process — Three intervention workshops were conducted as follows: workshop 1 aimed to investigate participants' attitudes towards gender relations and sexual negotiation; workshop 2 attempted to sensitize participants to their understandings of their own gender and their assumptions about gender relations; and workshop 3 offered information about STDs, introduced the female condom and showed participants how to use it. Interviews and focus group discussions took place after the distribution of female condoms to assess women's experiences using them, and the responses of male partners.

Senegal

Background — In Senegal, the study took place in Kaolack and Kolda, cities chosen to reflect the ethnic diversity of the country and the local incidence and prevalence of HIV and AIDS. Kaolack and Kolda are both poor cities experiencing rapid urbanization, but they have different ethnic profiles: Kaolack has a predominantly Wolof population whereas Kolda has a majority of Fulbe people. At the time of the study, Kaolack had the highest prevalence of HIV among sex workers in Senegal.

Research design — An interpretative qualitative approach was adopted. A rapid assessment first took place using group and individual interviews and observational techniques to collect data on the form and the context of sexual communication and negotiation. Ten research sites were subsequently identified within the two cities, and observations carried out in settings where nonconjugal encounters were likely to occur. These included hotels, bars, restaurants, dances and bus stations. Semi-structured interviews were then carried out with a total of 182 key informants. The target groups for these interviews included male heads of districts, leaders of women's associations or influential women in the area, 'housewives', women in paid work outside the home, registered and non-registered sex workers, and young people in youth associations. In Kaolack these individual interviews were followed by five group interviews that brought together women from different districts and ethnic groups, some of whom were involved either officially or unofficially in sex work. In Kolda 15 group discussions were held with sep-

arate groups for adult women, adult men and young people. Initially, it had been intended to select a subsample of study participants who would use the female condom, but such was the enthusiasm that all group members were given samples to use.

Research process — One person was selected from each group to act as liaison between the research team and the participants. With the help of this coordinator, five volunteers from each district/target community were selected to receive supplies of the female condom on a monthly basis. As a result of the different time scales followed by the study in the two areas, participants in Kolda were followed up over a six month period and those in Kaolack over three months. Fifteen out of the 50 participants dropped out during the follow up period. These were mainly sex workers who left the area.

Data analysis

In each of the individual studies, data were analysed thematically in relation to each of the research questions specified above. Thematic analysis commenced by examining existing records, documents, interview transcripts and fieldnotes to identify prevailing gender relations and their cultural and social determi-

nants. The impact of gender inequality on processes of sexual communication was then explored with attention being focused on factors constraining and enabling communication between women and men. Perceptions of risk were identified before and after the intervention, followed by participants' experiences communicating about and negotiating the use of the female condom with their partners. Finally, the responses of women and men to the female condom were assessed along with their implications for prevention.

Given the exploratory nature of the studies described here, the different samples selected and the qualitative nature of the data collected, it is not appropriate to report the frequencies with which particular statements were made — indeed to do so would run counter to the established principles of qualitative enquiry. Instead, the focus is on the recurrent themes and issues that arose at each site, as well as those that existed across the different sites in the study. Unless otherwise stated, the views cited are those considered by the principal investigator concerned to be typical of the overall pattern of women's and/or men's responses at that site. Minority and idiosyncratic views are reported as such.

COMPARATIVE ANALYSIS

In this section, data from the four research sites are reviewed to identify what the four studies taken together reveal about the potential of the female condom to contribute to sexual communication and sexual negotiation in ways that are empowering for women. Data from the four individual studies are analysed in relation to five key themes: (i) prevailing gender roles and relations, (ii) patterns and processes of sexual communication, (iii) perceptions of risk, (iv) the negotiation of safer sex, and (v) the reactions of participants and their partners to the female condom and its impact on gender relations.

Prevailing gender roles and relations

In each of the four sites, women participating in the study pointed to important gender differences in self understandings, behaviours, roles and expectations. In Indonesia, for example, women study participants considered themselves inferior to men, and deferred to them either out of fear or in deference to dominant cultural values (Setiadi and Widyantoro, 1993). In Costa Rica and Mexico on the other hand, where forms of subordination may be more subtle, there was evidence that women are beginning to question traditional roles and have not so fully internalized a sense of inferiority. Although distinct roles for men and women were apparent in all four sites, the reasons given for these differences varied. In Indonesia, for example, the Islamic faith was seen as

prescribing particular behaviours for men and women, whereas in Mexico and Costa Rica most women perceived gender roles as being shaped by a male-dominated cultural expectations.

Irrespective of the ways in which the women saw the reasons for differentiated roles, or indeed the merits of this differentiation, respondents in all sites saw women as more constrained, and perceived female roles as linked to expectations that limit sexual behaviour in a way that men's roles do not. One woman in Mexico commented that:

> *'In our society principally our sexual freedom is limited. A woman should be married in white, she shouldn't go out with a number of men because then she wouldn't be a nice girl. The more men who pass through your life the more devalued your image is.'*

Comments by women in all four sites suggested that female sexuality is more constrained and controlled than that of men. In all the settings where the studies took place, women were expected to have sexual relations exclusively with one man, while this was clearly not the expectation for men in these same cultural contexts.

Study participants commented that in addition to cultural expectations, the behaviour of women was also constrained by their economic dependence on men and the threat of withdrawal of this support. In Senegal and Indonesia, where polygamy may occur, the threat of a man taking another wife ensured greater female submission to male demands. In Indonesia, women expressed the view that men will be unfaithful or take another wife if a

woman gives poor service in the domestic and sexual arenas, and that compliance with his wishes is the best way of preventing this. One participant in Senegal highlighted women's economic dependence on men when she told researchers that she always complied with her husband's demands for sex ' ... or else he won't give me money to buy food'. While polygamy is illegal in Mexico, women here described how men commonly have more than one family, which limits the resources that can be offered to each woman and encourages greater compliance with male wishes.

In Mexico, Costa Rica and Senegal women were increasingly active in paid work outside the home. Women currently constitute a third of the economically active population in Costa Rica (National Centre for Women and Family Development, 1995) and a similar proportion work outside the home in Mexico (Garcia, 1993). Women participating in the study in Senegal reported that in spite of the traditional sexual division of labour whereby men are responsible for the production of cash crops, women are increasingly involved in work such as food production, crafts, clothing and domestic employment. However, men continue to hold land rights and have the power to authorize whether women can work outside the home.

Increased economic independence offers women a wider range of sexual and lifestyle choices. One woman in Mexico commented that:

'A clandestine relationship is more enjoyable, going out with a man who is

committed [married or with a regular girlfriend or lover] is better than with someone who is there only for me, and who because of that begins to limit my freedom'.

However, the new freedoms that women commented on were framed by traditional sex roles and the privileges afforded to male sexuality:

'I have lived alone for many years. In a way I have made myself, by myself. With many girlfriends who are professionals I have seen it; we are independent and they [men] see us in a competitive way... I feel many types of barriers; you are a professional and you live alone, they [men] have to be "careful" with you ...They still don't understand that it isn't a competition, but sharing'.

Women in this kind of situation are often acutely aware of being caught up in a set of contradictions not of their making: 'As time goes by, your being single is dangerous for married women, and your girlfriends marginalize you', commented another woman from the non-sex worker sample in Mexico. Even with increased economic activity, women reported feelings of frustration in relation to their work and professional ambitions. One woman in Costa Rica not untypically commented that she 'wanted to be a journalist or a physical education teacher. Any profession where I could get out and about and meet people'.[1]

In spite of increasing opportunities for paid work, a clear division of labour was still reported at home. Those women who were economically active outside the home still took the greater share of responsibility for domestic

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1   Ambitions of this nature are influenced by social class as well as gender. The sample of women in Costa Rica included more women with formal education than in other sites.

tasks and providing care for others. Indeed the role of caregiver was a valued role and a source of pride for most women interviewed. Moreover, women in Senegal who had become economically active outside of the home were not necessarily less economically dependent on men, and engagement with commerce could result in women facing additional sexual pressures. Respondents described how they were expected to exchange sexual services for commercial benefits such as access to transport, suitable accommodation and the smoothing out of customs formalities. The restaurants and bars run by women were often places where men expected to receive sexual services. Additionally, young women engaged in domestic work or selling food products were subject to sexual harassment from their employers and customers.

In Senegal, the registration of sex workers commenced in 1966. However, registered sex workers are still much less common than women offering sexual services on an informal but paid basis often out of economic necessity. As one such respondent explained:

> '*Before I got into this activity, I would serve as a maid in town, the maid's job could not yield a lot of money in relation to my needs, sexual activity can generate nightly the equivalent of a maid's monthly pay. At the beginning my parents were reluctant but now I am my family's main source of income. My father is now out of work and it's my mother, who sells vegetables and fish in front of our house, and myself, who provide for the household expenses*'.

Some women involved in sex work felt thwarted in their ambitions by tradi-

tional expectations of the female role. One sex worker in Costa Rica commented that she 'dreamed of making a family, having children, (and) having a man who loves me and looks after me'. Another woman from the same group said 'I dream of being a married lady, a housewife, (and) of finding a supportive man who loves me and my children'. The complex nature of gender relations is demonstrated here, in that women hope that men will play at least part of their prescribed gender role (that of provider), while it is also clear that economic dependence on men can lock women into a submissive role demanding their compliance with male wishes.

In two of the sites — Mexico and Costa Rica — some considerable questioning of traditional gender roles was apparent, and some women felt that they had broken out of traditional expectations, although often not without a struggle and not without paying a price. As a respondent in Mexico put it,

> '*We have rebelled. We consider ourselves less, we let them step on us, humiliate us, use us. In spite of my beliefs, I have let myself be stepped on, although I haven't wanted things to be that way. But we carry a cultural burden from centuries back which we are not going to get rid of in one generation, or because you have been to the university, or because you think a certain way; it's difficult.*'

Such women had clear ideas about their oppression. As one woman in Costa Rica described it,

> '*That is what women are for, to be screwed. At the middle level they see you as the secretary; in the home it's obvious. They see you as the secretary, as the one who screws, "I screwed her and now she is screwed"*'.

Findings from all four countries demonstrated how power is embedded in the gender relations characteristic of each site. Women in all four research sites were systematically socially disadvantaged *vis-à-vis* men, albeit to different degrees and with differing implications for their sexual relationships. Where women's levels of labour-market participation were increasing, such as in Costa Rica and Mexico, this did not necessarily lead to economic independence, mainly as a result of low wages. However, increased access to education and to the labour market appears to result in increased expectations about women's place in society and a greater likelihood that inequalities will be explained as cultural in origin and therefore potentially changeable. Thus, while respondents from Costa Rica and Mexico appear to be less satisfied with their lot, and in particular with their sexual relationships, this may be explained as much by a greater desire for independence as by more oppressive gender relations.

Women across all four sites continue to have the major responsibility for domestic work and child care, and even those who wished to be free of 'traditional' roles and definitions of women's work continued to gain a positive sense of self from being seen as caring. Where gender differences were most deeply riven into the culture and religion of a society, however, respondents were more likely to accept a definition of themselves as inferior to men and therefore to be less critical, or at least to have lower expectations about their lives in general and their relationships with male partners in particular.

Even where women had both a strong sense of their own autonomy and a strong desire for a different kind of relationship with men, as was the case for middle class study participants in Mexico, they were reliant not only on having a high degree of economic independence, but also on finding male partners who were committed to change. In order successfully to change gender relations, women need not only increased autonomy and economic independence but also a sense of empowerment and the experience of acting upon it. To be transformatory in the context of gender relations, empowerment has to be integrated both intellectually and experientially (Holland, Ramazanoglu, Scott et al., 1991).

Sexual communication

There were a number of parallels in the expectations and relationships underpinning sexual communication between men and women in each of the sites. The most important barrier to open communication about sex was the belief that talking about sex, and to some degree experiencing sexual desires and needs, is not appropriate for women, or certainly not for women who fear that questions will be raised about their character and morality.

In Indonesia, for example, women expressed the view that it was not appropriate for a woman to discuss sex or to express sexual desire openly to her husband. Non-sex workers participating in the study stated that such behaviour was 'improper', that they would be 'ashamed', and that they would be considered to be 'oversexed'. Women in the quite different cultural climate of Costa Rica expressed similar views, giving among

other the reasons for not talking with partners 'He may think I'm a bad girl' or 'Because it's vulgar, it is not polite. Women shouldn't even think about it' and 'I feel shy, inhibited'. In a range of contexts, therefore, cultural expectations about female sexuality and its expression inhibit the open discussion of sex. Women in Indonesia were, however, able to openly discuss contraception with their husbands and in general male partners were described as supportive of their wives' participation in family planning programmes, at least when female controlled methods were used.

Women in each country described how non-verbal communication was used to manage sexual interaction, especially that involving expressions of need. In Indonesia, women described ways in which they could express an interest in sex: 'If it's me who wants it, I pretend to show my thigh unintentionally, then he will know'. Women in Costa Rica, while saying that they made efforts to verbally communicate their desires, said this was difficult and found it easier to use actions rather than words. This illustrates the contradiction for women between having sexual needs met and maintaining a sense of being a 'good' woman. Showing too much sexual knowledge may cause questions to be asked about their propriety. 'As a woman, we are used to receiving, the man does everything. You are afraid they will label you, saying "Why do you know so much? Who have you been to bed with? How do you know?"' commented one respondent in Mexico.

Sexual relations in Senegal are underpinned by adherence to the Islamic faith and a set of prescriptive tradi-tional social norms that differ significantly from those found in other sites. In Senegal, women's desire and need for sex is acknowledged and can be expressed through a variety of symbols including wearing special loincloths and pearl belts, and using incense and perfumes in the house. Although open verbal communication is not considered appropriate, the symbols used indicate clearly to men that their wives desire sex. As one woman put it,

> 'No husband can resist his wife if she desires to have sexual intercourse and uses the set of appropriate means of communication without feeling the need to ask for it by word of mouth, which would be an extremely shameless act'.

Cultural norms and economic dependence underpin much of the sexual communication that takes place between men and women. In each site, women expressed feelings that demonstrated a lack of power to refuse undesired sexual activity with their husbands and partners, and in some cases the inappropriateness of refusing to have sex with a partner if he so wishes. 'A sane mind cannot imagine how a spouse could refuse to have sexual intercourse with her husband' commented one study participant in Senegal, while another said that 'Women must not wear pants in the night in order to make it easy for their husbands when [they] want to have sexual intercourse'.

In Indonesia, religious and cultural expectations may mean that women do not feel it is correct to refuse sex with their husbands: 'I don't feel right to refuse because I feel it's sinful. A woman is her husband's property, she is already bought', commented one

respondent. While women in the other sites did not appear to have internalized ideas about a man's right to sex, they often complied with men's desires in order to protect themselves from economic threat or, in some rarer cases, the threat of physical violence. Women in Mexico expressed a commonly held view that having sex, even when they did not want it, would 'avoid problems later'. Women in Indonesia also cited the fear that their partner would go elsewhere for sex as one reason for compliance.

A clear majority of women interviewed in each site reported being unable to communicate directly about sex in such a way as to influence the form and contexts in which it takes place, although some variations were found among some of the more highly educated and economically independent participants in Costa Rica and Mexico. However, adherence to strong cultural norms in Indonesia and Senegal assisted women in resisting sexual practices they did not want to comply with. Most women in Indonesia, for example, were able to resist oral sex because of cultural and religious norms that prohibit it. In Senegal, some traditional limitations to male influence over sex exist. For example, sexual intercourse should only take place at night and not on nights reserved for another wife. Intercourse is also prohibited during menstruation and, for some ethnic groups, during lactation. Outside of these limits though, force is considered an acceptable means of bringing about a wife's compliance. In all other sites, women expressed the fear that women who refuse to have sex with their husbands may be suspected of having extramarital sex. Interestingly, women in Senegal also described how

the wives of men who did not fulfil their economic and other obligations might take a lover without social sanction. However, since men in Senegal control wealth and decision-making, and since polygamy is widespread, women still find themselves in competition with each other for limited resources, which constrains their power within sexual relationships with men.

Overall, a clear majority of respondents at all sites described relationships between men and women characterized by inequality, and expressed the view that they had neither the power to communicate openly about sex, nor in many instances the ability to resist sexual demands that they did not want to meet.

Women involved in sex work described their relationships with regular partners in terms similar to those of women who did not engage in sex work. Paid transactions differed substantially, however, and open communication between partners was much more common. The contractual nature of the encounter between a sex worker and client meant that women were not so concerned with promoting an image of themselves as lacking in knowledge and experience. Registered sex workers in Senegal said that they expected to control the price charged and the context in which sex occurs. These women usually take clients to their own or a friend's room, or to a hotel. Women who are not registered appeared to have less power to negotiate the form and context of the encounter. Clients generally choose where sex will occur and expect to pay a lower price for it. Unregistered women often do not wish to be seen as prostitutes and

avoid being defined as such by not fixing prices and hoping that men will show generosity after the event. Often no money changes hands, instead women bargain for services related to their other business dealings. However, even for sex workers in Senegal, symbolic and non-verbal communication is more usual than explicit verbal negotiation. Sex workers participating in the study in Costa Rica commented that while they were asked to offer a wide range of sexual services, the contractual nature of the relationship enabled some women to maintain boundaries, at least with some clients.

The key issue that emerges from all four studies was the extent to which gender expectations prevent women from being able to express their sexual needs and desires directly. Respondents expressed a range of reactions from lack of confidence to shame when speaking about sex, although in some cases, particularly among the Indonesian women, discussing contraception was more straightforward. Sex not infrequently failed to live up to expectations and while women had clear ideas about how they would like it to be, they were unable to ask for what they wanted. Reasons given ranged from powerful cultural prohibitions against women expressing sexual desire, to seeing any problems as their responsibility. Some women indicated that they would find it easier to communicate in more relaxed circumstances, but a clear picture emerges showing the contradiction between being sexually knowing and demanding, and being a 'good' woman. This tension leads to less direct attempts at communication which fall some way short of open discussion or negotiation. On the whole, sex workers

find it easier to set the parameters of a sexual encounter that involves payment, although this is not true in their personal relationships. Where non-verbal skills are used, they range from complex and relatively formal erotic practices such as in Senegal, through subtle seduction techniques, to the more common pattern of attempts to determine the form of a sexual encounter by accepting or rejecting certain kinds of sexual advances.

In all four sites, women had little control over the frequency of sexual contact and gave in to sex they did not want in order to avoid problems, ensure economic benefits or to prevent their partner seeking gratification elsewhere. Women rarely referred to such pressures as rape or even coercion, but saw their responses as pragmatic reactions to the inevitable. Interestingly, the two countries with the clearest gender divisions appeared to have culturally acceptable strategies of resistance — in Indonesia, women felt they could invoke cultural and religious norms to resist certain sexual practices, whereas in Senegal it was expected that men's desires could only be met if women's sexual desires and the household's economic needs were first satisfied. While such resistance is produced in a context that is not of the women's choosing, and in some cases with strong limitations placed on what is acceptable, there appears to be a stronger basis for negotiation, if not for open communication, in these contexts than elsewhere. The culture of individuality that is more prevalent in Mexico and Costa Rica is compromised in the sexual arena by men's power and greater autonomy, and places women in a weaker negotiating position.

Perceptions of risk

Levels of knowledge about STDs and HIV/AIDS varied between the groups of women involved in the study. Women in Costa Rica, for example, were able to clearly identify STD and HIV transmission routes and methods of prevention, while women in Indonesia more often gave inaccurate answers to questions on these same topics. The findings in Indonesia are consistent with contemporary studies in that same country which indicate that most women, even those with a high level of education, lack knowledge about HIV and AIDS and risks relating to heterosexual transmission (see, for example, Setiadi and Widyantoro, 1993).

However, even where participants had high levels of knowledge about STDs and HIV they did not generally perceive themselves to be at risk of infection. For example, only four of the women in the group of non-sex workers in Costa Rica saw any need to protect themselves, while the others simply said they were monogamous. These women identified the stability of their relationships and trust in their partners as the reasons why protection was unnecessary. Although some of them felt that there might have been cause for concern in the past, they stated that their partner had now 'changed' and in some cases had been tested for HIV: 'I have confidence in him although it is possible that he could get infected'; 'He has changed and I'm more sure of his conduct although I know he could fall into temptation'.

For women, 'trusting to love' was seen as part of the role of a wife. There was an in-built assumption that being a 'good wife' and therefore a good woman rendered them invulnerable. The sense that they were protected by their status appeared to operate on two levels: at the cultural level where marriage is symbolic of a sacred state, and at the level of the relationship whereby responsibility for the self is invested in the partner.

Women selling sex had no such sense of being protected. Sex workers involved in the study in Costa Rica said that since they are aware that they are at risk of infection, they take measures to protect themselves by using condoms. However, even here there is a question of trust when dealing with regular and known clients. Sex workers in Mexico had a good understanding of HIV and its transmission, perceived themselves to be at risk and used a range of strategies to insist upon condom use. However, they did not us the same strategies in relationships with husbands and boyfriends, instead 'trusting to love' in the same way as other women in this study.

Sex workers in Indonesia did have some knowledge about STDs and HIV and said that under certain circumstances they would attempt to negotiate condom use. Although they were fairly knowledgeable about the symptoms of STDs, the main strategy they used to avoid infection was partner selection, refusing foreign clients or sailors who were perceived to present a greater risk. Respondents considered that they were protected from disease by taking antibiotics and traditional medicines on a regular basis, and by always washing and douching after intercourse. They also reported inspecting clients' genitals and said that they would ask for a condom to

be used or refuse sex if they thought a client had an infection. This group was also much less likely to suggest condom use with 'regular' clients or 'friends', especially if it was assumed that the client's only other sexual partner was his wife.

The research illustrates a range of different positions in relation to HIV/AIDS and STDs varying from a high level of knowledge and little or no sense of risk, through a high sense of risk with little knowledge or even misinformation, to no knowledge and no sense of risk. Only a minority of women in the four studies had a high level of knowledge and a sense of risk proportionate to their sexual behaviour, and only a small proportion of this group were able to 'negotiate' safer sex on this basis.

Negotiating safer sex

Not surprisingly given the findings already described, negotiation for safer sex in the four sites was limited. Three principal reasons accounted for this. First, women did not generally perceive themselves as at risk of STDs and HIV infection. Second, open communication about sex between men and women was limited. Third, women expressed the view that methods of prevention were both undesirable and unnecessary within the context of a committed and loving relationship.

Sex workers participating in this study were most able and most likely to negotiate safer sex because of the commercial nature of the sexual relationship and a heightened sense of their own vulnerability. Women in both Mexico and Costa Rica used a range of strategies to persuade clients to use

condoms. The most common of these were to explain that it was good for both parties, telling the client to look for another woman if he did not want to use a condom, and explaining that they might get pregnant. If a client still resisted, about two thirds of the study participants said that they would continue to refuse to have sexual intercourse, while a third would go ahead but charge more, although the line between these two positions was not always clear.

Within the context of sex work, negotiation about safety and risk is often more open because the exchange is more explicit: women do not need to protect their reputation in the same way as women who are not engaged in sex work and are therefore more able to speak more freely. However, sex workers participating in the study in Indonesia said that they were often quite reluctant to speak to clients about potential health risks. Even when these women did suggest condom use, if the suggestion was rejected they tended to comply with the wishes of the client.

In Senegal, both men and women use symbolic gestures to indicate their willingness or availability for sex, so even for sex workers verbal negotiation about safer sex was limited. Male condoms were thought to be unerotic by study participants in Senegal. As one woman put it, 'With the men's contraceptive I do not feel anything and I do not want my partner to use it'. Here, as in perhaps other contexts, perceptions of sexual pleasure tended to override any concern for the protection of health.

Those most likely to negotiate for condom use were sex workers, partic-

ularly in Costa Rica, and women more generally in Mexico. The common theme that emerges from respondents not engaged in paid sexual activities is that of love, stability and assumed monogamy providing symbolic protection. As has been suggested elsewhere, 'trusting to love' is a particularly risky strategy to adopt (Scott & Freeman, 1995).

Responses to the female condom

The principal objective of this multi-site study was to assess the impact of the female condom on sexual communication and 'negotiation' between women and men. It is important, however, to begin by saying something about the acceptability of the female condom in the particular contexts in which it was introduced, since an unfavourably received technology is likely to impact less strongly on sexual communication than will one which is more positively evaluated.

While the female condom was received favourably by the vast majority of participants at each site, initial concern was expressed when the female condom was first shown. Some women were worried by its unaesthetic appearance, whereas others were concerned about the potential reactions of partners. Among the concerns expressed were worries about anatomy and the potential for the condom to cause harm; the size of the condom and fit; worries about insertion; and anxieties about whether the female condom would heighten or lessen sexual pleasure. For those women who were not comfortable touching their own genitals, the female condom presented the greatest challenge.

Most of these concerns were allayed through the experience of using the female condom. In Mexico one women reported that her initial reservations had faded once she had begun to use it: 'I didn't think it would be so safe and so comfortable, it isn't even hard to put on, it doesn't do anything to you, and the pleasure is the same'. In all countries, women claimed that curiosity and the novelty of the condom had encouraged men to try it out. In Senegal one woman observed that '... Men like discovering tricks, having experiences and new things as is the case with the women's condom'.

Most respondents and their male partners drew favourable comparisons between the female condom and its male counterpart. In Senegal a women working as a sex worker said:

> *'A lot of clients, once they have tried it ask me to use women's condom because they do not like the men's condom which in their opinion decreases vitality and may even make them impotent.'*

Sex workers gave particularly favourable accounts of the female condom. Listed benefits included increased lubrication making sex work more comfortable and encouraging clients to ejaculate more quickly; preferable to the use of sponges when menstruating; and easier to persuade clients to use. As another sex worker in Senegal reported:

> *'I prefer the women's condom. Before with the men's condom I suffered during sexual intercourse. I have a narrow vagina, I felt so bad and I had things like tears especially ... when the man's drunk and he takes time to ejaculate. Now because of the lubrication of the female condom my partners ejaculate*

rapidly, which tires me less. And instead of pain I feel smoothness.'

Introducing the female condom in the context of a group setting had a clear impact on sexual communication between men and women. Women in all sites, but most especially those in Mexico and Costa Rica, expressed feelings of empowerment triggered by having a form of protection over which they had control. 'I feel better knowing I have it, that I'm armed with it, that I have the power'; 'It is like having control, power. Apart from that it feels good' observed two women participating in the study in Costa Rica. Another woman in Mexico commented enthusiastically that:

> *'It feels really great ... You feel really free. Oh, it's the best invention since birth control! I like it better than the male condom because even when you are menstruating you can use it, you can control the situation, you are taking care of yourself, you don't depend on another person ... You can change positions without any problem and begin again'.*

Women in all study sites commented on how important it had been to learn about the female condom in groups and in a generally supportive environment.[2] This helped them talk about their experiences and value themselves. In Costa Rica one woman said, '... it meant a lot because I have learned to value myself more as a person, as a woman'. Another woman at this same site commented 'It has been important for me to be able to share, to be able to study my experiences, to see that I wasn't alone in the things

that I have gone through (and) that those experiences were not exclusive to me.'

Communication skills were crucial in gaining male agreement for use. The wives of drivers and construction workers in Indonesia were particularly successful in persuading husbands to use the female condom. Women's ability and willingness, developed through group sessions, to assert the desire to use protection in the first place was key in sustaining the use of the new device. It is important to note, however, that although the women in Indonesia were reticent to raise any issues about sexuality with their husbands that might cast doubts over their being 'good women', issues of family planning had been discussed previously, and male support for this had already been forthcoming.

In Senegal, the female condom was perceived by respondents as lying firmly within the female domain. As such, it did not challenge male power or virility, which was a positive factor in encouraging men to accept its use. However, some men did express concern that the female condom would facilitate greater freedom for women, including increased opportunities to engage in sex outside of marriage.

In this same country, women were often able to use powers of persuasion even when male partners were reluctant to use the female condom:

> *'Some time after the start of the follow-up my husband began to grow weary of the women's condom and no longer wanted to have sexual intercourse with*

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2   This is not to say that in the absence of group activities the female condom does not offer a useful female controlled prevention technology. It is to suggest that when introduced alongside such activity, its capacity to offer women a way of reducing sexual risk is enhanced.

it. I appealed to his feelings and gently told him that I was much attached to it because it is an excellent way of contraception which does not present any inconvenience and as we had agreed to space out my pregnancies, he had to accept it. I made tasty dishes for him and did everything to coax him'.

Using all their resources and utilizing local cultural norms, women in Senegal were sometimes able to work together with their husband's other wives to persuade men to continue to use the female condom. One respondent told the researcher:

'When you came to tell us about the female condom my co-wife was away on a trip. When she came back she heard about it in conversations among women and informed me of her fear of STDs and AIDS as well as her wish to participate in the follow-up group. Then I asked the researcher on the project whether it was possible and it was. Thus my co-wife and I were accomplices and my husband could not prevent both of us from using the female condom'.

Women in Senegal also reported that the female condom had been incorporated into sexual play between husband and wife, often becoming in itself a mechanism for increased sexual pleasure: 'When my husband wanted to have sexual intercourse with me ... he went to look for the women's condom himself, tore the sachet and placed it in my vagina with gestures which pleased me as much as they did him'. The impact of the female condom on sex play was extremely important in Senegal where the major concerns expressed by the women at the beginning of the study were about whether or not the female condom would enhance sexual pleasure.

Women also reported a greater degree of male involvement in using the female condom than might have been expected given findings about poor sexual communication. In each site, a small number of women who had some difficulties with insertion asked for and were offered help by partners. This involvement may be very important in encouraging the beginning of a sexual dialogue between men and women, and also helped men feel that they still had influence over the form of protection used: 'I told my husband that I had difficulty gripping the internal ring and placing it because of the lubrication. As he could help me he was then very proud of succeeding in introducing it into me correctly' reported one respondent in Senegal.

The promotion of the female condom within the context of a respected research programme also enabled women to encourage men to continue use. In addition, in Senegal women were able to use the dual legitimization of community support, by arguing that most local women had taken up the female condom, to influence the decision of their partners.

Sex workers in all the sites reacted more positively to, and reported that their clients also favoured, the female condom over the male condom. The former put more control into women's domain, and some sex workers did not even tell their clients prior to sex that they were using the female condom. In Mexico, sex workers largely imposed the condom on clients rather than negotiating use, although men could be persuaded because of a sense of adventure and novelty: 'You can make them feel ignorant for not knowing it existed and take advan-

tage of the novelty of it and the desire of the client to be adventurous and experiment'. In Indonesia, sex workers reported feeling more confident about persuading clients to use some form of protection after the intervention, and that the female condom provided new bargaining power with clients who refused to use the male condom.

CHAPTER 5

CONCLUSIONS

Findings from this international study of gender relations, sexual negotiation and the female condom suggest that women are constrained in their sexual behaviour and choices by two major factors: economic dependence on men which makes it more likely that women will comply with male wishes, and gender stereotypes which inform expectations of female and male sexual behaviour and create problems for sexual communication.

The choices women make about when, how, where and with whom they have sex are more constrained than those of men. Even with husbands and in the contexts of long-term relationships, women express reticence in discussing sexual matters with partners: either because they feel this is inappropriate and 'unfeminine', or because of fears that such discussion will be ill received by partners. Although women sex workers find that the contractual nature of relationships with clients facilitates a more open discussion of sexual matters, some find it difficult to openly communicate and negotiate with clients.

The evidence from this study suggests that the female condom will be most successful in enhancing sexual communication and women's empowerment in the following contexts:

- with sex workers who already have some experience of negotiating safer sex with clients, such as those women participating in the research in Mexico and Costa Rica;

- with couples where men are already supportive of family planning, such as those in Indonesia;

- where a sense of community involvement is thought important and where, through this, men can be reassured that acceptance is high among their peers, as in Senegal;

- where the male condom is unpopular, thus rendering the female condom a preferable alternative; and

- where the female condom can be eroticized and introduced into sex play, such as in Senegal.

The female condom may have less impact on sexual communication and negotiation where there is little or no tradition of talking about sex, where women believe themselves to be at low risk of infection, and where partners 'trust in love' as a means of protection against STDs and/or HIV.

The women in this multi-site study reported that men, be they regular partners or clients, were with only rare exceptions unenthusiastic, if not hostile, towards the use of male condoms. Male condoms were considered to decrease pleasure, pinch, rub and cause men to lose their erections.

Although some women expressed concern about the decrease in sensitivity said to be associated with the male condom, the majority of the women not favouring the use of the male condom in these studies focused on men's problems with condoms and

the difficulties of overcoming these. Findings from this study suggest that, when introduced in a particular context, and when accompanied by group work and training of the kind described earlier, the female condom does not have the same negative associations that inhibit the use of the male condom.

Interestingly, some of the women who were most successful in introducing the female condom into their sexual relationships were operating in contexts where there was least likelihood of open verbal communication and negotiation. They include women sex workers who simply imposed the female condom on their clients and found that the latter either did not notice it, or were happy not to be asked to use male condoms. The other context in which the female condom seems to have been relatively easier to integrate was amongst the non-sex worker sample in Senegal. Here, the important factor was the legitimacy of women's engagement in erotic play in pursuit of their husbands' pleasure, which meant that the female condom could be eroticized and read as an indication of the woman's willingness to have sex.

For the majority of the sex workers participating in these studies, protected sex with a regular partner was not considered appropriate. This distinction was often extended to regular clients who counted as friends. This is an understandable distinction and is probably one that, while potentially risky, is emotionally necessary.

The need for trust in intimate relationships (Giddens, 1990 and 1991), and the contradictions that this raises in relation to the practice of safer sex (Mane & Aggleton, 1996; Scott and Freeman, 1995), were salient to all the women taking part in this study. It is difficult for women to accept that they may be at greatest risk from those closest to them, especially if this entails openly acknowledging matters it is sometimes more convenient to ignore. Using the female condom other than for contraceptive purposes is likely to entail acknowledging that a partner is not trustworthy. This is particularly difficult in situations where monogamy is prized and individual failure is stressed in the context of a partner's infidelity. It may then be easier to promote female condom use in social contexts where it is openly acknowledged that men may have multiple partners, but where they resist taking responsibility for this in relation to their own sexual practices and condom use.

In all sites, study participants were willing recruits with relatively high levels of motivation to learn more about sex, sexuality, contraception and health matters or simply to participate in some special set of activities focused on their needs. It is clear from the data that the majority of women found that the process enhanced their confidence and sense of themselves as competent social and sexual actors with rights to some autonomy with regard to their bodies and sexuality. It was also clear that where women were able successfully to introduce the female condom into their sexual relations, this in turn increased their sense of empowerment. The success of this particular research/intervention design means that the likelihood of successfully introducing the female condom into these, or any other, settings or situations without group work, training and other similar develop-

mental work, may not enjoy the same level of success. It is clear that the most successful interventions to prevent further HIV transmission are those that respect the needs of the local community and are gender aware (Mane, Aggleton, Dowsett et al., 1996).

For those women who have little or no experience touching their own genitals, the female condom can present some problems with insertion, although it these difficulties appear to decrease with time, may be alleviated with some assistance from willing partners, and may relate more to anxieties about the body than to female condom use itself.

Somewhat paradoxically this study of *Gender relations, sexual negotiation and the female condom* suggests that the female condom can be introduced with success in certain contexts and circumstances, and without major disruption to the present balance of power in heterosexual sexual relationships. However, since the female condom may be used as a tool in the development of women's sexual confidence and autonomy, this may open up the possibility of greater equality in sexual relations, between men and women. There are indications that the introduction of the female condom can increase women's sense of self-efficacy and self worth in ways that have effects on their lives beyond the immediate issue of condom use. This possibility for seeing both the intervention and the condom as having some transformatory value is illustrated in the words of one Mexican woman:

'After the workshops, it's like you find more words to talk to them [men] dif-ferently, and they feel good with the condom. That was when the change happened and I decided that I can have a voice and a vote, and it is not only his decision. I have a right to feel loved and desired'.

The female condom also offers women a method with which to protect themselves where none existed previously. This increases options for women, especially those who want to protect themselves against HIV and other STDs as well as pregnancy, but who face resistance from men who do not want to use male condoms. The female condom also offers an alternative to the male condom which is more dependent on male compliance and not under women's control. Follow up work needs to be undertaken, however, to ascertain the extent to which the use of the female condom can be sustained over time without the need for wider social and attitudinal change.

Recommendations

The following more specific recommendations derive from the findings of this multi-site study:

- The female condom provides women with an extended choice of means of protection. A number of recent studies have demonstrated that extending choice and enhancing women's options increases the number of protected sex encounters (Elias & Coggins, 1996; Gollub, 1996). Increasing the availability of the female condom therefore has an important role to play in reducing sexual risk.

- There is clear evidence that the female condom is used within, and

integrated into, the context of broader, local social norms about sexuality and reproduction. This has implications for how the female condom is best presented to women and their partners, and emphasis the importance of interventions that are context aware and context specific.

- Introducing the female condom into a given community is unlikely to be sufficient to promote its extensive use or encourage any significant change in sexual communication between men and women. The female condom needs to be introduced within a context of appropriate training and group work which helps women to build their confidence and skills in sexual communication.

- The female condom, when introduced in the context of a planned intervention, can impact on sexual communication and add a new dimension to it. There appears to be an inverse relationship between the level of open, verbal sexual communication before the intervention and the impact of the female condom on sexual communication afterwards.

- It may be particularly helpful to introduce the female condom into environments where there is some history of male condom use, but where this use is characterized by inconsistency and unpopularity. The female condom is well received when the male condom is an unpopular alternative.

- Interestingly, and somewhat paradoxically, the introduction of the female condom in a planned intervention may have the dual effect of helping women to feel empowered, while not making men feel threatened. This provides fruitful grounds for further exploration of issues around negotiation and the power relations between men and women.

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Notes:

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners – governmental and NGO, business, scientific and lay – to share knowledge, skills and best practice across boundaries.

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