ADDRESSING THE CO-OCCURRENCE OF HIV AND GENDER-BASED VIOLENCE: A POSITION PAPER

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Abstract:

Gender inequalities around the world have resulted in exceedingly high rates of HIV among females. Over the last twenty years, power imbalances in sexual and social interactions have left women vulnerable to HIV infection. Socioeconomic and biological factors and predominantly gender roles have contributed to increased rates of violence against women, which in turn perpetuates a feminization of HIV. This position paper examines the co-occurrence of HIV transmission and gender-based violence. In this effort, it is necessary to analyze the role that males play in interventions designed to prevent such violence and infections. This paper examines interventions that utilize three different approaches to participant involvement; female-alone approach, couples-based approach, and a male-alone approach. Evidence from the literature examined suggests there are benefits worth replicating from each type of intervention approach. However, only one study demonstrated sustained reduction in both HIV transmission and gender-based violence. The public health significance of this paper is that it promotes a new idea, based upon relevant findings, in which recruitment of youth and adolescents rather than adults, may explain the success of the program. Working with males, aged 8-16, to prevent the risky gender-based violence behaviors associated with subsequent HIV infection, will be more effective in overcoming cultural barriers and harmful social norms of masculinity that extend dangerous health outcomes for women.

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I. INTRODUCTION

The gender-based power imbalances of many countries' cultures have resulted in exceedingly high rates of HIV among young women. This feminization of HIV requires that public health practitioners examine and question the harmful norms of masculinity that drive poor health outcomes. Much previous research has highlighted the increasing co-occurrence between these norms and the subsequent spread of HIV, and gender-based violence (GBV). This position paper addresses gender-based violence corresponding to a rise of HIV infection among women.

I performed a literature search that further corroborated findings stressing the importance of reducing behaviors that lead to GBV, in order to reduce the increasing proportion of women enduring HIV infection. This search and my prior knowledge lead to an exploration of how males factor into gender-based violence and HIV intervention preventions. It is increasingly pertinent to understand the role that males play because such conditions commonly arise from social ideas of male dominance. To better understand this role, I sought out studies for review based upon findings from the literature, prior knowledge, and specific interests. Six interventions were selected. These interventions belonged to one of three groups: interventions with only female participants, interventions with couples, and interventions with only male participants. A discussion of the articles selected highlighted strengths and weaknesses of intervention methods and approaches. This position paper calls attention to important findings from this examination of the literature, to promote a new idea; the involvement of the youth and adolescent male populations in interventions to reduce behaviors that initiate gender-based violence and the consequential infection of HIV among women.

II. BACKGROUND

A. Feminization of HIV

Recently, there has been a feminization of HIV/AIDS. Feminization of HIV/AIDS means that the proportion of all individuals infected with HIV/AIDS is increasingly female. The term feminization was first coined by Diana Pearce, in 1978, to discuss the disproportionate burden of poverty experienced by female-headed households. Pearce compiled statistics to illustrate that women were accounting for a persistently "larger proportion of the economically disadvantaged" (Pearce, 1978). Feminization is now used regularly to describe how "women have in the last 20 years moved from those least affected by HIV to those in whom the disease is spreading fastest" (Quinn, 2005). In the past decade, every single region of the world has experienced an increased proportion of women living with HIV/AIDS (Blumenthal, Ruiz, Dube, Dunn-Georgiou, and Glading, 2008). Of the 33.2 million infected people throughout the world, two-thirds live in sub-Saharan Africa. Sixty-one percent of these persons are women and adolescent girls (UNAIDS/WHO, 2007). Dr. Quinn, professor of infectious disease at Johns Hopkins, noted that at the start of the pandemic in the early 1980s, men accounted for almost 90% of cases (Quinn, 2005). However, the proportion of infected women compared to men has risen steadily, from 35% in 1990 and 41% in 1997, to 48% in 2004 (Obaid, 2005). Dr. Quinn suggests that in the 1980s homosexual men and hemophiliacs endured the first unbalanced proportion of HIV/AIDS infection. Intravenous drug users and heterosexuals then became the populations among whom the disease was spreading fastest (Quinn, 2005). However, "now, it is having the most profound impact on women" (Quinn, 2005). In fact, in developing countries, young women are three to six

times more likely to be infected with HIV than men. “Young women are the most affected group in the world: They represent 67% of all new cases of HIV among people aged 15 to 24 in developing countries” (Quinn, 2005). The increased instances of transmission via heterosexual sex, versus homosexual sex or intravenous drug use, have lead to the shift in female infection rates. Females are both more biologically and socially vulnerable to HIV infection, yet the feminization is affected more by social burdens that biological factors. Both vulnerabilities warrant further explanation, provided below.

i. Biological Factors

The feminization of HIV/AIDS has occurred for a number of reasons. Both biology and the socio-economic standing of women and girls contribute to this health disparity. Females are physiologically two to four times more likely to contract the disease, than men and boys are (Pan-American Health Organization, 2007). This physiological disparity exists predominantly because of the vulnerability of the female genital tract (Blumenthal, Ruiz, Dube et al., 2008). Women are more prone to micro-lesions, in which the HIV can be transferred (Jewkes, Levin, and Penn-Kekana, 2003). The vagina and cervix create a much larger surface area susceptible to exposure, compared to the penis. Furthermore, when the virus is transferred through the semen there is a higher viral content, than when transferred through the vaginal mucus. A thin layer of mucous membrane protects the lining of the vagina and womb. The thinness of the vaginal membrane, especially compared to the penile tissue, exacerbates this higher viral content potency, as the thinner membrane provides less protection. Not only is this membrane thin and fragile, but also, in order for HIV to enter, cuts or abrasions are not necessary, and the virus can

penetrate it at any point. The larger amount of fluid exchange from males to females also contributes to an escalated likelihood of infection.

In addition, semen remains longer in the vagina, even after cleaning and urinating, prolonging possibility of infection. If that semen is infected, it is exceptionally dangerous for a woman during ovulation. The Federation of American Societies of Experimental Biology reported that women experience higher rates of infection during ovulation because of a natural fragility in the immune system (2012). Dr. John Wherry notes, that the "adaption which allows male sperm to survive long enough to fertilize an egg, may also open the door for other types of infection" (2012). Finally, an adolescent females' susceptibility is intensified because of developmental changes occurring in the reproductive anatomy. At this age, the genital tract is particularly vulnerable as it undergoes significant changes (UNAIDS, 2012).

ii. Socioeconomic Factors

Socio-economic status has a significant impact on women's susceptibility to HIV. Gender imbalances create power imbalances in sexual and social interactions, which increase vulnerability (Weiss and Gupta, 1998). Throughout the world, women have less economic opportunities, less social rights, and less access to legal services, hindering their ability to garner protection against abuse and exploitation (Worth, 1989). A lack of control over and access to resources creates barriers for females, in preventing HIV infection. Cultural norms dictate that women perform the non-economic activities of the household. Because of domestic responsibilities women are expected to also be the caretakers of family members. This does not leave extra time left for women to earn money, produce food, or attend school (UK Consortium on AIDS and International Development, 2008). They become further impoverished and

malnourished, and their family members remain in poor health. Consequently, women's mobility and ability to seek health-related services, which could contribute to preventing HIV, is severely limited, perpetuating a cycle of vulnerability (UK Consortium on AIDS and International Development, 2008).

In impoverished families, girls are often forced to relinquish educational pursuits to partake in income-generating activities. As a result, females are more likely to be undereducated, unemployed, less likely to own land, and less informed about health issues predominantly, information about preventing HIV. Condom use and HIV prevention is strongly correlated with attaining primary education, thus completing schooling is vital for females. Women who complete primary education are more than twice as likely to use condoms, and women who complete secondary education are between four and seven times more likely to use condoms (Piot, Obaid, and Heyzer).

Education or a lack thereof, has numerous other connections to HIV infection. Educational disadvantages lead to reduced economic opportunities, perpetuating poverty and the woman's reliance on men for financial support (Blumenthal, Ruiz, Dube et al., 2008). Many women report they have been forced into marriage or relationships for financial support. In such relationships, power is distributed unequally between the man and the woman, and women are unable to negotiate condom use or insist upon monogamy. In many countries in the developing world, women's self-efficacy is often hampered by their financial dependency on men. "Economically vulnerable women are highly dependent on men's financial contributions and are thus less likely to succeed in negotiating protection and less likely to leave relationships they perceive to be risky" (Vundule, Marforah, Jewkes, and Jordaan, 2001).

Most importantly, gender-based power imbalances in a country can also contribute to a lower status among the country's women. The existing gender roles grant men the power to determine the sexual health decisions of the couple. A clear expression of male dominance, as both a cause and consequence of women's unequal position to men is wife-beating. The disadvantageous status of women in many parts of the world stipulates that wives and spouses should still expect to be beaten at the whim of their male partners. Inquiring about women's perceptions of these beatings highlights the degree to which women's subservient gender roles have become ingrained and socially conditioned. The UN Statistics Division collected data from 33 countries through the series of Demographic and Health Surveys to investigate (2010). The report found that women continue to accept and justify wife-beating, illustrating a deeply entrenched social conditioning of gender inequality. In countries all over the world, approximately 29% of women agreed that wife-beating was acceptable when the women argued with her husband and 25% agreed it was justifiable for refusing to have sex (UN Statistics Division, 2010). In some countries 74% of the female respondents accepted wife-beating for refusing to have sex with the husband (UN Statistics Division, 2010). Such statistics represent a very detrimental mind-set. When violence against women is deemed permissible by not only males, but women as well there is a dangerously deep-rooted sense of male dominance within that society.

In the United States, Silverman et al. conducted a study to assess the perceived social norms and behaviors that contribute to dating and partner violence (2006). The authors found that "the combination of peer-supported norms of male multiple partnering and adversarial sexual beliefs appear to support increased male sexual risk, lack of accountability for sexual risk, and rationalization of rape" (Silverman, Decker, Reed, Rothman, Hathaway, Raj, and Miller,

2006). Men involved in the study were rationalizing rape with the belief that women claiming rape are liars, and by perceiving rape as uncommon. Multiple partnering was also a social norm, which coupled with the above perceptions creates a potentially dangerous environment for females (Silverman, Decker, Reed et al., 2006). Most strikingly, participants in the focus groups rationalized the senselessness of condom use during rape. One male said: "if she doesn't want to do it, then she'll leave when you're trying to put a condom on" (Silverman, Decker, Reed et al., 2006). Among this group, the issue with rape is not whether it is tolerable or not. Rather, the men take issue with the impracticality of using a condom during rape, because that would allow the women to get away. This awareness of and indifference to the coercion of intercourse highlights how dangerous social norms can be to women.

Reluctance to request condom use also occurs because women are expected to prioritize the needs and desires of their male partners; this becomes a problem if their partner prefers unprotected sex (Wingood and DiClemente, 1998). Women may also fear negotiating condom use because of the potential for violent repercussions (Wood, 2000). Cultural condemnations of pre-marital sexual activities deter women's ability to gain information and resources pertaining to safe sex. Females do not want to appear promiscuous, fearing social exclusion and stigmatization. Knowledgeable adults hesitate to provide information, as they do not want to appear to be encouraging sexual promiscuity (Kistner, Ulriske, Nkosi, Parker, Kelly, Jacobs, and Fox, 2003). Women endure barriers when trying to obtain contraceptive materials such as condoms, and consequently struggle to adopt appropriate preventative practices (Jewkes, Levin and Penn-Kekana, 2003).

B. Gender-Based Violence

Gender-based violence (GBV) is a situation in which violence is directed against a person because of his or her gendered identity (Kistner, Ulrike, Nkosi, 2003). Although most often associated with violence against women and girls, it can describe violence against a person based upon either gender, male or female. However, as it is derived from cultural and social norms that perpetuate unequal power relations, which more often instill men with authority over women, females are more commonly victims of gender-based violence (amfAR AIDS Research, 2005; and Goldberg). According to the United Nations, violence against women is any act that leads to, or is likely to lead to "physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (WHO, 2011). As of 2006, the percentage of women experiencing physical violence in their lifetime ranges from 12% to 59% worldwide (UN Statistics Division, 2010). In China, Hong Kong SAR, 12% of women were exposed to physical violence once in their life, and in Zambia, 59% of women reported exposure to violence.

The proportion of women who have been victims of sexual violence, which encompasses "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting", also ranges worldwide (WHO, 2011). The lowest percentage of reported violence occurs in Azerbaijan, where 4% of women have endured sexual violence (UN Statistics Division, 2010). The largest proportion of sexual violence occurs in Mexico, where 44% of women reported sexual violence (UN Statistics

Division, 2010). In the United States, nearly 1 in 5 women have been raped in their lifetime (Black et al., 2011).

The most common form of gender-based violence is intimate partner violence (IPV) (UNAIDS, 2012). The United Nations defines intimate partner violence as "behavior in a relationship that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors" (WHO, 2011). A study conducted by the World Health Organization demonstrated the problem of violence against women is worldwide and widespread. Based upon interviews with approximately 24,000 women in 15 sites throughout 10 countries, the WHO found that among women 15 to 49 years old between 15% and 71% of women ever in a relationship endured sexual or physical violence by their partner. In Japan, 15% of women had reported intimate partner violence; while in Ethiopia and Peru 70% of women had reported IPV (WHO, 2005). The National Intimate Partner and Sexual Violence Survey for 2010 reported that 1 in 4 women experienced severe physical violence by an intimate partner in the United States (Black et al., 2011).

It is important to note that when assessing violence against women statistics, there are methodological shortcomings and a lack of reliable, comprehensive and comparable data available (UN Division for the Advancement of Women, 2005). Under-reporting among IPV victims often results in inaccurate data collection, indicating that the rates of violence against women are higher than expressed.

Gender-based violence is reported to be most common in countries and communities where gender roles are strictly defined and enforced (Kistner, Ulrike, Nkosi, et al. 2003). Such roles that link the concept of masculinity to toughness, male honor, or dominance also contribute, as do cultures in which punishment of women and children is physical, because

violence is tolerated or expected as a means of conflict resolution. In societies where females are financially dependent on males, because of their limited access to employment, education, and the same services and resources acquired by males, gender-based violence is more common (Kistner, Ulrike, Nkosi et al. 2003). Children from impoverished families are exposed to conditions that make them more vulnerable to sexual exploitation, and they are often at risk of rape during their daily subsistence tasks (Kistner, Ulrike, Nkosi, et al. 2003). Countries that do not have a standard operating procedure for reporting sexual violence to judicial authorities, and perform inadequate documentation, follow-up, and prosecution of cases experience higher rates of gender-based violence, as well as those with low conviction rates for violent criminals (Kistner, Ulrike, Nkosi et al. 2003). A lack of authoritative or state involvement in gender-based violence arises because of a cultural acceptance of traditions that do not question unequal gender norms. Finally, areas that have little or no organizations dealing with GBV, whether they pertain to research, law, education, social activism, political advocacy, or service provision, will also have higher rates of gender-based violence (Burger, Bhuyan, Avni, DuVerlie, Prieto, and Feldman-Jacobs, 2002). Limited access to education, health care, transportation, and justice make women among the most physically, socially, economically, and politically vulnerable.

In areas with low rates of gender-based violence against females, women have authority and autonomy outside of the home, and financial independence from their male partners. A supportive family structure, which could provide intervention if necessary, has found to be beneficial (Kistner, Ulrike, Nkosi et al. 2003). Communities with sanctions against GBV also reduce the likelihood of violence against women (Burger, Bhuyan, Avni et al. 2002).

It is also important to highlight the individual factors of males, which contribute to the use of violence against an intimate partner. Family background, education, emotional and

relationship status, and community, social, and political factors all contribute to gender-based violence in domestic partnerships. Males with limited resources, who lack opportunities to advance socially, demand another outlet to exert control. This often results in control over females, particularly, their female partners (Boonzaier, 2005; Jewkes and Abrahams, 2002; and Kalichman et al., 2009). Furthermore, men are able to pursue and maintain multiple partners simultaneously, and power disputes support their reluctance to use condoms (Carter, Kraft, Koppenhaver, Galavotti, Roels, Kilmarx, and Fidzani, 2007). Research has identified that social factors such as these have a significant impact, and are most applicable toward successful interventions (Burger, Bhuyan, Avni et al. 2002).

C. Gender-Based Violence and the co-occurrence of HIV

Women who have experienced violence in their lives are three times more likely to become infected with HIV, than women who have not (UNAIDS, 2010). With more and more frequency, research is highlighting a disturbing trend concerning women's sexual experiences. The first sexual experience of young women is often forced, yet it is still considered a routine aspect of the relationship (Wood and Jewkes, 1997; and Jansen, 2002). Forced intercourse is often violent, which can cause cuts and tearing of the genital area. This increases the chances of infection, as passageways for HIV to enter the bloodstream are created through the abrasions. Furthermore, coerced sex diminishes a women's ability to negotiate safe sexual practice that would prevent HIV (Wood and Jewkes, 1997). Condoms will not likely be used. This increased presence of rape is particularly dangerous among adolescent girls, as their intensified vulnerability was highlighted in the Biological Factors section (see II.A.i).

Violence between intimate partners also contributes to increased risk of HIV infection. The same concepts of inability to negotiate condom use and other preventative behaviors arise because of a lack of communication between partners, in which women are often unwilling to bring up such topics (UNAIDS, 2010). This unwillingness stems from both fear of negotiation repercussions, as well as a lack of comfort expressing such requests (UNAIDS, 2010). Research has indicated that men who are violent towards their female partners are more likely to have sex more often, to have sex with concurrent and/or casual sexual partners, and to have higher total numbers of sexual partners (Dunkle and Jewkes, 2007).

As depicted in Figure 1 (pg. 14), violence against women plays a role in direct and indirect pathways to HIV (Adapted from Heise, Ellsberg, and Gottemoelle, 1999). Partner abuse, in the form of sexual assault, can directly lead to HIV if the abusive partner is infected and coerces his partner into unprotected sex. Partner abuse can also indirectly lead to HIV infection because of the emotional and mental damage inflicted. Such a violent trauma has the potential to lead to a range of risky-behavior, on behalf of both the male and the female. This includes high-risk sexual behaviors, such as having multiple partners and engaging in unprotected sex, which in turn, may cause HIV (Heise, Ellsberg, and Gottemoelle, 1999).

The violence can become cyclical, as gender-based violence is both a cause and consequence of HIV infection (Keogh, Allen, Almedal, and Temahagili, 1994). Although a woman may have become infected because of violence or sexual abuse inflicted by her partner, disclosing her HIV status to her partner may prompt additional violence (Medley, Garcia-Moreno, McGill, and Maman, 2004). Women also fear abandonment, rejection, discrimination, and accusations of infidelity from their partners, families, and communities (Medley, Garcia-Moreno, McGill, et al. 2004).

Worsening the impact of gender-based violence is the lack of medical treatment sought out after experiencing instances of sexual or physical violence. The National Violence Against Women Survey reported that only one-third of injured female rape or physical assault victims had received any form of health care (Tjaden and Thoennes, 2000). A study by Miller, Decker, Raj, Reed, Marable, and Silverman also illustrates the negative health effects of intimate partner violence (2010). It is very important that women who have been sexually or physically abused seek health care afterwards to avert any health consequences that may arise because of said violence. Not simply in danger of HIV infection, women abused by their partners are more likely to suffer from emotional distress and physical health limitations. This can lead to isolation, and an inability to work, resulting in a loss of wages, which further limits their ability to care for themselves and their children (WHO, 2011). However, Miller Decker, and Raj et al. reported that among 448 females "IPV victimization was associated with both poor current health status … and having foregone care in the past year" (2010). Also of concern, is the young age of these clients. The participants of the study were ages 14-20 years old, highlighting how even adolescents are impacted by social norms that perpetuate violence and gender inequality (Miller, Decker, Raj et al, 2010).

When discussing the co-occurrence of HIV and violence against women it is important to acknowledge the mutually interacting role these elements have upon each other. Singer developed the Substance Abuse, Violence, and AIDS syndemic to describe the inseparable connection between these conditions (1996, 2009). HIV and gender-based violence is a reciprocal relationship and other factors also have a significant influence. Alcohol contributes to increased HIV infection rates as well as gender-based violence. The synergistic relationship between these conditions makes identifying appropriate intervention goals difficult. It also

impedes evaluation of why an intervention was successful or not successful. Each of these factors, including cultural, socioeconomic, and individual factors, serve as potential connections between the syndemic conditions (1996, 2009).

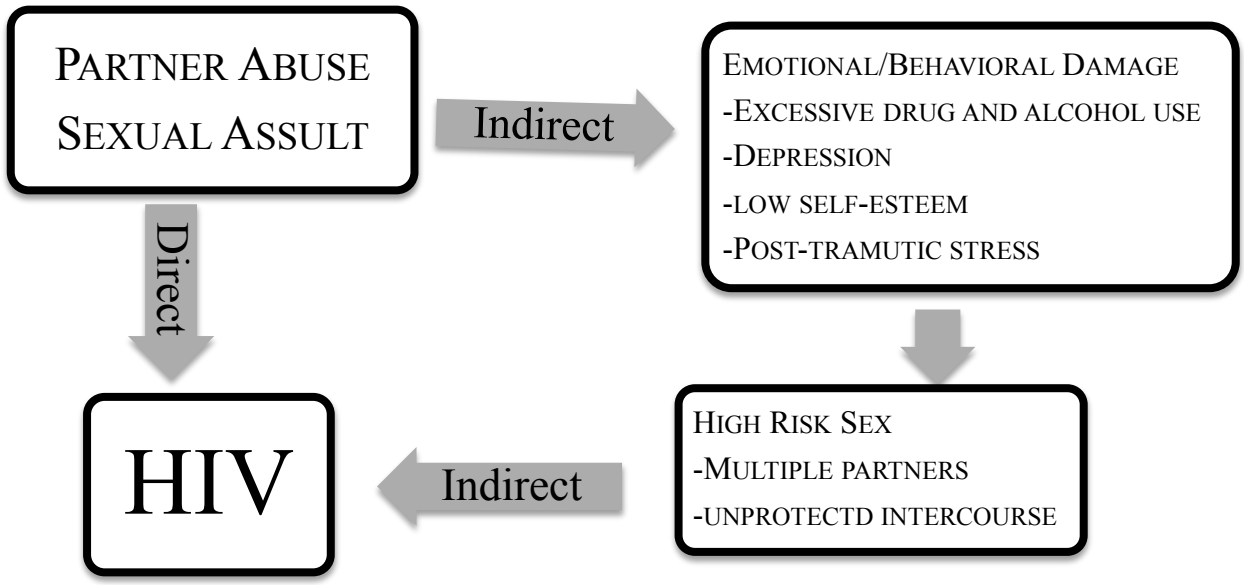

FIGURE 1: Violence against Women: Possible Direct and Indirect Pathways to HIV
Adapted from Heise, L., Ellsberg, M., and Gottemoelle, M. (1999). Ending Violence Against Women. Population Reports, December 1999. Series L (11).

D. The Role of Males

The relationship between gender-based violence and HIV is one that stems from long-standing social norms that perpetuate a power imbalance in favor of males. Women's risk of contracting HIV is largely dependent on the behavior of the men in their lives, which includes their attitudes towards gender-based violence (Dunkle and Jewkes, 2007). Ending gender-based violence requires the transformation of existing gender and social roles to achieve gender equality. The examination of literature and both theories of health behavior and health education explored in this paper distinguish that this transformation is largely dependent on male involvement. To

pursue societal change within an appropriate cultural context, it is essential to include males into the process. Encouraging men to develop alternative ways of defining masculinity and to embrace healthier gender roles confronts the root cause of the inequalities and disparities, resulting in more sustainable change, as "both violence perpetration and sexual risk taking arise from a common underlying cause, and that this cause is social ideals of masculinity" (Wood and Jewkes, 2007).

Research has found that men often perceive health-seeking behavior as unmanly or weak, which encourages the decision to pursue a range of risky-behavior (Mehta, Peacock, and Bernal, n.d.). As such, "successful" performance of masculinity often depends on the ability to control women. Therefore, the current feminization of HIV cannot be effectively contained without challenging the current gender norms which tolerate the control of and the use of violence against women (Kalichman et al., 2009).

Transforming existing gender and social roles requires gender equality, which is largely dependent on male involvement (World Health Organization, 2007). This is pertinent to development as women are predominantly the gender experiencing inequality, thus a movement on their behalf will not be as effective if initiated without the support of the dominating gender, the men in the community. Integrating men into an intervention confronts the root causes of the problem (World Health Organization, 2007). The social norms dictate gender inequality, which is what fuels the gender-based violence, which leads to HIV infection. Thus, it is necessary to discuss gender inequality with men, to produce any sustainable and lasting change. Approaches that deal solely with women may not address gender inequality in such a permanent way. Gender-determined roles and cultural norms allow men to make the reproductive decisions of partnerships, thus their engagement is crucial in promoting safe and responsible sexual behavior

(Mehta, Peacock, and Bernal, n.d.). Therefore, the current feminization of HIV cannot be effectively contained without challenging the current gender norms which tolerate the use of violence against women.

III. THEORETICAL CONSTRUCTS

When determining which theoretical constructs would be most relevant to this paper I focused on the Social Cognitive Theory and the Theory of Gender and Power because of their relevance to, and frequency of which these theories were mentioned in the literature. The theory of gender and power directly relates to gender-based violence, as it is a theory framed by how the roles and inequalities of gender affect individuals (Wingood and DiClemente, 2000). The social cognitive theory is an applicable theory because it emphasizes behavior change and the mutually influencing elements of the individual, their behaviors, as well as their larger environment (Bandura, 2004). Pursuing a reduction in HIV and GBV benefits from the complex and reciprocal framework that the social cognitive theory provides. This explains its frequent use to structure HIV prevention interventions.

The transtheoretical model is also a commonly used guide for HIV interventions. This theory explores behavior change through the "Stages of Change". The five stages that make up this model are precontemplation, contemplation, preparation, action, and maintenance (Prochaska, Velicer, 1997). This model explores behavior change occurring at different levels of readiness. Individuals advance beyond their current stage by utilizing different strategies to identify the pros and cons of moving forward. Once an individual determines that the benefits of the next stage outweigh the shortcomings, they progress to the next stage of change, with the ultimate goal being the stage of maintenance (Prochaska, Velicer, 1997). The transtheoretical model has proven to be useful in ending intimate partner violence (Burke, Dension, Gielen, McDonnel, and O'Campo, 2004).

Women have effectively utilized the constructs and process of change to end their experiences of intimate partner violence, but these processes are information-centric. The social cognitive theory stresses that behavior change requires more than information. Individuals must develop skills to engage in the behavior, and must learn how to utilize these skills consistently and under difficult circumstances (Bandura, 2004). Because this paper revolves around both violence against women and HIV, I did not include articles that reviewed interventions based upon the transtheoretical model. The social cognitive theory's attention to skill development, as well as its emphasis upon the reciprocal relationship of numerous conditions, was determined to be more pertinent for future public health interventions and research.

A. Social Cognitive Theory

The Social Cognitive Theory (SCT) is often utilized as a theoretical foundation for HIV prevention interventions. It is a foundation particularly useful if such interventions also focus on gender-based violence. The social cognitive theory identifies the six core determinants of knowledge, perceived self-efficacy, outcome expectations, goals, and perceived facilitators and impediments (Bandura, 2004). Gaining knowledge of health risks and benefits provides stimulus to individuals in their attempt to change practices so that they may live healthier lifestyles. Without this information and the belief of their personal efficacy in achieving this behavioral change, the process would never begin. Bandura explains that knowledge and self-efficacy are the "foundation of human motivation and action… Whatever other factors may serve as guides and motivators, they are rooted in the core belief that one has the power to produce desired changes by one's actions" (2004). This focal point of the SCT is important in HIV prevention and/or preventing gender-based violence because both of these issues have existed for

generations, which can feel overwhelming and make an individual doubt that change is possible. These constructs of the social cognitive theory can be empowering and essential in addressing individual doubts.

Outcomes expectations are expressed as material losses and benefits, social reactions, and self-evaluative reactions (Bandura, 2004). These regulate and affect behavior in different ways, all of which are relevant in reducing gender-based violence and its subsequent transmission of HIV. Social reactions are pertinent to this paper as they are a guiding force of the social inequalities that perpetrate violence against women. Personal goals that encourage individuals to see how a behavior change will benefit their self-interest and broader life values also serve as excellent motivators. "Long-term goals set the course of personal change… Short-term attainable goals help people to succeed by enlisting effort and guiding action in the here and now" (Bandura, 2004). In order to attain these goals, both short-term and long-term, it is important to address perceived facilitators and impediments. This relates to self-efficacy as well.

SCT depicts four core aspects of human behavior. Intentionality, forethought, self-regulation, and self examination are represented in interventions that base their design, implementation, and analysis on the social cognitive theory (Bandura, 2004). These are all significant in HIV interventions. Intentionality is necessary because individuals must have an action plan or strategy to reduce HIV risk behavior. To do so, forethought, or the setting of goals and anticipation of desired outcomes, such as reducing risk of transmission, serves as motivation. Self-regulation is essential to successfully adopt and maintain standards. Finally, self examination allows a participant in an intervention to reflect on behavior and understand the full impact of their behavioral change and all the aspects involved (Bandura, 2004).

Furthermore, it is relevant in HIV prevention programs because of its presentation of human behavior as a function of dynamic and reciprocal forces. The SCT recognizes the person, their behavior, and the environment all change each other (Bandura, 2004). This is essential in HIV prevention, especially when considering gender-based violence, because it is not simply a person or an environment that results in behaviors such as gender-based violence, but they are causes of each other. A woman in a community where violence is pertinent is more likely to experience gender-based violence and potentially as a consequence, HIV infection. This is not due a single person's actions, but the behaviors of generations of a population that have lead to an environment in which GBV is tolerated.

B. Theory of Gender and Power

The theory of Gender and Power was originally developed by Connell in 1987. Since, numerous subsequent researchers have expanded upon this founding work. Wingood and DiClemente built upon the theory by characterizing gendered relationships between men and women through the sexual division of labor, the sexual division of power, and the structure of cathexis to explain the cultural bounded gender roles assumed by men and women (2000). A very large literature grounded in feminism or sociology of gender recognize social mechanisms constraining women's daily lifestyle practices by producing gender-based inequities in women's economic potential, women's control of resources, and gender-based expectations of women's role in society (Connell 1987, Wingood and DiClemente, 2000). These inequities and disparities lead to exposures and risk factors, which interact to increase women's vulnerability (Connell 1987, Wingood and DiClemente, 2000). Wingood and DiClemente take this approach, using the Theory of Gender and Power as a framework to address gender based violence and its correlation

to the spread of HIV, because these vulnerabilities are what contribute to HIV; increasingly through gender-based violence.

The theory of gender and power recognizes physical and social exposures that lead to HIV susceptibility (Wingood and DiClemente, 2000). Having a history of sexual and physical abuse is one such physical exposure. Increasingly, the first sexual experience of young women is often forced, yet considered a customary feature of the relationship (Wood and Jewkes, 1997; and Jansen, 2002). Forced intercourse is often violent, causing tearing of the genital area, which may lead to HIV infection, as passageways to enter the bloodstream are created through the abrasions.

Both having a partner who disapproves of practicing safer sex and having a steady high-risk sexual partner are also physical exposures. Women prioritize the needs and desires of their male partners, leading to reduced condom usage, as the majority of males prefer unprotected sex (Wingood and DiClemente, 1998). Women may also fear negotiating condom use because of the potential of violent repercussions (Wood, 2000).

The social exposure of traditional beliefs and conservative gender and cultural norms is another relevant construct of the theory of gender and power. The social norms that are derived from a culture largely shape explanations of why gender-based violence occurs. As Strebel et al. further explains, "the links between gender roles, GBV, and HIV risk are complex and culturally specific" (2006).

IV. METHODS

Based upon prior knowledge and specific interests, I selected research articles for the examination of the role of males in HIV prevention program and/or the co-occurrence of HIV risk and gender-based violence. The search engines PUBMED, the University of Pittsburgh Pittcat+ University Digital Library System, and the International Journal of Men's Health were used to isolate relevant articles.

Six articles were identified for review. Selection criteria of these articles were that they were available in full text, published in English, addressed HIV prevention or risk reduction, and published before 1990. To explore the role of males in HIV interventions it was necessary to identify studies that involved only female participants, only male participants, and interventions that involved couples as participants. I selected two of each type of intervention approach. Articles were excluded if they did not meet the above criteria.

For the background and literature review, I used PUBMED with variations of following search terms: *sexual health, HIV, HIV prevention, gender-based violence, intimate partner abuse, violence against women, gender roles, patriarchal cultures, the role of males, male involvement*, *couple-based interventions, program evaluation, health education, safe sex,* and *women's health*. I expanded upon these findings by using MeSH headings from PUBMED. MeSH headings included: *relationship-based, spouse abuse, negotiating, preventative health services, health knowledge, attitudes and practice, HIV infections/transmission*, *HIV infections – prevention and control, power and control in relationships, social environment,*

violence/psychology, sexual behavior, risk assessment, interpersonal relations and *sexual partners – psychology*.

To identify six articles to use to assess the role of males in interventions, I used articles from the literature review as well as conducted a separate search on PUBMED and the International Journal of Men's Health database. The search identified a review article, which in turn identified 35 studies on the intersection of HIV and adult intimate partner violence, I came across the study "Intimate Partner Violence and Safer Sex Negotiation: Effects of a Gender-Specific Intervention" by Melendez, Hoffman, Exner, Leu, and Ehrhart, from 2002, in which the authors examined the effects of a gender-specific HIV prevention intervention among women reporting recent experiences of gender-based violence.

Because of my interest in the United States, as well as prior knowledge about the high rates of gender-based violence and the feminization of HIV in South Africa, articles reviewing studies in these areas were selected and sought out over other options. The devastating and rapidly growing HIV epidemic in South Africa is one of the worst in the world (Kalichman et al., 2009). Using PUBMED, the terms *HIV prevention intervention* and *gender-based violence* yielded nine results. Only three of the results were available in full text, and two of the three were used: "Integrated Gender-Based Violence and HIV Risk Reduction Intervention for South African Men: Results of a Quasi-Experimental Field Trial" by Kalichman et al. and "Efficacy of an HIV Prevention Program Among Female Adolescents Experiencing Gender-Based Violence" by Wingood et al. The third was discarded because the follow-up assessment for the study had not yet been published; only the description of the study design was available. The article by Wingood et al. was a highly relevant because it addressed co-occurrence of HIV and gender-based violence and included adolescents.

The Wingood et al. article prompted a search of other articles by this author. This search yielded the article "Application of the theory of gender and power to examine HIV related exposures, risk factors and effective interventions for women" also written by Wingood as the lead author. Within this article the authors identified the article by Kamenga et al. "Evidence of marked sexual behavior change associated with low HIV-1 seroconversion in 149 married couples with discordant HIV-1 serostatus: experience at an HIV counseling center in Zaire" as a study that explores the efficacy of a couple-based approach to HIV risk reduction. This article met inclusion criteria, and was also selected as one of the studies for review.

In PUBMED, I used the search terms *HIV prevention intervention* AND *couples* AND *efficacy* with the free full text available filter activated, to identify a relevant article discussing a couples-based approach to HIV prevention, of which the study's efficacy was discussed. This search yielded six results. Only the article "The Efficacy of a Relationship-Based HIV/STD Prevention Program for Heterosexual Couples" by El-Bassel, Witte, Gilbert, Wu, Chang, Hill, and Steinglass was relevant.

To find a second article that approached HIV prevention with only male participants, I searched the International Journal of Men's Health database. The search terms *HIV* AND *gender-based violence* AND *men* yielded 1 result that was published between 1990 and 2012. "The Men as Partners Program in South Africa: Reaching Men to End Gender-Based Violence and Promote Sexual and Reproductive Health" by Peacock and Levack was a relevant article which met selection criteria.

V. FINDINGS

A. Female-only Interventions

i. "Intimate Partner Violence and Safer Sex Negotiation: Effects of a Gender-Specific Intervention" (Melendez, Hoffman, Exner et al., 2003)

Melendez, Hoffman, Exner et al. recognized that violence against women, particularly intimate partner violence, was a serious issue in the U.S. and conducted a study to abate the effects that intimate partner violence has in the spread of HIV to women (2003). To assess the impact that a gender-specific intervention would have on preventing sexually transmitted diseases and sexual abuse among women experiencing intimate partner violence, Melendez, Hoffman, Exner et al. recruited 360 women in a randomized trial. Of the 360 recruited, 152 had experienced current or recent abuse. A baseline assessment was conducted, after which, participants were randomized into one of three groups. 128 women participated in a four session group intervention, 112 were in an eight session group intervention and 120 were in the control group, in which there was only the baseline assessment (Melendez, Hoffman, Exner et al., 2003).

The authors determined that negotiation of safer sex should be the cornerstone of the intervention. To achieve confidence with safer sex negotiation, participants in the four and eight session interventions met consecutively each week, once a week, to discuss: (1) why should I care about getting STDs and HIV? (2) How do I avoid partners who don't care? (3) What's the best way to protect myself? (4) How can I find out if we are infected? (5) How do I ask my partner to use protection? (6) How do I influence my partner to use protection? (7) How do I

refuse sex or unprotected sex? (8) How do I continue protecting myself and others? (Melendez, Hoffman, Exner et al., 2003) In the four-session group two topics were discussed at one meeting, while in the eight-session group, one topic was discussed each week. The intervention also dealt with negotiation skills by discussing communication around safer sex as well as refusal or avoidance of unsafe sex. Many of the sessions also dealt with abusive partners. The sessions were designed to be highly-action oriented, with role-playing, problem solving, letter writing, attitude confrontation, storytelling, and modeling among the interactive techniques employed (Melendez, Hoffman, Exner et al., 2003).

These topics were discussed with two female facilitators at each session, with one facilitator matching the ethnicity of the majority of participants. This means that at least one facilitator was either Black or Latina, as 72% of participants were Black or African-American, 17% were Latina and the remaining 11% were Caucasian or Asian (Melendez, Hoffman, Exner et al., 2003).

To measure the effects of the intervention, a baseline and follow-up assessment utilized a comprehensive structured format, with both closed and open-ended items. The assessment measured abuse, sexual risk behavior, and alternative strategies for safer sex, negotiation, and data analyses.

Melendez, Hoffman, Exner et al. reported that for abused women in the eight-session group, the intervention proved effective in maintaining consistent safer sex and decreasing unprotected sex, from baseline to follow-up, at the 1-month and 1-year assessments, but not the 6-month assessment (2003). There was not a statistically significant difference between the four-session group and the control group, yet the authors note that participants in the four session group were “in the direction of more improvement” (Melendez, Hoffman, Exner et al., 2003). Of

those women who were in a physically abusive relationship at the baseline assessment, they were expected to experience more maintenance of consistent safe sex, and decreased unprotected sex if in one of the intervention groups (Melendez, Hoffman, Exner et al., 2003).

Participants in the eight-session intervention group, who reported abusive relationships at the baseline assessment, were eight times more likely to utilize an alternative safer sex strategy than those in the control group, and four times more likely than those in the four-session group. However, this was at the 1-month follow-up assessment, while there were no significant differences at the 6-month and 1-year follow-up assessment (Melendez, Hoffman, Exner et al., 2003).

At the 1-month assessment abused women from the eight-session group were five times more likely to negotiate safer sex than those abused women in the control group, and three times more likely to do so at the 6-month follow-up (Melendez, Hoffman, Exner et al., 2003). However, yet again, there was no significant difference at the 1-year follow-up, nor did the abused women in the four session intervention group show any difference from the controls. Women who reported intimate partner violence at the baseline assessment and who participated in the eight-session intervention group also showed more intention to negotiate than those in the four-session and control groups (Melendez, Hoffman, Exner et al., 2003).

The intervention did not have an effect on abused women's comfort in assertiveness, having a safer sex discussion, or self-efficacy to negotiate, regardless of intervention grouping. Among women who reported having a safer sex negotiation, those in physically abusive relationships had similar instances of subsequent abuse compared to those who did not have a safer sex negotiation conversation. "There were no differences between intervention groups and controls with regard to subsequent physical abuse among women who had a safer sex

discussion" (Melendez, Hoffman, Exner et al., 2003). The authors explain that this indicates that women who have a safer sex negotiation did not increase or decrease the likelihood of abuse.

Melendez, Hoffman, Exner et al. feel as though the results of this intervention show that a long-term, comprehensive intervention can influence abused women to negotiate safer sex with their partners in the short term (2003). However, it is important to question if this sufficient. When reading the results of this article it seemed as though the intervention did not help end abuse or unprotected sex, thus is ultimately a disappointment. This seems especially true as the authors explain, "there was no evidence that having a safer sex discussion mediated a decrease in unprotected sex" (2003).

ii. "Efficacy of an HIV Prevention Program Among Female Adolescents Experiencing Gender-Based Violence" (Wingood et al., 2006)

Wingood et al. published "Efficacy of an HIV Prevention Program Among Female Adolescents Experiencing Gender-Based Violence" in 2006 to address the emerging concern that HIV prevention interventions are neglecting the needs of young women experiencing intimate partner violence (Wingood et al., 2006). The authors introduce the research article with an explanation of the risks incurred by women who are victims of gender-based violence. Women are exposed to increased risk of HIV infection through both social and biological mechanisms. DiClemente described the efficacy of an HIV prevention program as one that reduced risky sexual behaviors, decreased the incidence of sexually transmitted diseases, and enhanced psychosocial mediators such as condom use self-efficacy and HIV prevention knowledge (DiClemente et al., 2004). However, the authors recognized that victims of gender-based violence experience the program differently and deal with separate barriers to program efficacy.

Thus, a second evaluation was conducted, to assess an HIV prevention intervention among this vulnerable population.

Between December 1996 and April 1999, 1130 African American females were recruited and screened at the community health services agencies in Birmingham, Alabama. Fifty-three percent of those screened were eligible to participate in the study. Eligibility criteria consisted of being female, African American, reporting vaginal intercourse in the preceding 6 months, and providing written informed consent. 522 women participated, of which 146 had reported a history of gender-based violence at the baseline assessment. Gender-based violence was categorized as "young women who had ever been coerced into having intercourse against their will by their boyfriend or who had been physically abused (i.e., they had been kicked, slapped, hit, or pushed or had had something thrown at them) by their boyfriend" (Wingood et al., 2006).

Using a randomized controlled trail design, the researchers randomly assigned participants to either the four-session HIV prevention intervention of a four-session general health promotion condition. The HIV prevention sessions were theoretically based upon the social cognitive theory and the theory of gender and power. Both the HIV intervention and the general health intervention consisted of interactive group sessions of ten to twelve participants, being lead by two African American females, over four consecutive Saturdays. The general health program focused on "the importance of exercise and proper nutrition" (Wingood et al., 2006). Over the four sessions, the HIV intervention engaged participants in presentations on pride and self-worth, reducing the risk of HIV and other STDs, condom use and communication skills, exploring gender roles and power and control in relationships, promoting healthy relationships, and providing information about community resources (Wingood et al., 2006).

The researchers collected data at baseline, at six months, and at a twelve month follow up. Data was collected with a self-administered survey, a face-to-face interview, and self-administered vaginal swab specimens. The survey addressed socioeconomic characteristics and psychosocial mediators of HIV preventative behaviors. The interview was conducted by a trained African American female (Wingood et al., 2006).

At the baseline survey, 28% of participants reported that their boyfriend had either coerced them into having intercourse against their will, or had physically abused them. These participants were randomized into the study conditions, so that 14% participated in the HIV prevention intervention, and the other 14% were in the general health intervention. Of those in the HIV prevention intervention, 86% completed the twelve month assessment. In the general health intervention 89% completed the twelve month assessment (Wingood et al., 2006).

The results illustrated that participants in the HIV prevention group were more likely to use condoms consistently, less likely to have acquired an STD, reported fewer instances of unprotected vaginal intercourse, had higher HIV prevention knowledge scores, had more favorable attitudes towards using condoms, reported fewer perceived partner-related condom barriers, demonstrated greater proficiency in applying condoms, and had higher condom use self-efficacy scores (Wingood et al., 2006). In addition, researchers assessed whether the HIV prevention intervention increased subsequent risk of gender-based violence and found that participants in the general health intervention did not differ from those in the HIV prevention intervention. This indicates that "the intervention reduced these young women's risk of HIV without placing them at harm for further victimization" (Wingood et al., 2006).

iii. Summary

In both the studies that worked with women alone, the authors concluded the interventions were a success. Melendez, Hoffman, Exner et al. explained that the results "indicate that a long-term, comprehensive intervention can influence them [women with a recent history of abuse] to negotiate safer sex with their main partners" (2003). Women with abusive partners, who participated in the eight-session groups, were five times more likely than the women in the control group to initiate a safer sex discussion at the one-month follow-up. Women who were randomized in the intervention group also expressed higher rates of intention to negotiate than those in the control group (Melendez, Hoffman, Exner et al., 2003). Such are important steps in ending the spread of HIV through gender-based violence. The authors explained the intervention's specificity to women led to its success. Depicting negotiation skills training by highlighting the relevance of it to empowerment in the women's sexual relationships as well as through the collective understanding of gender roles is an approach worth replicating. Most importantly, for further intervention success, using specific guidelines and techniques to overcome resistance, as well as how to ensure one's point is being heard, are beneficial (Melendez, Hoffman, Exner et al., 2003).

However, this female-alone intervention did not satisfactorily address all of the issues. Melendez, Hoffman, Exner et al. conclude that the intervention successfully gave abused women the skills and confidence to negotiate safer sex and condom use with their partners, yet the authors also noted that "there was no evidence that having a safer sex discussion mediated a decrease in unprotected sex" (2003). This is a significant oversight of the intervention's success. Although the intervention provided women with essential information and awareness that change is possible, to make that change a reality, more is required. It is not enough to give the women

the ability to communicate with their partner; that communication must lead to understanding and willingness on behalf of the male to adjust his harmful behavior. The authors of this study found that there were similar rates of subsequent abuse among women, regardless of whether or not a safer sex negotiation took place. This was depicted as a successful outcome, however, it seems that because subsequent abuse was still occurring, something was lacking from the intervention.

Wingood et al. developed an intervention which, when compared to the results of the Melendez, Hoffman, Exner et al study, expanded upon the success of developing negotiation skills by putting those skills into action. The authors found the participants in the program reported more consistent condom usage than women placed in the control group (Wingood et al, 2006). This intervention lead to acquisition of more HIV prevention knowledge, development of more favorable attitudes towards condom use, as well as greater proficiency in applying condoms. The women of Wingood et al.'s intervention were able to utilize the skills and knowledge gained to change unsafe sexual practices (2006).

This is of particular importance because the participants in the study were all adolescents. Working with adolescents makes this intervention a means of primary prevention. Providing 9-16 year old study participants with information this early in their lives aims to prevent risky practices and patterns from developing. Thus, the intervention had a success in changing behaviors, not simply attitudes.

Wingood et al. attribute the decrease of unprotected sex in these women's relationships to building intervention around the social cognitive theory and the theory of gender and power (2006). As a result, not only were the women reporting much higher rates of safer sex, but also, the authors explained that the "intervention did not increase the incidence of subsequent abuse

during the 12-month follow-up period. … [the] intervention reduced these young women's risk of HIV without placing them at harm for further victimization" (Wingood et al, 2006). This finding of the follow-up assessments is one of the most crucial for further interventions. Wingood et al. were able to develop and execute an intervention which achieved the goal of preventing the spread of HIV by combating gender-based violence (2006). This study was the only one reviewed that sustainably reduced both unprotected sex and gender based violence.

B. Couple-based Interventions

i. "The Efficacy of a Relationship-Based HIV/STD Prevention Program for Heterosexual Couples" (El-Bassel, Witte, Gilbert et al., 2003)

Industrialized nations such as the United States are also experiencing sustained rates of heterosexually acquired HIV infection. El-Bassel, Witte, Gilbert et al. found that it is occurring particularly among African American and Latina women (2003). This experience of infection among female minorities relates to the infection rates among the women in developing countries, as they are also marginalized.

El-Bassel, Witte, Gilbert et al. developed Project Connect to study the connection that couple and relationship dynamics play in prevention strategies (2003). Citing previous works that have determined couple counseling has been successful in promoting HIV counseling and testing, and condom use, the authors sought to use this couple-based therapy literature to develop relationship-based interventions that are delivered to the couple together, rather than the woman alone. El-Bassel, Witte, Gilbert et al. wanted to test their hypothesis that relationship-based interventions will be more successful when delivered to couples together (2003). This hypothesis

is based on three main arguments. Most importantly, the authors found that "research suggests that individuals acting unilaterally to introduce safer sexual practices may be confronted with negative reactions, including isolation, threats to terminate the relationship, or physical violence" (El-Bassel, Witte, Gilbert et al., 2003). This argument is crucial to the cornerstone of this position paper, as the literature review also stressed the difficulty experienced by women in HIV prevention interventions, particularly when acting and participating alone.

The authors also hypothesized that relationship-based interventions may more successful when delivered to couples together, because of the following arguments. El-Bassel, Witte, Gilbert et al. worry about the ability of an individual to accurately and comprehensively relay the new knowledge and skills learned to their partners (2003). Such requires a set of "relationship-specific communication skills" that the authors do not assume all individuals have (El-Bassel, Witte, Gilbert et al., 2003). In addition, El-Bassel, Witte, Gilbert et al. argue that couple counseling will create a supportive environment in which partners may feel more comfortable and willing to disclose personal and sensitive information (2003).

Between 1997 and 2001, Project Connect recruited 388 women between the ages of 18 and 55 years old, with a regular male sexual partner, whom she had been in a long-term relationship with, had at least episode of unprotected sexual relations with in the past 30 days, reported no recent instance of abuse from said partner, and was a patient at one of the hospital's outpatient clinics. Further eligibility required women to know or suspect their partner of HIV/STD risk criteria. The study recruited 217 couples who met eligibility. The study had three groupings. The couple condition had couples participating in six weekly relationship-based sessions in which both the male and female received the intervention. The woman-alone condition had only the female participating in the intervention. The third condition, the education

control condition, provided only a single HIV/SID information session to the woman alone. Everyone was asked to participate in a follow-up assessment three months after the conclusion of the intervention (El-Bassel, Witte, Gilbert et al., 2003).

El-Bassel, Witte, Gilbert et al. used the AIDS Risk Reduction Model as a conceptual framework (2003). This model is guided by the social cognitive theory to organize behavioral change information and skills development directed at HIV risk reduction. The content of the sessions, for both the couples' condition and the woman-alone condition was the same to ensure the study would accurately demonstrated the difference between intervention participants. A female facilitator lead weekly intervention sessions, lasting two hours each. There was an individual orientation session designed to increase motivation for attendance as well as reduce and address misperceptions about the intervention. There were also five couple-based sessions exploring the relationship of woman and her partner, issues of intimacy, the meaning of monogamy, and how all of these factors relate to HIV protection, and potentially act as barriers. The importance of relationship communication, negotiation, and problem-solving skills were also incorporated. Project Connect also highlighted how relationship dynamics may be affected by gender roles and expectations. Women in the control group participated in a one-hour educational session, in which a video was shown, followed by a question-and-answer period (El-Bassel, Witte, Gilbert et al., 2003).

All groups demonstrated an increase in the percentage of protected sexual acts, but the couples group and the woman-alone group, showed more of an increase between baseline and follow-up than the education control group. However, most notably, "among those assigned to either active intervention condition, there were no significant differences in outcomes as a function of intervention delivery mode" (El-Bassel, Witte, Gilbert et al., 2003).

In light of the lack of differences in outcomes between the couples group and the woman-alone group, El-Bassel, Witte, Gilbert et al. offer three explanatory factors (2003). The relationship context received the most focus, which regardless of grouping, enabled women and their intimate partners to discuss sexual issues and explore protection options. The authors also note the potential for response bias. El-Bassel, Witte, Gilbert et al. speculate that the couples enrolled in the study include males who demonstrate more receptivity to their female partners' desire to engage in a discussion and thus HIV protection behavior (2003). Thirdly, the authors note the "dose-effect" consideration. Additional exposure may have produced increases in percentage of protected sexual acts because attendance was higher among the woman-alone group, than the couple group (El-Bassel, Witte, Gilbert et al., 2003).

ii. "Evidence of marked sexual behavior change associated with low HIV-1 seroconversion in 149 married couples with discordant HIV-1 serostatus: experience at an HIV counseling center in Zaire" (Kamenga et al., 1991)

Kamenga et al conducted a study to determine if the effects of a counseling program lead to increased condom usage, and a subsequent decrease in HIV transmission between heterosexual couples in which one of the partners in HIV positive and the other is not (1991). The need for this study arose because at least 80% of all cases of HIV infection in Africa were assumed to have been acquired through heterosexual contact (Kamenga et al., 1991).

The authors of this article identified 149 married couples in Zaire with discordant HIV-1 serology. This means that one member was HIV positive and the other was not. Once the eligible married couples were recruited, medical, contraceptive and sexual practice history, and demographic information was collected, using a trained Zairian health worker of the same sex as

the participants who spoke in the tribal language most familiar to the participant. Blood was also taken to reconfirm HIV status. After the notification of HIV status took place, all couples participated in monthly counseling session, at which condoms were distributed as was a sexual activity calendar. During these counseling sessions the couples were encouraged to save any condom wrappers used each time a condom was used, and to use the calendar to indicate when sexual intercourse took place. With a counselor of the same sex, participants separately discussed their sexual activity and condom use. Any discrepancies in recollections of condom use and sexual activity were discussed with the both couple participants together (Kamenga et al., 1991).

This protocol was repeated every six months, along with physical examinations to assess HIV serostatus and determine if any other sexually transmitted diseases had been contracted. Couples were involved in these repeat sessions from March 1988 to September 1989. The average length of follow-up was fifteen months. If a couple failed to keep scheduled appointments at the clinic three consecutive times were dropped from the study. Only couples who successfully kept their scheduled appointments for at least six months of the 18-month study period were included in the report findings. Initially, 168 couples were recruited, but only 149 were incorporated into the data analysis (Kamenga et al., 1991).

At the conclusion of the follow-up period, data analysis revealed the sexual practices of the couples. Before the counseling intervention less than 5% of the couples reported using any type of barrier contraception. After only one month of the notification of HIV serostatus and initial counseling session, 70.7% of the couples reposted using condoms during all instances sexual intercourse (Kamenga et al., 1991). Consequently, only 4%, or six out of the 149 couples became concordantly HIV positive, meaning both members of the couple contracted the disease. The rates of abstinence as increased, from 0% before the intervention, to 28% afterwards. For

couples in which the HIV seropositive partner was the male, 25% were practicing abstinence and 62% reported using condoms for all intramarital sexual intercourse. For couples in which the HIV seropositive partner was the female, 18.2% were practicing abstinence and 81.8% reported using condoms for all intramatital sexual intercourse. Discrepancies exist based upon which sex the HIV seropositive member was (Kamenga et al., 1991).

Kamenga et al. also point out that men in adulterous relationships were not as likely to use condoms outside of their marriages (1991). Nevertheless, these men still used condoms with their wives. "The higher rate of extramarital promiscuity following HIV-1 serostatus notification in men with HIV-1 seropositive wives compared with the rates of HIV-1 seropositve men with HIV-1 seronegative wives reflect a general concern that condoms are not absolutely protective as well as some degree of refusal to use condoms on the part of these men" (Kamenga et al., 1991). This corresponds to the finding that HIV-1 seronegative men whose wives were HIV-1 seropositive were more likely to use condoms, compared with men who were the HIV-1 seropositive member of the couple (Kamenga et al., 1991). When the man is the person in the relationship in danger of contracting HIV, his willingness to use condoms increases substantially. Again, the cultural norms that emphasize the males' superiority in decision-making propel this behavior. Condom negotiation is not as successful for women, and men will not always agree to use protection, yet when a man wants to use a condom the woman submits to his request.

Response bias influenced outcomes of the Kamenga et al. study. To be eligible for the study participants had to have at least one member of the couples be HIV positive. Participants may be more likely to engage, because of the context of the study. Had the study only recruited couples who were already aware of their HIV serostatus, attendance may not have been as high.

iii. Summary

Both programs addressed the issue of HIV infection through intimate partners, by approaching the partners together, rather than through the women alone. The intervention developed by El-Bassel, Witte, Gilbert et al. did not indicate that relationship-based prevention programs were more effective than women-alone interventions, yet both the intervention by El-Bassel, Witte, Gilbert et al.(2003) and by Kamenga et al. (1991) demonstrated many benefits to this approach. Kamenga et al. (1991) were not comparing the outcomes of the couple-participants to woman-alone participants, as El-Bassel, Witte, Gilbert et al. (2003) were. This lack of a comparison in both studies results in a different way of outlining outcomes. El-Bassel, Witte, Gilbert et al. found that "no significant differences in outcomes were observed between women who received the intervention together with a partner and women who received the intervention alone" (2003). Thus, although participants in both groups reported significantly safer sexual behaviors at follow-up, and demonstrated increased condom use compared to the control group, the lack of significant differences observed between intervention groups indicated less benefits to a relationship-based prevention program approach. Kamenga et al. only observed couples in their study, who also reported increased safer sexual behavior at the follow-up assessment (1991).

Both studies "demonstrated it is feasible to conduct a couple-based intervention… and that these men are willing to participate in an HIV/STD intervention with their partners" (El-Bassel, Witte, Gilbert et al., 2003). This finding has significant implications for public health, as it reveals the efficacy of an alternate method for HIV prevention. Not only is this alternate method important because it explores new options for intervention approaches, but also because

it highlights beneficial outcomes that were not relevant in the female-alone or the male-alone approaches.

C. Male-only Interventions

i. "Men As Partners Program in South Africa: Reaching Men to End Gender-Based Violence and Promote Sexual and Reproductive Health" (Peacock and Levack, 2004)

In 1996, the international reproductive health organization, EngenderHealth, established the Men As Partners (MAP). This program develops interventions based upon the principle that a man's attitude and behavior can either undermine or promote sexual and reproductive health. Men As Partners promotes alternative and healthier ways of defining masculinity. The program encourages males to change existing practices in which men view health-seeking-behavior as a sign of weakness or one that equates a range of risky behavior with being 'manly'. It is important to increase access to information and services that can overcome these dangerous perceptions (Peacock and Levack, 2004).

Before the intervention in South Africa, the Men As Partners program staff performed a community needs assessment. For the program, they involved adult males of varying demographics, and were not selective. Rather they encouraged as many men that were interested to come to the workshops. Males involved were employed and unemployed, married and single, religious and agnostic, South African and refugee or immigrant, and HIV positive and negative (Mehta, Peacock, and Bernal, N.D.). Based upon demonstrated community needs, MAP encouraged males to share the responsibility of the sexual health by challenging gender roles

relating to household and caring responsibilities, since it is the females' responsibility to care for children, not the males' (Peacock and Levack, 2004).

Peacock and Levack conducted the study in eight communities throughout South Africa including urban, semi-urban, and rural communities (2004). To garner higher participation rates, EngenderHealth held the program at locations where the men were already frequenting, for example their workplaces, sporting events, religious centers, trade unions, prisons, bars, local community halls, and in residences (Peacock and Levack, 2004).

Workshops were a week long and addressed how gender roles affect men's lives. They addressed violence, sexual and reproductive health, parenting, and support and care for people living with AIDS. The workshops included interactive educational activities encouraging a participatory group approach. The staff also distributed printed resources and handouts (Peacock and Levack, 2004).

Peacock and Levack performed an analysis of the results, which demonstrated that knowledge, attitudes and practices of participants had shifted significantly (2004). At follow-up assessment, the men reported that they had relinquished their previous perceptions of condom use as "unmanly" and recognized the benefits of discussing sexual health and behavior with their partners (Peacock and Levack, 2004). The program led to males viewing safe sexual practices as well as shared involvement and decision-making in sexual activities more positively.

Prior to the training, 46% of participants agreed that males must make all the decisions in a relationship. After the training, that proportion had dropped to 26% of participants agreeing that men must make all the decisions. This illustrates that the workshop helped the men realize the importance of including the female in the decision-making process. Before the workshop, 57% of participants believed that when a woman says 'no' to sex, she does not really mean it.

After the workshop, more participants understood that when a woman says 'no' to sex, it is the man's responsibility to respect that wish, and not force sex upon her; only 41% of men still thought 'no' to sex, indicates a women doesn't really mean it (Peacock and Levack, 2004).

The results of the workshops demonstrate that this program can contribute to increased condom use if replicated. However a limitation of the program in South Africa is that a societal crisis largely motivated the men's involvement in the workshops. The AIDS epidemic in South Africa is still one of the worst in the world and EngenderHealth referenced this crisis to persuade men to enter the MAP program (Peacock and Levack, 2004).

Men As Partners provided an environment in which males could talk to each other about social norms that perpetuate irresponsible and unsafe behavior. This program created a safe space where everyone felt comfortable and welcomed (Peacock and Levack, 2004). This underpinning was crucial in the men's willingness to participate, ask questions, and learn.

ii. "Integrated Gender-Based Violence and HIV Risk Reduction Intervention for South African Men: Results of a Quasi-Experimental Field Trial" (Kalichman et al., 2009)

Kalichman et al. note that previous HIV prevention interventions have predominantly targeted women, and recognize that this approach is not always enough (2009).

> "Women who suggest using condoms with a resistant sex partner may experience adverse consequences, including raising partner suspicions about their sexual histories. Women who initiate condom use may find themselves vulnerable to rejection and potential loss of financial support from their male relationship partners" (Kalichman et al., 2009).

The authors determined that men are essential in HIV prevention interventions. Yet, even with their involvement, men's attitudes create a significant barrier to progress. In many societies it is culturally ingrained for men to identify themselves as the stronger sex, and thus expected to control their female partners. The authors reference the Men As Partners program and the Stepping Stone program as community-based programs that target men for HIV risk reduction. However, they were dissatisfied by what they found. The MAP program had not yet provided results of their intervention and the Stepping Stone intervention did not reduce HIV transmission (Kalichman et al., 2009). In response, Kalichman et al. developed their version of an integrated intervention to reduce GBV and HIV transmission risks among South African men (2009).

The intervention was grounded in the social cognitive theory, adapted specifically for South African men, and pilot tested for cultural appropriateness and community accepted. Using a quasi-experimental design, 475 African men from two demographically similar communities in Cape Town, South Africa were recruited through chain recruitment and social networks. Participants were randomly assigned to either the GBV/HIV intervention, or the Alcohol/HIV intervention. The former stressed reducing gender-based violence in an HIV risk reduction program, while the latter focused on the relationship between alcohol and HIV risk reduction (Kalichman et al., 2009).

The GBV/HIV intervention consisted of five sessions on gender violence and HIV risk reduction. Behavior change self-efficacy and altering risk-related outcome expectancies were the focus. Participants explored personal and community consequences of gender-based violence and HIV, discussed gender roles and behavioral alternatives, identified high-risk sexual behaviors leading to problem solving, developed condom use and communication skills, role-

played talking with others about domestic violence and HIV, and trained men to encourage others to take part in risk reduction behavior changes (Kalichman et al., 2009).

For the alcohol/HIV condition, one 3 hour interactive group session was held among a small group of people consisting of 8 to 12 men per group. This was the control portion of the intervention study, so it did not address gender based violence, nor did it include an aspect teaching the males participants peer advocacy (Kalichman et al., 2009).

Data collection was done through a baseline assessment conducted before the first group intervention session, following up with assessments after 1-month, 3-months, and 6-months. Participants were paid to complete the assessments, but not for their involvement in the group sessions (Kalichman et al., 2009).

The data analysis illustrated that there were no differences for retention of AIDS knowledge or reduction of AIDS stigmatizing attitudes, yet the GBV/HIV prevention condition demonstrated greater intentions to reduce HIV risk behaviors compared to the alcohol/HIV intervention. Furthermore, the GBV/HIV participants reported more communication with their partners about condom usage, as well as showed increased likelihood of getting tested for HIV. However, the alcohol/HIV prevention group reported fewer instances of unprotected sex and demonstrated greater condom use that the GBV/HIV condition at the short-term follow-ups. Despite increased communication among GBV/HIV participants about condoms, it was the alcohol/HIV participants who were reporting a higher likelihood of using condoms. The men in the GBV/HIV prevention condition initially reported less acceptance of violence against women that the alcohol/HIV participants did at the 1-month follow up, but only by a slight difference, and at the 3-month and 6-month follow up there was statistically no significant difference. Participants in the GBV/HIV intervention were overall less likely to have lost their temper with

the females in their lives and at the final assessment, reported a lower likelihood to hit or push a sex partner (Kalichman et al., 2009).

This study is important because it shows the role that men have in HIV prevention interventions and how significantly gender-based violence plays into such an intervention. Kalichman et al. note

> "We observed reductions in negative attitudes toward women and reductions in the propensity to act violently against women among participants in the GBV/HIV intervention. Men in the GBV/HIV intervention also increased their talking with sex partners about condoms and were more likely to get tested for HIV over the follow-up period, both behaviors that are conceptually consistent with partner protective actions" (2009).

This data analysis identifies an important first step in addressing social norms that perpetuate violence against women, which lead to increased HIV transmission. It is only a first step however, as the intervention did not have as much efficacy in reducing instances of violence against women partners, reducing unprotected sex, using condoms, or reducing the number or sex partners. These behaviors increase HIV risk and indicate participants did not retain sexual risk reduction knowledge or skills (Kalichman et al., 2009).

iii. Summary

In the male-alone interventions conducted by Peacock and Levack (2004), and Kalichman et al. (2009), the data indicated shifts in attitudes among male participants had occurred as had some safer sexual practices, yet there was "limited evidence for enhanced HIV risk reduction in the GBV/HIV integrated intervention" (Kalichman et al., 2009). Peacock and

Levack determined that for the participants who completed a pre and post-training interview bookmarking the Men As Partners intervention, "there has been a general positive attitudinal shift regarding issues related to sexual violence and relationships" (2004). However, although the authors saw a positive behavioral shift after the intervention, it was only minimal (Peacock and Levack, 2004).

Kalichman et al. found that men involved in the integrated gender-based violence and HIV risk reduction intervention were less likely to lose their temper with their partner, less likely to have hit or push a partner, and were initially less accepting of violence against women (2009). Despite these shifts among the male participants, it did not last at subsequent follow-up assessments (Kalichman et al., 2009). In addition, outcomes results demonstrated that those who were randomized into the alcohol/HIV prevention condition "offered greater potential for sexual risk reduction than that realized in the GBV/HIV prevention intervention" (Kalichman et al., 2009). Furthermore, Kalichman et al. explained that the intervention did not reduce unprotected sex, beget monogamy, or increase condom use (2009). The authors were still optimistic about the study's results, as the success with the alcohol/HIV condition creates a possibility for success with an approach that integrates alcohol reduction, gender violence prevention, and HIV risk reduction (Kalichman et al., 2009). Alcohol, gender-based violence and HIV are reinforcing components of a complex cycle that generate risky behaviors.

VI. DISCUSSION

An evaluation of the literature highlighted strengths and weaknesses of different intervention approaches. Each study demonstrated beneficial methods in efforts to reduce HIV incidence rates. There were also significant barriers identified that impeded progress. Separating studies by the type of participant recruitment utilized allowed for a clearer understanding of the role that males have in intervention effectiveness. Male participants did not have necessarily better outcomes than female or couple participants. However, the assessment of these studies still revealed that involving males is valuable. Adjusting male involvement, so that participants are young males, aged 8-16, rather than adults, will incorporate the advantageous findings of working with males. The following section lays out the shortcomings and benefits that formed this recommendation.

The female-alone interventions and the male-alone interventions both used group-sessions to disseminate program information and materials. The group sessions were interactive allowing for participants to practice skills learned and put the information gained into action. This is beneficial because it gives the participants the opportunity to develop self-efficacy and comfort with new material before being obligated to utilize it outside of the intervention. As the social cognitive theory denotes, skill development and self-efficacy are crucial to behavior change so that program participants can successfully execute desired practices learned in the intervention, not only consistently, but also under difficult circumstances.

Although the relationship-based approach did not allow for interactive group sessions, self-efficacy was still achieved among participants. The couple-based interventions held sessions

involving only the individual or the couple at a time, rather than in a larger group. This more intimate setting allowed for significant involvement and communication among participants and the facilitators. Acceptance and compliance of information gained in the intervention by Kamenga et al. stems from the relationships developed between the participants and the counseling team and trained nurses (1991). The close personal rapport ensured confidentiality and extensive follow-up, which led to "frank and open discussions" (Kamenga et al., 1991). Such is important as it allows for a deeper understanding of the issues and dangers associated with unprotected sex. This is an essential part of the behavior change process. As the social cognitive theory explains, knowledge and self-efficacy are the crux of the behavior change process. Acquiring a health education provides motivation for participants to change practices so that they may lead healthier lifestyles (Bandura, 2004). The comfort participants felt having thoughtful and detailed conversations with their counselors, about the risks unprotected sex allowed for self-efficacy to develop. Participants engaged in counseling sessions that offered an opportunity to ask questions and correct misunderstandings about safer sex. As a result, they developed confidence with condom usage, and thus subsequent low rates of HIV-1 seroconversion.

The study by Kalichman et al. further demonstrated the relevance of complex and inter-related dynamics that affect both violence and HIV. Males in the control group, who did not participate in an intervention focusing on reducing behaviors that lead to gender-based violence, but instead were educated on the significant relationship between alcohol and HIV infection, reported fewer instances of gender-based violence (2009). The realization that alcohol integration could be beneficial in future public health interventions is useful, however it is also important to keep in mind that neither the GBV nor the alcohol condition successfully mitigated instances of unprotected sexual encounters or lead to sustained decrease of violence against

women. The new knowledge gained was initially utilized to some degree, yet the participants did not maintain new attitudes, thus behavior change was also not maintained. In fact, behavior change never really took hold. Again, these outcomes demonstrate that despite initial educational success, something prevents participants from neither retaining these new ideas nor integrating them into their lives. This paper ascribes masculine social tendencies as an overwhelming contributing factor to this lack of development.

In all but one of the studies reviewed, HIV infection was not the principal outcome variable used to measure results. Only the study by Kamenga et al. tested participants for HIV status after completion of the intervention and in any subsequent follow-up assessments. Wingood et al. and El-Bassel, Witte, Gilbert, et al. tested participants for STD symptoms, but HIV was not one of them. The primary outcomes of El-Bassel, Witte, Gilbert et al. did not focus solely on HIV outcomes; rather the authors list STD symptoms as one of the primary outcomes of the study. The other three outcomes were: the number of unprotected vaginal sexual acts with the study partner, the proportion of protected vaginal sexual acts with said partner, and the number of sexual partners in the past 90 days (El-Bassel, Witte, Gilbert et al., 2003). For the Melendez, Hoffman, Exner, et al. study, the primary outcome was also concerned with a reduction in unprotected vaginal and/or anal intercourse (2003). However, in the same study, the use of an alternative strategy for safer sex, such as engaging in outer course, was the secondary outcome and there was no mention of a measure for STD symptoms of HIV status (Melendez, Hoffman, Exner et al., 2003).

Although these research authors aim to assess the impact and study the effects of their relative HIV prevention interventions, they do not do so by identifying if participants contracted HIV after the program. Such reveals that all the researchers except for those in the Kamenga et

al. study determined that prevention did not denote a focus on HIV status outcomes. Instead, HIV is considered a secondary or sometimes tertiary outcome of these prevention programs. The studies measured results based upon knowledge, intentions, psychological mediators associated with HIV-preventative behaviors, and reported rates of condom use. The studies are expecting that the new information and learned behaviors will lead to HIV prevention. The preventions' primary outcomes are whether or not participants retained new perspectives and observed new practices, which in turn are expected to lead to lowered incidence of HIV infection.

In the Men as Partners program, HIV outcomes are tertiary outcomes, not measured by the researchers. The Peacock and Levack study is the only intervention, whose means of reducing HIV is by reducing behaviors and practices that are associated with gender-based violence (2004). Ultimately, achieving such should result in a decrease in women's vulnerability to HIV and the practices that contribute to that vulnerability. Both the Wingood et al. and the Melendez, Hoffman, Exner et al. studies are concerned with a population that had endured gender-based violence, and want to prevent further abuse, but HIV prevention behaviors and psychological mediators are the primary intervention aims (2006). In the Wingood et al. study, the primary outcome in use of a condom during every episode of vaginal intercourse in the preceding 30 days. Participants in the Wingood et al. study also provided vaginal swab specimens to investigate the presence of STDs, but HIV was not tested for (2004). In the Kalichman et al. study the primary outcomes were sexual risk, sexual protective, and gender-based violence (2009). Although in the Kalichman et al. study the authors design the interventions groups so that half of the participants are taught about the benefits of reducing gender-based violence, and its co-occurrence with HIV, the other half is taught about the co-occurrence of alcohol and HIV risk behaviors (2009).

The unique intervention approach of the Men As Partners program was the one of two interventions that spoke to the recent literature that ascribes the feminization of HIV with gender-based violence. Although gender-based violence was not a primary outcome for all study participants in the Kalichman et al. study, it was one of the guiding concepts in intervention design. The other studies that integrated gender-based violence did so, by assigning gender-based violence reduction as a secondary outcome. The authors wanted to see a decrease in violence against women, yet not as a direct result of the skills developed. Rather, these studies strive to avoid subsequent abuse rates when new skills and attitudes are practiced outside of the intervention. The interventions promote behavior change that results in lower HIV infection rates, without incurring violence against women as a consequence of the change that has occurred. Peacock and Levack describe a study that aims to have participants adapt new understandings and practices to directly reduce gender-based violence. This is because they see a reduction in GBV as a means of subsequently reducing HIV incidence rates. The skills learned are meant to reduce GBV which will in turn reduce HIV infection rates. Kalichman et al. strove to initiate a similar chain in behavior change, yet found more success in reducing violence against women with the participants who were in the alcohol risk reduction group.

Framing an intervention with this perspective also demonstrated that it is viable to conduct a HIV prevention intervention in an alternative manner. Discussing HIV and teaching participants about protection, but with an overall goal of preventing gender-based violence, rather than HIV, still led to increased safer sexual health practices (Peacock and Levack, 2004).

It is probable that this program benefitted from this approach because the participants were males. As discussed in the literature review, in most communities and within most relationships, males are allotted more control than women are. Also, as El-Bassel, Witte, Gilbert

et al. explain, “individuals acting unilaterally to introduce safer sexual practices may be confronted with negative reactions, including isolation, threats to terminate the relationship, or physical violence” (2003). Therefore, when participants are only females it is important to teach women how to avoid violence, and it is possible that this can lead to the end of intimate partner violence; however, there is also a significant amount of control that is out of the females’ hands., When a program is designed to teach males about the importance of avoiding violence against women, the control that is allotted to males results in more successful behavior change.

With that in mind, the inclusion of males in prevention interventions was not enough. Although both the Peacock and Levack study and the Kalichman et al. study demonstrated what El-Bassel, Witte, Gilbert et al. also noted, that “men are willing to participate in an HIV/STD intervention” (2003), these male-only approaches did not garner sustained behavior change. The only intervention which demonstrated not only attitude changes, but also behavior changes, was one whose participants were adolescents. The involvement of youth results in more success because their exposure to harmful cultural practices that prioritize masculinity and male needs over women has not become as deeply ingrained as it has among adults.

VII. RECOMMENDATIONS

As discussed in the literature review, cultural norms and generations of gender inequality have contributed to much of the gender-based violence and intimate partner abuse that occurs. All but one of the six studies reviewed worked with adults who were immersed in these norms. As a result, the age of the participants was a significant contributor to the lack of a lasting impact, especially among males. Despite the encouraging outcomes mentioned after the first follow-up of the interventions, results waned by the second or third follow-up assessment in most of the studies. However, the Wingood et al. intervention demonstrated that when working with adolescents both HIV risk reduction and reduced instances of gender-based violence can result (2006). Of all the articles discussed, only the participants in the Wingood et al. study sustained lowered rates of violence. "The HIV prevention intervention did not increase the incidence of subsequent abuse during the 12-month follow-up period" (Wingood et al., 2006). In the study by Kalichman et al. rates of violence initially subsided, but by the 6-month follow-up assessment, reports illustrated the intervention impacts had not been maintained (2009). No other study developed data that showed a significant reduction in gender-based violence. Consequently, I recommend that future interventions work directly with young males, rather than adults.

Youth is a distinctly influential period that shapes how individuals live out their lives. Previous studies have proven how youth participation is effective in modifying sexual health practices and addressing responsible decision-making (Senderowitz, 1997). Thus, an intervention targeting this age is sustainable because it provides knowledge and empowerment in this age of development, which motivates responsible behavior for the rest of their lives. It facilitates young

people's understanding of how influential gender norms and their perceptions of sex and sexuality can be. The social exposure of traditional beliefs and conservative gender and cultural norms can impact their lives in both negative and positive ways.

Males in their early teens can be perpetrators of intimate partner violence, or teen dating violence (TDV). A study by Reed, Silverman, Raj, Decker, and Miller examined the link between TDV and perceived peer and community gender attitudes relating to violence (2011). The findings suggest that at as early as 14, perceived norms of violence perpetration as well as problematic gender attitudes lead to intimate partner violence (Reed, Silverman, Raj et al., 2011). In the background section above, I discussed a study conducted by Silverman et al. (see section II.A.ii), in which peer-supported norms and perceived social norms promoted dangerous sexual behaviors. The participants of this study are adolescent males, aged 13-20, illustrating how early on individuals emulate the attitudes and practices of their peers. It is necessary to prompt young people to responsibly question these norms and values that their communities validate. Such would hopefully initiate a continuing assessment of how these values are jeopardizing their and their peers' health and survival.

The Wingood et al. article demonstrates that lasting change is possible (2006), and the articles by both Kalichman et al. (2009) and Peacock and Levack (2004) show that male involvement is a legitimate approach to HIV prevention through a reduction of gender-based violence. In both the male-alone interventions there was a significant attitudinal shift identified. Furthermore, in the Kalichman et al. article, the authors explained that behavior changes were reported at 1-month the follow-up assessments (2009). The men were showing initial retention of the information, and it was successfully changing their practices so that violence against women lessened. However, these changes were not maintained as the men became more removed from

the intervention and more integrated back into their communities. These communities reinstated the peer-supported social norms which lead to gender-based violence.

This is attributable to the predominant means of working with adults rather than children and adolescents. Adjusting cultural traditions and patriarchal norms to end gender inequality will more likely occur by educating younger generations early, to introduce them to new understandings before they also become ingrained in the existing standards that endanger women. As most of the interventions discussed above demonstrate, there is still a gap in the desired and actual outcomes with the current approaches.

To fill this gap, future intervention would benefit from replicating the best practices of the six interventions above, and adapting them into a program that recruits youth participants, particularly males. Future interventions aiming to reduce the spread of HIV infection through gender-based violence should utilize the following:

Peacock and Levack noted their asset-based approach strongly contributed to the successful promotion of gender-equality (2004). This was made possible by the community health needs assessment performed before the implementation of the Men As Partners program. The staff was able to adapt the workshops based upon the discovered needs (Peacock and Levack, 2004). This is an important step to replicate in future interventions as it also provides a means to adapt the program framework to fit the context of the new community that the intervention will take place.

Peacock and Levack (2004), as well as Melendez, Hoffman, Exner et al. (2003), El-Bassel, Witte, Gilbert et al. (2003), and Wingood et al. (2006) discuss the importance of gender roles. It is an essential focal point of any GBV prevention program. As emphasized in throughout this paper, but predominantly in the Background section, gender roles significantly influence

gender-based violence, thus it is crucial to incorporate and underscore their relevance in interventions (see section II.A.ii, II.B, II.C, and II.D).

Kalichman et al. also encouraged future intervention to integrate gender roles, but by incorporating alcohol education as well (2009). Participants of their study demonstrated superior knowledge and behavioral change when assigned to the alcohol reduction/ HIV risk reduction condition, compared to the GBV/HIV condition, indicating the important role that alcohol plays in preventing unprotected sex and subsequent HIV transmission (Kalichman et al., 2009). As Singer explains through the Substance Abuse, Violence, and AIDS syndemic, these issues are all mutually influencing each other (1996, 2009). The reciprocal relationship of gender-based violence, HIV, and alcohol require interventions to address all three conditions.

One of the most important contributions of the Kamenga et al. study was the intervention's success with participants because of highly trained staff who were able to develop empathetic and personal relationships leading to honest and open communication (1991). Like the staff at the Men As Partners training, the counseling staff created an environment in which participants felt comfortable and safe. Initiating the program by telling the couples their questions, thoughts, and concerns would be met with respect was crucial in their willingness to participate and learn.

Another important lesson learned from these studies was the benefits of physically practicing skills learned. In the Kalichman et al. study participants were taught about sharing the skills and ideas they had learned in the intervention. Participants selected individuals in their lives that they wanted to communicate the importance of HIV prevention and gender-based violence with (Kalichman et al., 2009). This advocacy component attempts to expand the reach of the intervention. If participants successfully connect with non-participants the new ideas that

challenge the existing gender roles may more successfully integrate into the community. However, Kalichman et al. note that the intervention would have been more successful had the males had the opportunity to practice new techniques (2009). When discussing differences between the four-session and eight-session intervention groups Melendez, Hoffman, Exner et al. suggest the latter group was better able to facilitate change because it provided women with more time to role-play, practice, and rehearse ways of successfully communicating and negotiating with difficult partners and ensuring safer sex (2003). The workshops in the Men As Partners program also incorporated a participatory approach, and interactive education activities that contributed to successful outcomes (Peacock and Levack, 2004*)*.

Those seeking to do further research on this topic should investigate why the results from the Kalichman et al. study changed in such a short time. In the first follow-up assessment the number of participants who responded yes to "hit a sex partner in the past month" was lower than it was at the subsequent 3-month and 6-month follow-up assessments. It would be valuable to understand why males did not maintain lower rates of non-violence with their sexual partners. This paper speculates that this reversion to former practices is caused by the deeply-rooted gender roles and peer-supported social norms that endanger women.

Future research would also benefit from identifying the previous successes and failures of youth-based violence prevention programs. Understanding the effectiveness of interventions with young and adolescent participants may shed light on the legitimacy of working with this population. Integrating peer-education models with youth may also be valuable.

A beneficial future intervention would be one that works with young, pre-adolescent males and adopts the Men As Partners approach to designing program material and activities, and selecting measurable outcomes. Framing a program so that the primary outcome increases

the proportion of protected sexual activities and consistent condom use, with a focus on reducing risky behaviors associated with gender-based violence, which in turn results in lower HIV infection rates, incorporates recent research findings that ascribe the feminization of HIV infection with its significant co-occurrence with violence against women. An intervention that had gender-based violence prevention as a central focus, should also address the emotional and mental issues that prevent safer sex practices. Informing male participants of the dangers of fear of negotiation and the importance of comfort when communicating with partners is also necessary in addressing gender-based violence. This paper recognized the social cognitive theory as an effective theoretical framework. Discussing gender roles and cultural norms would be an essential component of the program's material.

To appropriately adapt the program to any community context, a community health needs assessment should be implemented. Based upon the most successful components of the reviewed studies, this program should have an interactive group session dynamic, where over a series of meetings, participants can watch videos and participate in educational presentations, role-play, problem-solve, develop condom use and communication skills, practice these skills, and discuss personal goals. The intervention would also benefit from one-on-one counseling sessions that bookmark the beginning and conclusion of the program, which provide participants with an opportunity to express more private matters and ask specific questions. The one-on-one sessions will also orient participants to the intervention and initiate a personal rapport with program facilitators. Including a segment on the role that alcohol has with violence and against women and HIV infection would be beneficial, as would a segment that encourages participants to vocally advocate for risk reduction behavior changes among those not in the intervention. This may fit into a peer-education model for youths nicely.

VIII. LIMITATIONS

This position paper is limited in its final assessment because only six interventions were reviewed. To validate benefits and barriers a larger selection of case studies to draw from would be valuable. The methodology of this position paper most significantly limits findings as the article search performed was not comprehensive. I picked out articles that were relevant to this topic, but did not include all available articles. It would be beneficial to determine selection criteria after a thorough and all-inclusive literature review has been conducted. Using a systematic branching process, with key search terms from the findings of this review would yield results that would then be selected or eliminated based upon pre-determined criteria. Including as many eligible articles as possible would allow for a more complete examination of the literature, and thus a more extensive understanding of the role of males and adolescents in gender-based violence and HIV interventions.

This paper did not include research discussing youth in interventions in the background section because the benefits of involving young and adolescent males was determined at the conclusion of the examination of literature. It would be advantageous to review studies and articles that address the role of youth in interventions concerning violence, gender equality, and HIV. In addition, for future research it would be pertinent to consider key issues, which served as limitations within the studies themselves.

Because all six interventions utilized a survey or interview to gage program impacts, it is probable response bias occurred. A significant gap in the literature on couples-based interventions also impedes the applicability of the study results discussed. There are a low

number of studies that have been performed, in which the participants are couples. Adding to that limitation, of the couple-based interventions selected, neither discussed gender-based violence predominantly. Another gap in the literature comes from unpublished works. This could significantly add to the depth of understanding this material.

Generalizability was a limitation among all six studies. For future interventions it is necessary to consider the applicability of the recommendations derived from these interventions before initiation of any program design. When developing an intervention it is important to identify circumstantial issues that may affect program participation, completion, or outcomes. Utilizing the best practices of these studies requires adaptability. The recommendations highlighted may not be as successful if they are not formatted to match the context of a new community or country in which they will be used.

IX. CONCLUSION

Encouraging young males to challenge the existing cultural norms and gender inequalities that allow for power imbalances in sexual and social interactions is the most effective way to address gender-based violence, and the subsequent spread of HIV. Previous interventions have produced important progress, yet the ongoing feminization of HIV indicates it is not enough. A new approach may be beneficial. There are programs which focus on HIV prevention among youth, and while most incorporate violence against women into the intervention, few assign gender-based violence as a central focus. Future research should strive to capture the success of the six interventions discussed above, but then apply these successes to programs that work with male youths, rather than adults. Working with young males, aged 8-16 to prevent HIV infection by promoting reduction in risky behaviors that are attributed to gender-based violence may result in sustainable interventions effects.

APPENDIX

TABLE 1: SUMMARY OF LITERATURE REVIEWED

Authors; (year)	Aim of the Study	Participants	Methods	Intervention	Results
R. M. Melendez, S.Hoffman, T. Exner, Cheng-Shiun Leu and A. A. Ehrhardt (2003)	To assess the impact of a gender-specific intervention to prevent sexual abuse among women suffering IPV	360 women were recruited, 152 who experienced partner physical abuse within the past year	Primary outcome variable: reduction in unprotected vaginal and/or anal intercourse Secondary outcome variable: the use of an alternative strategy for safer sex	Interactive group-sessions were conducted weekly to discuss communication and negotiation skills, through role play, problem solving, etc. Assessed at 1-month, 6-month, and 12-month follow ups	Although some outcomes demonstrated beneficial attitude changes, and higher "intention to negotiate", the results did not indicate such behavioral changes took place. Also, there was no evidence that having a safer sex discussion mediated a decrease in unprotected sex, nor did subsequent abuse decrease.
G. M. Wingood, R. DiClemente, K. Harrington, D. Lang, S. Davis, E. Hook III, M. Kim Oh, & J. Hardin (2006)	To study the effects of an HIV intervention among female African-American teens with a history of GBV.	522 African American female adolescents, 146 who reported a history of GBV at the baseline assessment	Primary outcome variables: consistent condom use. Participants provided a vaginal swab specimen for STD testing	The HIV prevention group emphasized gender roles, HIV knowledge, communication and condom use skills, in interactive group sessions. The general health group focused on exercise and nutrition. Assessed at 6-month and 12-month follow-ups.	Participants randomized to the HIV intervention used condoms more consistently, were less likely to have a sexual disease, and demonstrated more proficient condom skills. intervention reduced these young women's risk of HIV without placing them at harm for further victimization
N. El-Bassel, S. S. Witte, L. Gilbert, E. Wu, M. Chang, J. Hill, and P. Steinglass (2003)	To determine the efficacy of a relationship-based HIV prevention program for heterosexual couples.	217 women, 18-55 years, with a male partner, were recruited from outpatient clinics.	Primary outcome variables: number of unprotected vaginal sexual acts with study partner, number of STDs, and number of sexual partners, in the past 90 days	Relationship-based sessions were provided for both the couple-based and woman-alone groups. In the education control condition the women took part in one HIV/STD information session. Assessed at a 3 month follow-up.	The intervention was effective in reducing the proportion of unprotected sexual acts. No significant differences in effects were observed between couples receiving the intervention together and those in which the woman received it alone.

TABLE 1 CONTINUED

Kamenga, R. Ryder, M. Jingu, N. Mbuyi, L. Mbu, F. Behets, C. Brown, and W. L. Heyward (1991)	To assess the effect of an HIV-1 counseling program on Zairian couples with discordant HIV-1 serology	149 married couples in Zaire with discordant HIV-1 serology	Primary outcome variables: reported rates of condom use and rates of HIV-1 seroconversion.	At counseling sessions couples discussed benefits and barriers of safe sex, noted dates of intercourse and whether a condom was used. Assessed every 6 months for 18 months and underwent test for STDs and HIV.	Reports of condom use during all sexual intercourse increased among the majority of participants. Only six couples seroconverted, so that both members of the relationship became HIV positive.
D. Peacock and A.Levack (2004)	To assess if a program can engage men in reducing GBV and promote men's constructive role in sexual health.	139 males, aged 18-74 were recruited from urban and rural areas throughout South Africa.	Outcome measures: knowledge, attitude, and practice related questions on male and female gender roles, HIV/AIDS, gender-based violence, and practices between partners	Participants engaged in workshops carried out over a period of four to five days consisting of 35 hours of educational activities. Follow-up assessments were held before, immediately after, and 3 to 4 months after the intervention	Knowledge of HIV/AIDS increased up to three months after the training. Participants demonstrated attitudinal changes for most issues covered. There was a sustained attitudinal change for most questions related to gender roles. There was only a minimal behavioral shift.
S. C. Kalichman, L. Simbayi, A. Cloete, M. Clayford, W. Arnolds, M. Mxoli, G. Smith, C. Cherry, T. Shefer, M. Crawford, and M. O. Kalichman (2009)	To determine if an intervention targeting men can integrate HIV prevention with GBV prevention and produce effective results.	Recruited 475 African men living in two demographi cally similar townships in Cape Town South Africa.	Primary outcome variables: sexual risk, sexual protection, and gender-based violence behaviors Other outcomes measured: AIDS knowledge, risk reduction intentions, acceptance of violence against women, and alcohol use	The intervention emphasized sexual transmission risk reduction and gender based violence reduction through skills building and personal goal setting, and by addressing gender roles. The control group consisted of a 3 hour interactive group session. Assessments were held 1-month, 3-month, and 6-months post intervention.	The GBV/HIV participants reduced negative attitudes toward women in the short term, and increased talking with sex partners about condoms. There were no differences for AIDS knowledge or stigmatizing attitudes. The alcohol/HIV condition reported less unprotected sex, fewer alcohol involved sexual encounters, and greater condom use that the GBV/HIV condition.

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