Men's role in HIV/AIDS prevention for women: Exploring different views

DAVID PÉREZ-JIMÉNEZ, PhD; IRMA SERRANO-GARCÍA, PhD; ARACELIS ESCABÍ-MONTALVO, PhD

Objective: **Explore the role male partners should play in interventions that emerge from an empowerment perspective for the prevention of HIV/AIDS in women. Explore the social and cultural context, rationale and format for interventions if male partners are incorporated.**

Background: **Heterosexual women have become the most at risk group for HIV infection. Most of the HIV/AIDS prevention efforts have excluded the participation of male partners. Interventions with women have not been as affective as desired since the negotiation of safer sex method, such as the male condom, is not under their control.**

Methods: **Thirteen focus groups were conducted in Puerto Rico, Dominican Republic and Mexico. Groups were conducted with HIV/AIDS prevention researchers, service providers, and heterosexual men and women who participated in HIV/AIDS prevention interventions. The taped conversations were transcribed and analyzed using content analysis according to a set of defined categories and sub-categories.**

Results: **The majority of participants agreed that men must be incorporated in HIV prevention efforts with women. Many conditioned this participation, while some expressed their opposition. Regarding the ways of participation many favored working with men and women separately at the beginning and integrating at the end. They recommended considering working at a group level.**

Conclusions: **The HIV/AIDS epidemic has put in the forefront the need to consider non-traditional approaches to promote behavior change. A group-base intervention with couples may be an effective way to prevent the HIV/AIDS epidemic.**

Key words: HIV/AIDS, Prevention, Heterosexual men, Heterosexual women

HIV infection is an important threat to women's health and well-being, particularly for those belonging to minority groups. Rates of AIDS cases in this population have been steadily increasing in the United States, Latin America and the Caribbean, mainly by heterosexual contact (1-2). In the United States 56.3% of female adult AIDS cases are reported as stemming from heterosexual transmission as compared to 60.8% of those women in Puerto Rico, 74.8% of those men and women in Dominican Republic and 22% of those men and women in Mexico (3-6). Interventions that focus Latinas in the US and in their countries of origin are particularly pertinent to understand and help to curtail the spread of the epidemic in Latin America and in the U.S. (7, 8).

Because of this situation, different intervention modalities have been developed and implemented. Some of them have proven to be effective in preventing HIV infection in heterosexual populations (9). While most of these efforts recognize the need for women to change the power relationships in which they find themselves so they can negotiate safer sex practices more frequently and more effectively (10-12), others suggest the need for new methods that women can control without negotiating with their male partners (13).

Many interventions have been found to be effective in reducing sexual risk behaviors (14-16). Gender-specific skill-building interventions focused on cognitive-behavioral skills have also been effective in reducing risky sexual behaviors among at-risk women (15,17-19).

However, the question that still remains controversial is: Why does HIV infection continue to increase in

University Center for Psychological Services and Research, Department of Psychology, University of Puerto Rico, Río Piedras Campus

Address for correspondence: David Pérez-Jiménez, PhD, PO Box 23174, San Juan, Puerto Rico 00931-3174, (787) 764-0000 x 5785 (787) 764-2615 (fax), E. mail: daperez@uprrp.edu

heterosexual women? The answer to this question is complex and multifactor. There are reasons for women's HIV risk of infection including: a) women's biological vulnerability (20); b) women's participation in sexual work and drug use (21); c) women's lack of risk perception to HIV/STD's (22-23); d) poverty and social class (24-25); e) ethnicity (26-27); f) cultural values such as *marianismo, machismo,* and *familismo* (8); and h) gender dynamics in male-female relationships (28-36).

In recent years there has been a growing interest in understanding how gender issues are related to the risk of infection with HIV in women (28, 32). For example, women with steady partners report less consistent condom use than those without a steady partner (37-38).

Power relationships between men and women have also been a central topic in the discussion concerning interventions for women (28-29,39-41). Adolescent women have also been found to perceive themselves with less personal and interpersonal power than men (40). These women may not feel they have the resources necessary to negotiate safer sex with their partners.

Although some gender-specific interventions for women have been proven effective, some authors have commented that women-only programs are insufficient to deal with relationship issues. Those who support this idea argue that male partners play a central role in women's risk and must be part of prevention efforts (28-29,32,36,42, 43). Some authors have argued that traditional HIV prevention efforts focused on women have been "myopic" because they "often treat women's risk behavior separate from the behavior of men, without acknowledging gender power differences" (32). These authors maintained that these efforts have ignored the role of men in sexual decision-making by reinforcing the belief that women are the only ones responsible for safer sex. It is assumed that HIV prevention initiatives with women would be more effective if men were also targeted.

The *Joint United Nations Programme on HIV/AIDS* focused the 2000 World AIDS Campaign on the prevention of HIV/AIDS among men worldwide (43). The campaign was based on the assumption that "engaging men as partners in the effort against AIDS is the surest way to change the course of the epidemic" .They identified the following five reasons why it was necessary to focus on men: 1) "men's health is important but receives inadequate attention"; 2) "men's behaviour puts them, at risk of HIV"; 3) "men's behaviour puts women at risk of HIV"; 4) "unprotected sex between men endangers both men and women"; and 5) "men need to give greater consideration to AIDS as it affects the family".

Recent research supports the need to work with men because, although HIV prevention initiatives with this population have been limited, some have also been proven effective in reducing risk behavior (44-46). For example, a motivational-skills intervention was implemented with African American men and it was found to be effective in lowering the rates of unprotected vaginal intercourse and increasing condom use (46).

Other researchers studied men's attitudes toward the female condom and found that the majority of participants had limited or no knowledge about it (47). They also found that some participants had negative reactions about using this condom with their female partners like the "strangeness" and "bigness" of this condom, while others had more positive reactions like endorsing the idea that women have the right to use it and its possibility enhancing pleasure. Authors concluded that educating men about this condom might facilitate its use with women. This study is one example of how HIV prevention interventions with men are effective not only for men, but as a consequence for women.

Although, the issue of men's participation in HIV/AIDS prevention for women has been suggested, it has not received the attention it merits, particularly with the salience of these issues within the HIV/AIDS epidemic (28). Those that have considered it are divided. Some believe that women must be empowered by themselves (women-centered efforts) so they can challenge the relationships that oppress them (10,18). Others believe that interventions with men must be developed separately so that their awareness and behavior can be changed as well (gender-specific interventions) (18,32,48). Others yet believe that interventions should focus on couples or mixed groups (49) thus intervening with both genders (simultaneous). Another possibility yet to be tested is that of interventions that focuses on women initially and then integrates their partners (sequential).

With this preoccupation in mind, we implemented a research project to explore the role men should play in HIV/AIDS prevention interventions among heterosexual women. We explored and compared the opinions of HIV/AIDS prevention researchers, HIV/AIDS prevention service providers, and heterosexual men and women who participated in an HIV/AIDS prevention project. Researchers and service providers were chosen because they have been directly involved in the design and implementation of prevention activities. The participation of heterosexual men and women was critical for their experience as participants in prevention interventions. Our interest arose from our concern with the increase of HIV/AIDS through heterosexual transmission, from previous experiences working in projects focused exclusively on women and from incipient efforts that have begun to consider men's role.

Method

We conducted 13 focus groups: five in Puerto Rico, four in Dominican Republic and four in Mexico[2]. In each set of groups: (a) one included HIV/AIDS researchers; (b) one prevention service providers from community-based organizations (CBO's); (c) one heterosexual women; and (d) one heterosexual men that had already participated in HIV/AIDS prevention interventions. In this article we present data of the thirteen focus groups regarding the following variables: 1) participation of men in HIV/AIDS prevention interventions with women; 2) forms of participation; and 3) levels of intervention.

Participants. Researchers, service providers, heterosexual men and women from Dominican Republic and Mexico were recruited by personnel from CBO's (*Pro-Familia* in Dominican Republic and *IMIFAP* in Mexico) that our team had previously contacted in these countries. In Puerto Rico participants were identified by using a Service Directory that exists for the Island.

A total of 94 participants attended the focus groups. Of this, 13 were researchers, 32 service providers, 28 heterosexual women and 21 heterosexual men. The amount of participants was very similar in each country with 30 from Puerto Rico, 36 from the Dominican Republic, and 28 from Mexico.

Researchers. Of the researchers that participated in the focus groups, seven (54%) were men and six (46%) women. The average age was 41 with a range of 28-53. Most researchers were married (n=6, 50%) while four were divorced (33%) and two were singles (17%). Forty-six percent (n=6) completed master studies and 38% (n=5) doctoral studies. Six participants identified with the Catholic religion, while another six said they had no religion. The majority (n=7, 54%) had been working in HIV/AIDS for more than 10 years.

Service providers. Of this group, 17 (55%) participants were women and 14 (45%) men. The average age was 34 with a range of 23-58. The majority was single (n=17, 53%) followed by those that were married (n=6, 19%), divorced (n=5, 16%) and in consensual relationships (n=4, 12%). The majority completed a bachelors degree (n=12, 39%) followed by those who completed master studies (n=8, 26%). Most of the service providers identified with the Catholic religion (n=17, 53%) followed by those who did not identify with any religion (n=8, 25%).

Heterosexual women. The average age was 39 with a range of 21-62. Most were married (n=9, 35%) followed by those in consensual relationships (n=7, 27%) or single (n=5, 19%). Ten (37%) had completed high school. The majority self identified with the Catholic religion (n=23, 82%), and lived in urban areas (n=18, 72%). Most were unemployed (n=8, 33%), followed by those working part time (n=7, 29%) or full time (n=6, 25%).

Heterosexual men. The average age was 28 with a range of 18-45. Most men were single (n=16, 76%), followed by those that were legally married (n=3, 14%). Most of the participants completed high school or college (n=18, 86%), and most self identified with the Catholic religion (n=13, 62%), and lived in urban areas (n=18, 90%). Most men were working part time (n=10, 48%) or full time (n=8, 38%).

Instruments. We obtained participant's socio-demographic data with diverse versions of a socio-demographic questionnaire (SDQ) and also developed focus group guidelines.

Socio-demographic questionnaire. The SDQ that was administered to researchers had 23 close-ended questions. We asked questions regarding: gender, nationality, education, religion, marital status, income, main research area, and funding. Meanwhile, the SDQ for service providers had 36 close-ended questions and one open ended question. This questionnaire had the same questions regarding socio-demographic information as the previous one. This questionnaire had other questions about: work experience, services the agency provided, providers' role in the agency, and population served by the organizations.

The SDQ completed by heterosexual men and heterosexual women had 30 close-ended questions. Similar to the SDQ of providers and researchers, it had 30 questions about general socio-demographic information, plus another set of questions regarding participant's sexual behaviors, and HIV/AIDS risk perception.

Focus group guidelines. We used three different focus group guidelines to facilitate discussion. Although most of the questions were similar for all groups, some were different depending on the characteristics of the participants. The guidelines for the groups of men and women consisted of 26 questions and for the groups of service providers and researchers it consisted of 19 questions. With these questions we explored the following topics: (a) knowledge of prevention programs focusing on heterosexual men and women in their countries; (b) whether men should participate in efforts directed at women; (c) how that participation should take place; (d)

characteristics recommended for a project focusing heterosexual men; and (e) cultural issues that should be considered. We identified in bold questions facilitators had to ask in the focus groups; others were optional.

Procedure. The focus groups were held in January, February, March, April, May, and December of year 2000. Most were completed in 90 minutes. Each group had a facilitator and co-facilitator. Research staff and community collaborators of both genders moderated the researcher and service providers' focus groups. Meanwhile, facilitators and co-facilitators of the same gender as participants moderated the focus groups of heterosexual men and women. We implemented this format to facilitate that men and women felt comfortable in their respective groups.

Before initiating the focus groups they administered a consent form and the SDQ to participants. The facilitators explained norms for the group discussion, their roles and the study's goals. Their main duties were to facilitate the discussion using the focus group guidelines and to assure that all participants in the focus groups had similar opportunities to express their opinions. They explained the objectives of the study and discussed focus group norms. Some of the norms that we emphasized were: respect towards each other, and order during the discussion. They clarified that any answer to a question was acceptable; that no consensus between participants was necessary, and that the purpose of the discussion was to explore opinions rather than facts. By the other hand, the co-facilitator role was to take notes, handled the audio-recorder and helped with the adequate distribution of time during the discussion. All instruments and procedure to be used were approved by the Institutional Review Board of the University of Puerto Rico.

Conversations were audio taped with participant's authorization. When the conversation concluded participants were thanked for their collaboration and provided with a $25.00 incentive, except researchers. Researchers were given a gift worth a similar amount. We also paid an incentive to the participation organizations. To the CBO from Puerto Rico we paid $750 and to the CBO's from Dominican Republic and Mexico we paid $1,000. The difference in the stipends is because the CBO from Puerto Rico only recruited the participants for the focus groups of heterosexual men and women, while the other CBO's recruited the participants for all four focus groups.

Analysis. The taped conversations were transcribed and analyzed using content analysis according to a set of defined categories and sub-categories. Categories included: "participation of men in HIV/AIDS prevention interventions with women"; "forms of participation"; and "levels of intervention". The sub-categories included in the first category were: "men should participate"; "reasons why men should participate"; "men should not participate"; "reasons why men should not participate"; "conditioned participation"; and "reasons for conditioned participation". The sub-categories for the second category were: "sequential"; "simultaneous"; and "aen and women centered". Finally, the sub-categories for the last category were: "group"; "combination"; "couples"; "group and individual"; and "group, individual, couples". If new subcategories were identified during the analysis, they were added to the guide.

A group coding technique was used to conduct content analysis (50-51). Through this technique judges are recruited to code the groups without seen the judgment of the other judges, then they meet to compare their results and reach consensus. Those texts that judges did not agree on were not included in the analysis. The coding group was composed of two judges (one woman and one man) and one staff member. They were recruited and trained by research staff. We used *N-Vivo* qualitative software to conclude the content analysis. Finally, we selected those quotations or paragraphs that illustrate each category or subcategory, while responding to our research questions. The results include quotes all three judges agreed on during the coding process.

Results

In this section we present data regarding the general categories, followed by the sub-categories. Some quotes that exemplify each category are also presented.

Participation of Men in HIV/AIDS Prevention Interventions with Women

In Table 1 we present the number of quotes per group for this category. Across all groups most participants favored men's participation in HIV/AIDS prevention efforts with women. Only 10 quotes were identified against their participation.

Reasons why Men should Participate. Participants mentioned many reasons why men should participate including: 1) prevention is a right and the responsibility of both, men and women; 2) it would facilitate prevention and sexual negotiation; and 3) it is a way to learn about men's opinion. They mentioned that men should be incorporated because empowerment must be promoted with both, men and women, and that prevention would be more effective. They also think that the incorporation of men will help

Table 1. Participation of Heterosexual Men in Prevention Efforts

	Category						
Group	**Men should participate**	**Reasons men should participate**	**Men should not participate**	**Reasons men should not participate**	**Conditioned participation**	**Reasons for Conditioned participation**	**Total**
Researchers	11	23	6	9	13	6	68
Service Providers	15	26	3	13	3	23	83
Heterosexual Women	19	30	1	-	-	-	50
Heterosexual Men	8	19	-	-	3	1	31
Total	**53**	**98**	**10**	**22**	**19**	**30**	**232**

decrease violence and unwanted pregnancies, and improve the quality of relationships and communication between the genders.

> *Me [...] when I hear [...] that women have to conquer their space, that men have to yield their power, with that kind of discourse I do not agree, because it is not easy to yield power, nor is it easy to conquer someone else's space [...] Its like it was a fight between them, a conflict, a war, and it can't be that way. In other words I understand that they have to share things, share education, share growth, share power, share prevention. That's how I visualize it. Then I understand that this will only be achieved if we can work together [...] reflect together [...] see the problem jointly, in other words when we analyze we are both there, we can even discuss [...] so as to reach consensus, reach an agreement and to see what happens to the other, we have to see it together. [I don't think that] working separately we can explore issues much [...] if we do not try to create spaces where men and women can share their reflections. (R)*[3]

Service providers consider that including men will promote an integral view of human health and sexuality. They also stated that gender equality means that both, men and women should assume responsibilities for HIV/AIDS prevention. One participant stated:

> *… I believe that if the men do not accompany women to these workshops we are not going to achieve what we seek […] which is integral health. We don't do anything with projects for women if they do not exist for men or if they are not given the opportunity to attend. I believe it is very important that this space is opened for men and if it can be opened jointly with women I think will be even more fruitful. (SP)*

Comments from the groups of men and women were 99% in support of men's participation. Some of the reasons they gave included: 1) prevention is the responsibility of both members of a relationship; 2) men are most frequently responsible for infecting women; 3) to find out what men think; 4) because men resist using safer sex protection; 5) as a way to create risk perception in men; and 6) because men's responsibilities for their own sexuality may increase. Women were more vocal about this issue than men.

> *I think it [is] ok, because we always need men's opinion. When we try to negotiate condom use we rehearse […] to see what they will answer. Every woman knows her partner, but we need to know men's opinion, because sometimes men are offended when their woman asks them to use a condom… [They think] that you are dating someone else [...] we need to learn to decide about our bodies and they must respect that and be responsible for their own sexuality. (W)*

One man expressed:

> *… from my point of view it is simply that we, men and women have the same rights [...] Then, what is more beautiful than having sex, knowing everything you can do to prevent AIDS and sexually transmitted diseases, and to do that together. I think that strengthens the relationship and you can enjoy your sexual relations with more happiness, […] more fun. (M)*

Reasons why Men Should Not Participate. Some researchers and service providers expressed some doubts about the incorporation of men. They indicated that it was not necessary to incorporate men if the goal was to empower women or if they were discussing women's needs and problems. They also stated that the genders should

remain separate because gender construction processes for men and women are different. They added that there was no evidence of the effectiveness of projects including both genders. One researcher argued that incorporating men is underlying the emotional, historical and social dependence on men.

> *Look, what's true is that the presence of the other, hinders, even if you... because mere presence is the contradiction. You are underlining, in a couples' program, you are underlining, the emotional, historical and social dependence on men, then it doesn't work. It is a contradiction (R).*

Another issue raised by one researcher was that recruiting women would be more difficult if men are present in the intervention.

In other words, knowing how hard it is to recruit, for example, you add men and no women will come. [...] imagine, examine the recruitment literature, the hardest bone to chew on is recruiting women. There are no ways to organize them, because they do not have, socially, the construction for this. Not men, in other words, I have facilitated workshops for men for years, and they do not leave. They attend. You do it with women and you have to try three times and even then... (R)

One service provider argued that men and women must be separate because they have different needs: "... I think there have to be projects designed and directed for men and by men, because in this historic moment I do not see them together, because we have different needs, we are different beings..." (SP)

Conditioned Participation. Researchers and service providers were more inclined than other groups to condition men's participation. Some of the conditions offered by researchers were discussing power relations before integrating men and women; and working with both genders during adolescence. Service providers argued that it is necessary to work certain aspects with women such as self-esteem, power relations and empowerment, prior to working with men.

> *And I [...] would not integrate that woman's couple, before 6 months, to any process, because that will break everything I have been working on with that woman until that moment. So [...] I think it is very important to work with self-esteem, empowerment, with women, and once they identify their own worth, their power and have some tools, have preventive information, they will make decisions and become aware of things, and at some point in the process, integrate men. (SP)*

One service provider argued that it is necessary to know the level of machismo and the social construction of masculinity in the area where men live before inviting them to the intervention. Other argues that the decision of incorporating men will depend on the themes that will be covered during the intervention. If the theme is empowerment they must not participate because men don't need to be empowered, but if the theme is sexual negotiation then men must be invited.

Ways in Which They Can Participate. We defined this category as participants' suggestions regarding the way in which heterosexual men should participate in HIV/AIDS prevention projects designed for women. Table 2 illustrates the frequencies of quotes per category by group. When asked how men could participate, most expressions in all groups favored working with men and women separately at the beginning and integrating them at the end of the intervention (sequential). This would allow for: (a) trust building before joining the groups; (b) increasing awareness before they interact; (c) working out minor differences before working with more complex situations; (d) facilitating a more mature analysis; and (e) discussion of themes that are more pertinent to men and women. One woman commented the following:

I [...] would put women apart, men apart and at certain point, at some point in the workshop join them together to see what I learned [...] For example, [...] negotiation, we negotiate between women [...] but now, negotiating in front of my partner to see how it goes, to see if it really works or doesn't work. How I convince him. (W)

On the other hand, a man commented:

> *[…] there must be one part where they are separated, because, although it should not be that way, it is a reality that when men are with men and women with women, there's more trust when speaking, when disclosing [...] although the couple must be together [...] there must also be a space where men can be alone and they can [...] say, talk and then after that [...] or before the integration with his partner or with the woman [...] there can be more openness and more integration in the couple. (M)*

Levels of Intervention. We defined this category as the different ways in which we can work with men in HIV/AIDS prevention projects directed at women. As can be seen in Table 3, opinions were divided regarding intervention levels. Researchers suggested interventions at the institutional and community levels, while service providers favored working with couples. Women favored most interventions at the group level; while men had divided opinions between working with couples and a suggestion to combine levels. Most participants

Table 2. Ways in Which Heterosexual Men Can Participate

	Category				
Group	**Men and women centered**	**Sequential**	**Simultaneous**	**Other forms of participation**	**Total**
Researchers	-	16	10	4	30
Service Providers	4	17	9	13	43
Heterosexual Women	4	7	12	5	28
Heterosexual Men	-	14	2	3	19
Total	**8**	**54**	**33**	**25**	**120**

suggested that persons of both genders facilitate the intervention.

Table 3. Levels of Intervention

	Category						
Group	**Group**	**Couples**	**Combined**	**Group and individual**	**Group, individual and couple**	**Other interventions level**	**Total**
Researchers	4	2	6	-	-	12	24
Service Providers	1	7	1	-	-	-	9
Heterosexual Women	12	4	5	2	-	5	28
Heterosexual Men	-	4	4	2	4	-	14
Total	**17**	**17**	**16**	**4**	**4**	**17**	**75**

Group. Most participants believe that interventions must be group based because participants may learn from the experiences of each other, as a way of knowing that what may happen to you may also happen to other persons.

> *I really like to start in a group because in groups they have the experience of " I tell my story and so-and-so identifies with me". Then that motivates other people to talk and give their opinions and see how they feel (SP)*

I think in groups, in groups in the sense that he can see that what happens to him, happens to the other one, happens to you. It happens to all of us in the same way. (W)

Couples. Those who favored interventions with couples commented that each person should hear the others' point of view. They also commented that more men would attend the sessions if they know that women will be present.

I think so, that if the man who is there is not her partner, even if I rehearse it, it will never be, in other words [...] I can generate the space for those women to practice negotiation with a man, but it will never be the same. In other words, this is a role play, unless we work with real couples, that the man who is there is really her partner, then that's another story. (SP)

It would be ideal with couples, because, maybe, what I am afraid to tell him, because he is so explosive and doesn't want to listen to me. We are here talking as a couple, we have built trust, I come and express myself, and he says and that's what you think? Yes. (W)

… I think that we must start with couples because this will avoid […] three steps […] less work because if you put them together, you talk to them openly about everything they'll be doing there. They see the way things will be done in this activity and it's all worked out because you worked with both of them. Then they already know that they will know each other. (M)

Group and Individual. Some participants commented that a group intervention would be more effective, but that some people need individual level interventions in which they can discuss confidential or intimate information.

> *–Maybe the best for a person is not an individual process, maybe a group process would be better and we also need to take that into consideration. The best situation [...] for many people [...] would be in a group, but there are other more private [issues] they prefer to tell individually. We'll have to take that into consideration according to the situation and the level of difficulty. (M)*

Group, Individual and Couple. Some participants commented that the intervention must focus on the

individual first, then on the relationship, and finally at the group level.

> *... First it has to be personal, I must be aware of my participation to do this, first personal and immediately with my wife, my partner and then in a group. [That's] where we are going to be stronger, but first with me, which is the most important that I must be aware, that I must work with myself, because if I don't work with myself I cannot give […] others, I cannot take what I am not practicing […] myself. (M)*

I think that it would definitively be in three stages. One stage at an individual level, one stage as a couple, and then one group stage. I think that would be a way to extract the maximum potential for each participant. (M)

Overall, service providers believe that men should be incorporated into HIV/AIDS preventive efforts focusing women. These interventions should work with couples in a sequential manner.

Discussion

The present investigation provides us with important information about the need to incorporate men with women in HIV prevention interventions. If we can agree in the fact that prevention efforts have not had the expected outcomes, we must ask ourselves why this happen and what measures we need to take to overcome that limitation. After more than two decades of the AIDS epidemic, promoting HIV prevention continues to be a major challenge, particularly in the most vulnerable populations. It is imperative to evaluate our efforts and have the capacity to accept it limitations in order to design more effective interventions. In promoting HIV prevention with women we need to look at the way we have been conducting our interventions and determine if different approaches are necessary.

This study has several important findings. First, the vast majority of participants agreed that men should participate in prevention interventions with women. Participants believe that it is more beneficial for both members of the relationship to include men as part of an intervention because men and women can discuss their needs and worries in front of each other on the same level.

Second, even though there's no doubt on most of the participants about the need to work with men, it is not clear how that integration should be made. This may be related with the false but generalized belief that men are hard to reach. Interventions conducted with men for HIV prevention are demystifying this myth (45, 46).

Third, the opposition to the participation of men came from the groups of researchers and prevention service providers. Why are some of them opposed to men's participation? Some of the reasons that they could have for being more skeptics about men's participation may include: a) having previous negative experiences with this population; and b) facing day by day difficulties in having access to this population.

Fourth, most of the comments supporting men's participation came from the groups of women. This is not hard to understand if we consider that women are the most affected group by the heterosexual transmission of HIV, and they suffer tragic consequences because of the gender inequalities. Usually, controlling prevention methods is not under women's control (28). They continually confront difficulties in trying to negotiate safer sex practices with their partners and experience their rejection when proposing the use of condoms or any other prevention method (52, 53).

Fifth, sequential format were most supported by all participants. This is in recognition that men and women have sensitive issues that may be difficult to talk openly in front of the other gender. Men must have their own space where they can talk openly about male issues and women must also have the space to talk openly about women issues. At the same time, they must have the opportunity to express in front of each other how they feel and what they think about certain issues regarding sexuality.

Finally, our data also shows that, although we may agree on incorporating men in HIV/AIDS prevention interventions with women, and in testing new strategies, we must be aware that that incorporation must be careful and planned. We must recognize that the strategies for recruiting men have to be, in some way, different than those used to recruit women. Men need to feel that going to educational activities will have an immediate positive effect for his partner and family, not only for him. If men perceive that the benefits are only for him, he may not feel motivated to assist because he feels that primary motivation is protecting his family. We must also recognize that men and women have different ways to analyze and interpret the reality and different perspectives about how gender relations must be. Finally, recognize that in relation with sexuality we have different needs and ways to understand it. In this sense, prevention interventions must promote reflection spaces where men and women are separate working issues that may be sensitive to talk openly in front of women. At the same way, promoting spaces where they can be together having a dialogue with respect and where they can have the opportunity to practice their skills.

Results presented before are a clear signal that it is time to recognize that heterosexual transmission of HIV happens

inside the context of a relationship consisting of at least two parts, the one who infect and the one who is infected (28). Based on these findings we would like to share some recommendations. First, efforts should be initiated including men in empowering interventions directed at women. Second, formative evaluation research should accompany these efforts particularly identifying factors that confirm and minimize identified barriers to joint gender participation. Finally, research efforts should be developed to compare same gender and dual gender interventions to see the impact of this change on their effectiveness.

If evidence presented shows that intervening only with women is not enough to reach the expected outcomes in reducing HIV, we must have the capacity to identify new ways that may be more effective. It is necessary to continue evaluating our efforts to determine in what we are failing so we can be in a better position to take corrective measures. In the context of the heterosexual transmission of HIV, if men have a responsibility for transmitting the virus, they may also play a fundamental role in it prevention.

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