

Gender-Based HIV and AIDS Risk Reduction Training for Health Educators in Katlehong, Johannesburg

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KEYWORDS Gender-Based HIV and AIDS Risk. Locus of Control. Self-efficacy. Sexual Assertiveness

ABSTRACT The aim of the study was to improve health educators' locus of control, self-efficacy, sexual assertiveness, and to reduce HIV and AIDS risk through training. A gender-based HIV and AIDS risk reduction training programme was used to train health educators in Katlehong, Johannesburg. Thirty- three health educators volunteered to participate in the study. Participants were invited through the organisation's internal communication channels. Participants were recruited from the organisation's two branches. Participants' locus of control, self-efficacy, sexual assertiveness and gender-based HIV and AIDS risk were assessed before training and after training. The instruments that were used to assess participants' psychological well-being were Roter's locus of control scale, general self-efficacy scale, sexual assertiveness scale for women, and HIV and AIDS risk was assessed using the gender-based HIV and AIDS risk scale. In addition, a qualitative design that used focus groups to get participants' views on how they would use the train-the-trainer gender-based skills they got from Tshenolo HIV and AIDS Prevention Project to protect themselves from HIV infection and to empower vulnerable girls and women, people at risk of HIV infection and those living with HIV and AIDS through training. Data were analysed using *t* related samples tests and thematic content analysis. The results of this study indicated that participants felt that the training programme equipped them with personal skills to deal with gender transformative HIV and AIDS prevention programmes and policies. The perception of participants in this study was that the gender-based training programme had adequately prepared them to help vulnerable groups experiencing gender inequality in the community. The quantitative results indicated an improvement in psychological wellbeing of participants and a significant reduction in HIV and AIDS risk after training. Future studies could focus on the longitudinal relationship between attending a gender-based risk reduction training programme and HIV incidence among participants.

INTRODUCTION

Issues affecting women have recently taken a centre stage in Africa and abroad. Women issues feature in development studies, affirmative action programmes, and health interventions (Kevane 2004). Gender-related studies are now looking at every sphere of human development and incorporate women interests in order to achieve a balanced society (Kevane 2004). Women and girls are represented in health matters as a disadvantaged group in Africa and other emerging economies of the world (Shannon et al. 2012). Men and boys are considered to be less prone to HIV infection than women and girls. It is estimated that 33 million people are living with HIV worldwide and 70% of this number live in sub-Saharan Africa (Shannon et

al. 2012). It is estimated that 58% of this number is made up of young African women (Shannon et al. 2012). Among the 15 to 25 age group in sub-Saharan Africa, 70% of HIV- positive adolescents and young adults are females (Shannon et al. 2012). This study was based on Tshenolo HIV and AIDS Prevention Project: a gender-based training programme that sought to empower women and to reduce HIV and AIDS risk among disadvantaged women in Katlehong, South Africa. The study assessed improvement in psychological functioning in terms of changes in locus of control, self-efficacy, sexual assertiveness and HIV and AIDS risk reduction.

Locus of Control and HIV and AIDS Risk

Research on locus of control among disadvantaged groups indicates that more women than men tend to have an external locus of control (Holland et al. 2010). It is argued in locus of control research that women experiencing environmental, physical and emotional difficulties tend to show more health risks than men living in the same environment (Lehavot et al. 2010). In health

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promotion, individuals with an external locus of control usually fail to adhere to recommended health promotion habits and sometimes they do not show compliance with medication regimen (Christensen et al. 2010). Studies on locus of control and health promotion show that women with an external locus of control generally show a low motivation towards contraception and the use of condoms to prevent sexually transmitted diseases, HIV infection and unwanted pregnancies (Gwandure 2007). HIV and AIDS prevalence is reported to be higher among women with an external locus of control than women with an internal locus of control (Raingruber et al. 2010). Poverty, violence, and other forms of unpredictable environmental conditions make women more vulnerable to HIV and AIDS (Shisana et al. 2010). Training interventions in modification of locus of control towards internality have shown a reduction in HIV and AIDS risk among participants (Alleyne and Gaston 2010). In view of these findings, this study sought to use a gender-based risk reduction training programme as a way of improving women's locus of control in HIV and AIDS prevention. This study posited that women-related health risks could be reduced through gender-based training and that women who are not exposed to gender transformative HIV prevention programmes are more likely to show riskier sexual behaviours than trained women.

Self-efficacy and HIV and AIDS Risk

Self-efficacy is generally described as the belief held by an individual that they can achieve their goals. It is argued that low self-efficacy is associated with HIV risk (Shai et al. 2010). It has been found among rural women in South Africa that low self-efficacy was associated with HIV risk (Shai et al. 2011). Low condom use self-efficacy was associated with gender inequality (Shai et al. 2010). Consistent condom use could be affected by low self-esteem. Gender inequality and low safer sex negotiation skills among low-income women could make them vulnerable to HIV infection (Shai et al. 2010). Studies on gender and HIV risk indicate that women in difficult circumstances are reported to have low levels of self-efficacy (Hoyt and Blascovich 2010). In particular, women living in violent communities tend to show low levels of self-efficacy (Sikkema et

al. 2010). Violence against women (VAW) is common in resource-poor communities in South Africa (Wechsberg et al. 2010). Women with low self-efficacy tend to have a negative self-image and they generally show low levels of personal initiative to improve their health and wellbeing (Gray et al. 2010). Individuals with high self-efficacy believe that they can change their lives. Self-efficacy is targeted by health educators as a risk factor in HIV and AIDS prevention (Jones et al. 2010). Studies on self-efficacy training and health improvement show that self-efficacy training for patients reduces health risks (Tsay 2003). This study sought to improve the self-efficacy of health educators working in violent communities in South Africa.

Assertiveness and HIV and AIDS Risk

Sexual assertiveness is characterised by an individual's ability to initiate sex, refuse to engage in unwanted sex and avoiding risk sexual practices that can result in unwanted pregnancies or the contracting of sexually transmitted diseases (Morokoff et al. 1997). Women with high sexual assertiveness skills are more likely to practise safer sex and to control health outcomes than women with low assertiveness skills (McCoy et al. 2010). Women with low sexual assertiveness skills are reported to be at risk of HIV infection (Summer et al. 2010). Some adolescents and young adult women with low sexual assertiveness skills could engage in sexual risk behaviours such as not being able to: make contraceptive decision without telling their partner, tell their partner that they are not prepared to have sexual intercourse without birth control, tell their partner that they want to make love differently, tell the partner that they are being too rough and telling the partner that they should stop foreplay at any time including the point of intercourse (Rickert et al. 2002).

In South Africa, sexual assertiveness skills are generally low among women from disadvantaged backgrounds (Jewkes et al. 2010a). Assertiveness can be promoted through training. Individuals who attend assertiveness skills training in health promotion tend to show higher assertiveness skills in health risk reduction at the end of training interventions (Paezy et al. 2010). This study explored how sexual assertiveness skills could be improved through training among health educators in South Africa.

Gender and HIV and AIDS Risk

Women constitute the greater number of people living with HIV and AIDS in the world (Hodge and Roby 2010). Studies on gender and HIV risk usually attribute HIV vulnerability among women to biological factors, gender inequality, gendered power relations, inhibitive social structure, low sexual agency among women, forced sex, lack of sexual autonomy and sexual pleasure-seeking, economic dependence on men and political violence (Higgins et al. 2010). Some women engage in sexual relations to please men and they might find it more feminine and culturally decent or appropriate not show that they are interested in sex (Akintola et al. 2011). Health educators now target factors that make women vulnerable to HIV infection in their health interventions (Jewkes et al. 2010b). In this study, gender-based HIV and AIDS risk reduction training focused on HIV risk factors such as biological risks, initiation of healthy sexual practices, shyness in negotiation for sexual pleasure, poverty, relationship power inequality and negotiation for safer sex (Shisana et al. 2009). These factors were discussed within the broad context of locus of control modification, self-efficacy improvement and sexual assertiveness skills training for HIV and AIDS risk reduction.

Aim of the Study

The study aimed to reduce HIV and AIDS risk among health educators by exposing them to a gender-based HIV and AIDS risk reduction training programme. The study sought to assess the efficacy of the training programme in improving participants' locus of control, self-efficacy, sexual assertiveness and the reduction of gender-based HIV and AIDS risk. The study sought to answer the following research question:

Will the Gender-based HIV and AIDS Risk Reduction Training Programme Help Health Educators Deal with HIV and AIDS Risk Among Women?

In order to answer the research question participants were asked to give feedback on the usefulness of the training programme to their work as health educators. The study formulated the following hypotheses in order to assess the impact of the training programme.

- (a) The gender-based HIV and AIDS risk reduction training programme will have no effect on participants' locus of control.
- (b) The gender-based HIV and AIDS risk reduction training programme will have no effect on participants' self-efficacy.
- (c) The gender-based HIV and AIDS risk reduction training programme will have no effect on participants' sexual assertiveness.
- (d) The gender-based HIV and AIDS risk reduction training programme will have no effect on participants' HIV and AIDS risk.

METHODS

Research Design

The study used a mixed method design in which qualitative and quantitative methodologies were used. The qualitative methodology enabled the study to capture participants' views about the value of the training programme to their understanding of gender-based HIV and AIDS risk and how it would help them deal with women clients in Katlehong. The study used a pretest-post-test design to measure the impact of the training programme on participants' locus of control, self-efficacy, sexual assertiveness and gender-based HIV and AIDS risk.

Sample

There were 33 health educators who participated in this study. Participants were employed by a non-governmental organisation as community health educators. The study sample was made up of social workers (N = 4), social auxiliary workers (N = 24), intern psychologists (N = 3), and intern counsellors (N = 2). The sample was largely composed of female participants. There were (N = 4) men and (N = 29) women. Katlehong is designated as a previously disadvantaged community. The non-governmental organisation from which participants were drawn is based in this area. The community has a history of crime and is mostly known for domestic violence, ethnic violence, drug and alcohol abuse, community riots, sexual assault, hijacking, teen pregnancy and gun violence (Minnaar 1994).

Measuring Instruments

(a) *Locus of Control Scale*

Locus of control was measured using Rotter's locus of scale (1966). The instrument measured locus of control in health educators. Scores above 12 points indicated external locus of control. Scores below 11 points indicated internal locus of control. The instrument is widely used in South Africa.

(b) *Generalised Self-efficacy Scale*

Self-efficacy was assessed using the general self-efficacy scale (Jerusalem and Schwarzer, 1995). The measure assessed participants' perceptions about their ability to manage health situations on their own. This measure is widely used in South Africa. Scores above 20 points indicated healthy functioning.

(c) *Sexual Assertiveness Scale for Women (Morokoff et al. 1997)*

The sexual assertiveness scale for women assessed women's ability to initiate sex, refuse unwanted sexual behaviours, and assertiveness in prevention of unwanted pregnancies and sexually transmitted diseases. The scale was developed by Morokoff et al. (1997). For example, one of the items was "I begin sex with my partner if I want to". For the purpose of this study 8 items put on a 4 point likert-type scale were used to assess sexual assertiveness in women. The instrument had a reliability of .85 (Cronbach alpha) in this study. Scores above 16 points on the scale indicated high sexual assertiveness.

(d) *Gender-based HIV and AIDS Risk Questionnaire*

The questionnaire had 36 items that assessed gender-based HIV and AIDS risk. The questionnaire was developed by the researchers. The study used research papers from UNAIDS, Medical Research Council, South Africa, World Health Organisation and Human Sciences Research Council, South Africa to identify common gender-related factors that make women vulnerable to HIV and AIDS. An example of the items in this questionnaire was "I believe women can negotiate with their partners for safer sex." The ques-

tionnaire had a reliability coefficient of .83 (Cronbach alpha). Scores above 18 points indicated HIV and AIDS risk.

The Training Programme: Tshenolo HIV and AIDS Prevention Project

The Tshenolo HIV and AIDS Prevention Project is a women leadership training intervention that seeks to empower women from disadvantaged communities against HIV and AIDS. This study was based on this ongoing project on women leadership initiative in HIV and AIDS risk reduction. The training programme for this study focused on locus of control, self-efficacy, sexual assertiveness and HIV and AIDS risk among women. The training programme was facilitated by the researchers. The training programme was run for three days. Participants took time off work to attend the training sessions.

Procedure

The first session involved the completion of questionnaires that were meant to assess participants' locus of control, self-efficacy, sexual assertiveness, and gender-based HIV and AIDS risk. After that, participants talked about their expectations of the workshop. They were later shown videos about HIV and AIDS in South Africa. After video watching, participants were put in small focus groups of about 10 participants in each group. The training focused on how locus of control affected women's ability to protect themselves from HIV infection in South Africa. The focus group discussion highlighted the relationship between low self-efficacy and HIV and AIDS risk among women. Participants discussed the relationship between sexual assertiveness and women's ability to prevent HIV and AIDS. In focus groups, participants discussed how they were going to assist women and girls at risk of HIV infection and people living with HIV and AIDS. The train-the-trainer focus group activities sought to equip health educators with skills to help and empower women in disadvantaged communities. The training intervention, sought to educate health educators about the need for women to negotiate with men about safer sex. The last session was an evaluative session in which participants completed questionnaires for the second time on locus of

control, self-efficacy, sexual assertiveness and gender-based HIV and AIDS risk. Participants, in focus groups, reported how the training programme helped them deal with gender-based HIV and AIDS risk among women in Katlehong.

Ethical Considerations

Participants were invited to participate in the study. They completed informed consent forms and were free to withdraw from the study. Participants' were not asked about their HIV and AIDS status and neither were they asked to disclose if they were victims of intimate partner violence.

Data Analysis

The qualitative aspect of the training programme analysed gender-based HIV and AIDS risk using thematic content analysis. The study identified recurrent themes from participants' reports. The major themes that were identified were poverty, single-motherhood, child neglect, the blaming of men by women for HIV infection, condom use stigma, poor sex negotiation skills and cultural factors. The study used *t* related samples tests to analyse pre-test and post-test data.

RESULTS

Qualitative Reports

Participant reports identified gender-based HIV and AIDS risk behaviours that they mostly encountered as health educators. Women and girls in Katlehong, were at risk of HIV infection and the development of HIV into full-blown AIDS due to the following factors: poverty, lack of medical aid to pay for HIV treatment, single-motherhood, abandonment, neglect and abuse of girl children by parents or relatives, sexual coercion, dependence on men for economic needs, women blaming men for HIV infection without making an effort to protect themselves, use of alcohol and drugs before sex, casual sex, condom use stigma, poor sex negotiation skills and failure of grannies to educate their girl grandchildren about HIV and AIDS. Participants discussed how these factors made women vulnerable to HIV and AIDS.

Quantitative Results

The results showed that the training programme improved participants' locus of control, self-efficacy, sexual assertiveness and reduced HIV and AIDS risk. The *t* tests for related samples showed that participants' locus of control differed significantly between pre-test and post-post, $t(32) = 3.83, p < .01$. Locus of control improved towards internal locus of control. Participants' self-efficacy differed significantly between pre-test and post-test, $t(32) = -3.51, p < .01$. There was a significant improvement in participants' sexual assertiveness, $t(32) = -4.28, p < .01$. There was a significant reduction in gender-based HIV and AIDS risk after training, $t(32) = 6.48, p < .01$.

DISCUSSION

The training intervention helped participants identify gender-based HIV and AIDS risk factors that were common among their clients in Katlehong. Participants were able to come up with practical solutions to reduce HIV and AIDS risk among women.

Poverty was identified as a gender-based risk factor among women in Katlehong. The findings are in line with previous studies which show that poverty makes communities more vulnerable to HIV infection and some people in resource-poor communities die of AIDS due to the unavailability of financial resources to buy HIV treatment medicine (Shisana et al. 2009). It was reported that most of the women and girls who visited the non-governmental organisation for psychosocial assistance lived in crowded residences, informal settlements and shacks. There was a tendency to rely on male sexual partners who provided financial support (Shisana et al. 2009). Most of the male partners had other sexual partners known to their female partners and serial monogamy was common (Shisana et al. 2009). The relationships were reported to be a form of polygamy that is acceptable in some African and Asian communities. Some of the dwellings were not secure enough to prevent intruders and rapists (Gwandure 2009). Participants suggested that health educators could help clients living in squalid conditions through advocacy and lobbying local authorities to provide shelter to the needy. Poverty was reported to weaken a woman's resistance to

unwanted sex (Shisana et al. 2009; Lehavot et al. 2010). Poverty is identified as worsening the spread of HIV and AIDS in South Africa (Shisana et al. 2010). In their focus group presentations, participants indicated that financial needs led unemployed women to stick to violent men who provided financial support. The results of this study confirm what was previously found in South Africa that poverty is associated with HIV and AIDS risk (Shisana et al. 2009). It was observed that people in underprivileged communities tend to engage in HIV risk behaviours such as “living for today”, that is, looking for immediate sexual gratification and meeting immediate survival needs such as food and shelter without long-term plans. It was reported in this study that some women without financial resources were engaging in transactional sex and risk sexual practices (Shisana et al. 2009). Participants suggested engaging women with limited financial resources in self-help projects that generated money. One such project suggested was the “Vukuzenzele Project” and the “Bead-making project” for women in Katlehong. Participants suggested that gender empowerment in HIV and AIDS prevention could be enhanced through financial freedom. Participants indicated the need for non-governmental organisations in South Africa to seek partnerships with international donor organisations that could provide financial resources to low-income women so that they start income-generating projects in the area.

Being a single mother was identified as a risk factor in HIV and AIDS prevention in Katlehong. Sometimes single mothers were reported to have multiple sexual partners thus exposing themselves to HIV infection (Meekers and Calves 1997). Many young men and old men in Katlehong were reported to visit single mothers for sex (Meekers and Calves 1997). It was reported that even some of the married men would approach single mothers for sex. There was a stigma about buying female condoms among women in Katlehong and that made them vulnerable to HIV infection (Shannon et al. 2012). Some of the single mothers were considered to be approachable since they did not have stable partners. The findings are consistent with research on gender and HIV risk (Shisana et al. 2010). Participants indicated that they could help single mothers by training them to value their lives, themselves and their body image. They could help single mothers promote good health

and prevent HIV infection by dispelling myths about condoms and the stigma surrounding condom use. This could be achieved by demonstrating to participants and clients how to use condoms correctly and consistently in the training sessions. Participants reported that they would train their clients on safer sex negotiation skills as a way of empowering girls and women against HIV infection (Kevane 2004). It was also underscored that even male clients and participants were going to be trained about gender inequality and how it exposes partners to HIV infection. Participants considered it as their next challenge having gone through the gender-based training programme to encourage single women living with HIV and AIDS in their communities to visit primary health care centres for treatment and to take antiretroviral drugs without inhibition.

Home desertion or abandonment of children by mothers and fathers was reported to be one of the reasons why girls in Katlehong had unwanted pregnancies, abortions, and sometimes living with males they did not love. Girl-headed families were common in Katlehong. Men were reported to exploit poor and desperate girl children (Hodge and Roby 2010). Sexual coercion due to relationship power inequality between men and girls is associated with HIV infection among girls and insecure women (Hoffman et al. 2006). Participants suggested that training girls in HIV prevention could be achieved through outreach health education programmes in schools, communities and during individual counselling sessions.

It was reported that there was a general tendency among women in Katlehong to blame men for infecting them with HIV and sexually transmitted diseases. Participants reported that women blamed men for casual sex, sexual assault and unwanted pregnancies. The findings are consistent with previous studies on intimate partner violence, gender inequality, sexual coercion and HIV infection in South Africa (Jewkes et al. 2010b). The focus groups acknowledged intimate partner violence but it also identified the blaming of men as a projective defence mechanism in which women avoided engaging in HIV and AIDS preventive behaviour themselves. It was pointed out that the passivity of women in sexual relations made them more vulnerable to HIV infection. It was indicated that health educators would advise women to report

violent men to the police and that victims of male-perpetrated violence would be referred to hospital for medical examination. Participants indicated that they would empower vulnerable clients by helping them realise that women need to protect themselves from HIV infection and unwanted pregnancies (Jewkes et al. 2010b). It was highlighted in focus group discussions that most of the women who visited Khanya Family Centre for counselling and psychosocial support, presented their situation in a way that implied that women were not enjoying sex with their male partners. It appeared as if most of them were having sex to please men and this naivety is associated with HIV risk (Akintola et al. 2011). Participants reported that most of their women clients in Katlehong tried to make counsellors believe that women were invariably abused by men in sexual relations. Participants, as health educators, highlighted the need for educating vulnerable women of their right to pleasurable sex and the need to be open about sex to their partners and counsellors (Higgins et al. 2010). Pretence and shyness were regarded as inhibiting factors that prevented women from achieving sexual health and HIV prevention (Kevane 2004; Akintola et al. 2011). Participants reported that women needed to be equipped with better sex negotiation skills in order to reduce HIV infection.

It was reported by participants that granny-headed families were at risk of HIV and AIDS. This is consistent with research on poverty, gender and HIV risk in South Africa (Shisana et al. 2010). Girls from granny-headed families found it difficult to discuss HIV and AIDS issues due to cultural barriers (Leclerc-Madlala 2009). The findings are in tandem with the view that some traditional values and poverty are associated with HIV risk (Leclerc-Madlala 2009). It was reported in this study that grannies would not talk about sex with their grandchildren because it was regarded as coaching children about sex before marriage. Participants indicated that children from such families were more likely to lack current information on HIV and AIDS prevention (Shisana et al. 2010). They could get false information about HIV and AIDS from friends. Participants indicated that they would target granny-headed families in HIV and AIDS risk reduction home visit campaigns.

Inferential statistics indicated that the gender-based HIV and AIDS risk reduction training

programme had a significant impact on locus of control orientation of participants. The results were in agreement with previous studies which indicate that training modifies locus of control orientation (Alleyne and Gaston 2010). Some of the health educators in this study lived in violent communities in which some men had little respect for women (Jewkes et al. 2010b). The improvement in locus of control scores among health educators indicated that health education awareness and training could reduce HIV and AIDS risk among participants. Even though participants were supposed to work as health educators to prevent HIV and AIDS risk, it was reported in this study that they were also vulnerable to HIV infection. The improvement in locus of control orientation after training was indicative of healthy psychological functioning after training (Alleyne and Gaston 2010).

There was a statistically significant difference in self-efficacy between pre-test and post-test scores. The results indicated that training health educators in gender-based self-efficacy improved their personal resourcefulness in dealing with gender-based HIV and AIDS risk (Shai et al. 2011). The findings were consistent with previous studies on self-efficacy and HIV risk (Gray et al. 2010). Participants felt that they were prepared to help women and girls at risk of HIV and AIDS (Jones et al. 2010). The findings of this study were in tandem with previous studies which indicated that training improves self-efficacy in participants (Tsai 2003).

Sexual assertiveness for women improved in participants after training. The results were similar to previous findings which indicated that training participants in assertiveness skills promotes health-protective behaviour (Sikkema et al. 2010). In this study, participants reported sexual assertiveness in HIV and AIDS risk reduction. Participants expressed a stronger desire to initiate sex without coercion and to refuse uninvited sexual offers (Summer et al. 2010). Participants also highlighted the relationship between unwanted pregnancies and HIV infection (Alleyne and Gaston 2010). Sexual assertiveness was perceived as important in protecting women from unwanted pregnancies, HIV infection and sexually transmitted diseases (Morokoff et al. 1997). They explained that even if men were traditionally expected to initiate sexual activity while women would be expected to respond, in HIV prevention, women should be in control of their

sexual health (Rickert et al. 2002; McCoy et al. 2010; Summer et al. 2010).

The results showed a statistically significant difference in HIV and AIDS risk before training and after training. The findings substantiate the argument that training participants in gender-based risk reduction skills reduces HIV and AIDS risk in South Africa (Jewkes et al. 2010a). In this study, participants showed in groups how women in Katlehong were at risk of HIV infection due to biological, social, economic and political factors that made them more susceptible to HIV infection than men living in the same area. For example, it was pointed out that girls reached puberty much earlier than boys and as a result, some male or female sexual perpetrators treated the girls as women and not children (Gwandure 2011). Participants, using knowledge they gained from the training programme, demonstrated how health educators could incorporate gender transformative HIV and AIDS prevention skills in training interventions.

LIMITATIONS OF THE STUDY

The study could have made use of a larger sample for the results to be generalisable to a wider population. However, due to the nature of participants required for this study, it was found suitable to use health educators from one organisation. The study used a mixed method approach, using both qualitative and quantitative approaches in one study. The problem of this approach is that some participants could be more vocal about an issue to such an extent that they could influence the responses of other participants. However, this perceived overflow effect could have been mitigated by the discussion in focus groups in which responses from different groups were critically analysed. The qualitative approach allowed for more elaborate responses from participants thus reflecting their feelings and experience working with vulnerable women in Katlehong.

CONCLUSION

The gender-based HIV and AIDS risk reduction training programme was found to be useful in empowering health educators come up with effective interventions for vulnerable women in Katlehong. Participants suggested ways in which women clients could be assisted and how

health educators could work better after going through the training programme to reduce HIV and AIDS risk. An improvement in locus of control, self-efficacy, sexual assertiveness and a reduction in HIV and AIDS risk among participants after training indicated the efficacy of the gender-based training programme. Future studies could focus on longitudinal designs to establish the relationship between gender-based risk reduction training and reduction in HIV infection among participants.

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