Programming Idea 5: Working with men and boys to promote gender equitable attitudes and behaviours

**What it involves:** This involves interventions to change norms and promote gender equality at the individual level through: i) group participatory education; ii) peer-based support; and iii) communication campaigns. They are aimed at boys and men including, youth leaders, fathers and sports coaches. Such efforts:

- Encourage participants to critically reflect (e.g. through role plays, story-telling and other interactive exercises) about masculinity and how it affects their lives, their relationships with women, and how it generates unequal power dynamics.
- Develop skills in expressing feelings without being violent, conflict resolution, promoting equity in couple relationships, and condom use.
- Provide safe spaces for men and boys through peer-based support groups to ask questions about masculinity, their health and other concerns affecting their lives.
- Incorporate communication campaigns that emphasize what can be gained by men changing their behaviour as well as offer male role models (e.g. celebrities, sports coaches) for positive behaviour change.
- Provide basic knowledge about HIV prevention, treatment, care and support, sexual and reproductive health and violence against women.

**Summary of the evidence:** A 2011 systematic review of 65 interventions on engaging men and boys to prevent sexual violence – mostly from North America, with only nine studies from low- and middle-income countries – showed significant results in reducing perpetration of sexual violence and/or other forms of violence in seven studies (107). Of the 47 studies that examined attitudes towards acceptability of violence, ten showed significant improvements in attitudes. Of the 25 studies that looked at gender norms, seven showed significant improvements towards more equitable norms. Another literature review (in 2007) on engaging men and boys for changing gender-based inequities in health showed that, of the 58 interventions from North America, Latin America, Sub-Saharan Africa and Asia, more than half showed positive changes in men's attitudes towards gender equality. In addition, some showed increased condom use (n=3), decreased self-reported STIs (n=1) increased contraceptive use (n=3), and increased use of sexual and reproductive health services by men (n=1) (108). Of the 15 studies that included outcomes related to violence against women, only four interventions showed reductions in acceptability of violence or in perpetration of violence. See Annex 1.4 for examples of interventions with men and boys.

**Conclusion:** This approach shows consistent results in terms of positive changes for violence against women outcomes in several studies included in the two reviews. However, many of studies used weak evaluation designs. Therefore, this programming approach is considered to be promising for addressing violence against women. It also shows positive results for HIV-related outcomes in several studies, albeit with weak designs and hence, it is promising also for HIV-related outcomes.
### Annex 1.4. Examples, programming idea 5: Working with men and boys to promote gender equitable attitudes and behaviours

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<th>Intervention and location</th>
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<td>Integrated gender-based violence and HIV risk-reduction intervention Cape Town, South Africa (169, 170)</td>
<td>African men of Xhosa cultural heritage (n=475) from two township communities in Cape Town</td>
<td>A small-group training of five three-hour sessions designed to simultaneously reduce gender-based violence and HIV risk behaviours. The sessions helped men examine meanings of masculinity, consequences of gender violence and HIV, explore alternative attitudes and behaviours, and practice problem-solving and skills in condom use and sexual communication. Participants were also trained to become advocates with their peers and others in their community.</td>
<td>Quasi-experimental design with two communities followed up at one, three and six months. Control groups received attention-matched alcohol and HIV intervention – a single three-hour session. Outcomes: AIDS knowledge; AIDS related stigma; risk-reduction behavioural intentions; sexual and substance use risk behaviours; domestic violence perpetration.</td>
<td>No differences between groups at follow-up for AIDS knowledge and AIDS stigma. At follow-up, compared to control group, men in the intervention group were more likely to: • express intentions to reduce risk (6 month follow-up) • talk with partners about condoms (1 month follow-up) • have been tested for HIV (1 month and 3 month follow-up) • show reduced negative attitudes towards women (1 month follow-up) • have reduced self-reports of hitting a sexual partner (6 month follow-up) Limitation: no randomization; communities not matched for baseline level of violence; weak measures of gender-based violence; generalizability limited to the Xhosa community.</td>
<td>The intervention did not demonstrate evidence for efficacy in reducing unprotected sex, reducing number of partners or increasing condom use. The pattern of risk behaviour changes suggests that the alcohol/HIV prevention intervention offered greater potential for sexual risk reduction than that realized in the GBV/HIV prevention intervention. These results suggest that future research may need to examine more complex integrated models, such as a tripartite intervention approach that integrates alcohol reduction, gender violence prevention, and HIV risk-reduction.</td>
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<td>Yari-Dosti: Promoting gender equity to reduce HIV risk and gender-based violence among young men India (171, 172)</td>
<td>Young Indian men (16–29 years) from three urban slum communities in Mumbai (N=875) and two rural poor communities in Uttar Pradesh (N=600)</td>
<td>Yari-Dosti (meaning friendship or bonding among men) involves peer-led, participatory group education, hourly sessions held every week over six months. Topics include: gender equality and sexuality; STI/HIV risk and prevention; partner, family, and community violence; reproductive system; alcohol and risk; and HIV-related stigma and discrimination. In Mumbai, a lifestyle social marketing campaign reached 100,000 residents, promoting messages of relationships without violence, egalitarian attitudes, a view of women and girls as deserving of respect and shared responsibility for sexual and reproductive health. The sessions helped men to simultaneously reduce gender-based violence and HIV risk behaviours. The sessions helped men examine meanings of masculinity, consequences of gender violence and HIV, explore alternative attitudes and behaviours, and practice problem-solving and skills in condom use and sexual communication. Participants were also trained to become advocates with their peers and others in their community.</td>
<td>Quasi-experimental trial: three arms in Mumbai – one arm with group education and lifestyle marketing campaign, one arm only group education, and a control arm. In Uttar Pradesh, there were two arms – group education vs control. Outcomes: attitudes towards gender norms; gender equitable man scale – GEM; HIV knowledge; perpetration of physical and sexual violence; condom use; number of sexual partners; stigma; self-reported STI.</td>
<td>At 6 month follow-up, compared to control group, intervention participants reported significant: • improvement in attitudes towards gender equity (i.e. scores reflected more towards the high gender equity end of the GEM scale) • increase in partner communication about sex, STI, HIV and condom use • increase in condom use at previous sex with all partners • decline in self-reported recent partner violence. Gender equitable attitudes (GEM scale score) was associated positively with decreased risk of STI/HIV behaviours in the intervention group. Limitations: Selection bias due to non-randomization, lack of baseline matching, weak measures of gender-based violence; generalizability limited to the Xhosa community.</td>
<td>Changes in attitudes and behaviours towards gender equality are a gradual and complex process. Initially many men denied their own biases and actions, or that it existed in society. As they progressed through the sessions, they acknowledged their own and societal attitudes and behaviours as inequitable. There is a need to reinforce group education with other societal level efforts. A similar intervention was undertaken in Ethiopia, with a three-arm quasi experimental design in three low-income communities in Addis Ababa with young men 15–24 years. This intervention showed similar results as the Yari-Dosti, with improvements in gender equitable attitudes, reductions in violence perpetration and improvements in STI and HIV related risk behaviours. Collectively, the results of Program H in Brazil and its adaptation in India and Ethiopia provide compelling evidence for this type of approach for individual level change.</td>
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