Reaching Men to Improve Reproductive Health for All Implementation Guide

Reaching Men to Improve Reproductive Health for All International Conference
Dulles, Virginia
September 15-18, 2003

Interagency Gender Working Group
USAID

Prepared by the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs

Reaching Men to Improve Reproductive Health for All

Preface

This Implementation Guide captures the programmatic issues discussed at the *Reaching Men to Improve Reproductive Health for All* international conference held in Dulles, Virginia, September 15-18, 2003. The conference was sponsored by the Men and Reproductive Health Task Force of the US Agency for International Development (USAID) Interagency Gender Working Group (IGWG). The Task Force is composed of representatives from USAID Cooperating Agencies (CAs) and other organizations and donors who are working to improve gender equity and increase men's positive participation in their programs and services. Additional information about the Men and Reproductive Health Task Force is available at the IGWG (www.igwg.org) and RHO (www.rho.org) web sites.

The Implementation Guide builds on the Orientation Guide that was commissioned in 2000 by the Task Force. While the Orientation Guide addressed the "why" of involving men in reproductive health with a gender perspective, this guide is designed as a tool to inform care providers, researchers, trainers, communicators, program managers, and donors on how to implement reproductive health programs that involve men while mainstreaming gender. Hence, this guide is one of the intended outcomes of the conference.

The primary **objectives** of the conference were to increase:

- **knowledge** about concrete and effective strategies to work with men on reproductive health issues with a gender-equity perspective;
- **commitment** to implement these strategies;
- **skills and access** to tools for implementing these strategies.

The conference was a culmination of careful planning over a two-year period that included a call for abstracts, their review and selection, as well as working closely with presenters to develop high quality presentations. The presentations were developed into this Implementation Guide and made available on CD-ROM.

This CD-ROM includes the following sections:

- About IGWG
- Implementation Guide
- Presentations
- Keynote Addresses
- Participants
- Resources - Additional Resources and Useful Web sites
- Contact Information

About IGWG - this section describes the Interagency Gender Working Group (IGWG).

The **Implementation Guide** provides examples of some of the effective programs presented at the conference. The presentations are available for viewing from the Guide by clicking on the title of the presentation. The guide is divided into an introduction followed by nine chapters that mirror the conference topics:

Preface and Acknowledgments
Abbreviations
Introduction
I. *Addressing Issues of Male Identity in Adolescent Men*
II. *Policy Initiatives and Strategies for Advocating the Involvement of Men in Reproductive Health*
III. *Involving Men in Reproductive Health Through Maternal & Child Health*
IV. *Men's Right and Empowerment in Improving Women's Reproductive health*
V. *Impact of Gender on Men's Health*
VI. *Successful Strategies in Reaching Men*
VII. *Successful Approaches in Educating or Changing Men's Attitudes*
VIII. *Tools and Programs for Monitoring and Evaluation*
IX. *Conclusion*
Annex - sample KAP (Knowledge, Attitudes and Practices) survey.

Presentations and Keynote Addresses - are provided in this section in their original state. The presentations available in both PowerPoint and as a PDF file can be accessed from the Guide by clicking on the title of the presentation.

Participants - includes the contact information for participants to the 2003 conference.

Resources - Additional Resources and Useful Websites includes additional sources of publications on involving men in reproductive health. Also provided are resources available on the Web including links to useful reference materials.

Acknowledgements

Many thanks to over 70 people who presented their work with men at the conference on *Reaching Men to Improve Reproductive Health for All.* This guide, written by Michèle Burger, would not have been possible without the contributions of these presenters and their comprehensive responses to additional inquiries. Harris Solomon, the lead editor, Judy Heck, copy editor, Michal Avni, Charlotte Feldman-Jacobs, Diana Prieto and Alfred Yassa also merit a special word of appreciation for their comments. Gary Barker, Lissette Bernal, Abhijit Das, Meg Greene, Manisha Mehta, Nancy Yinger, and Sarah Harbison, reviewed the document and provided valuable insights. Thanks also to Mark Beisser and Elizabeth Heinrichs for converting a one dimensional paper into a user-friendly CD-ROM tool.

Abbreviations

ANC	Antenatal Care
ARH	Adolescent Reproductive Health
BCC	Behavioral Change Communication
CAB	Community Advisory Board
CBO	Community-Based Organization
CMS	Community Mobilization Session
CPR	Contraceptive Prevalence Rate
DG	Democracy and Governance
FBO	Faith-Based Organizations
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FP	Family Planning
FWC	Family Welfare Clinic
GBV	Gender-Based Violence
GEM	Gender-Equitable Men
GO	Governmental Organization
HFWC	Health and Family Welfare Clinic
IEC	Information, Education, and Communication
KAP	Knowledge, Attitudes, and Practices
MAP	Men as Partners
MCH	Maternal and Child Health
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-Governmental Organization
PRA	Participatory Rapid Assessment
RH	Reproductive Health
RSH	Reproductive and Sexual Health
SDM	Standard Days Method
SHP	Sexual Health Problem
STI	Sexual Transmitted Infection
RTI	Reproductive Tract Infection
MTCT	Mother to Child Transmission
VCT	Voluntary Counseling and Testing

Introduction

This Implementation Guide illustrates examples of how to develop, implement, and evaluate reproductive health (RH) programs that involve men with a gender-sensitive perspective – that is, in ways that promote gender equity and improve health outcomes for men and women. These program examples were presented at the conference, *Reaching Men to Improve Reproductive Health for All*, held in Dulles, Virginia in September 2003.

> USAID Policy on Family Planning and Reproductive Health: USAID's Office of Population and Reproductive Health provides assistance for family planning and related reproductive health activities, which may include linking family planning with maternity services, HIV/AIDS and STD information and services, eliminating female genital cutting, and post-abortion care. Any reference to reproductive health, reproductive health care and reproductive health services in this Guide refers to such activities. USAID funds are prohibited from being used to pay for the performance of abortion as a method of family planning or to motivate or coerce a person to practice abortion.
>
> USAID has defined family planning and reproductive health in Appendix IV of its Guidance on the Definition and Use of the Child Survival and Health Program Funds, dated May 1, 2002. Primary elements include: expanding access to and use of family planning information and services; supporting the purchase and supply of contraceptives and related materials; enhancing quality of family planning information and services; increasing demand for family planning information and services; expanding options for fertility regulation and the organization of family planning information and services; integrating family planning information and services into other health activities; and assisting individuals and couples who are having difficulty conceiving children.

The primary audience for this guide is in-country reproductive health program managers and technical staff of implementing agencies, government, and non-governmental organizations. Readers of this guide will note that many programs described here engaged multiple stakeholders, demonstrating the need for (and feasibility of) working with men across sectors.

Working with Men is Feasible

Surveys and research suggest that men are willing to change their attitudes, beliefs, and behaviors. Men want to be supportive partners and caring fathers; they want to know about pre and postnatal care. They also want to help their partners avoid unwanted pregnancies, protect themselves from STIs, including HIV/AIDS, and avert violence. Programs with youth confirm that young men are open to considering alternative means of expressing themselves that do not rely on virility and violence. Such expressions and features that in varying degrees make a person a man are often termed “masculinities.”

The data in the table below, taken from the *Orientation Guide*, highlight program areas in which working with men would improve the reproductive health of men and women.

Reproductive health statistics that inform the basis for involving men

- Nearly 600,000 maternal-related deaths occur each year.
- 74% of contraception worldwide is through female methods.
- Vasectomy constitutes only 7 % of worldwide contraceptive use; it is declining in some countries.
- Three hundred and forty million new cases of STIs (excluding HIV) occur per year among people ages 15-49.
- More than half of the people currently infected with HIV/AIDS are women.

(IGWG Orientation Guide, Involving Men in Sexual and Reproductive Health, Men and Reproductive Health Subcommittee, USAID, 2nd edition, 2002.)

Programs can address such challenges and help improve health outcomes by working with men:

- Men can help reduce maternal-related death by recognizing symptoms that require immediate attention and by assuring their partners get the medical attention they need.

- Programs can inform men about dual protection, no-scalpel vasectomy, female methods and their side effects, and facilitate role playing discussions about contraceptive methods, including withdrawal and periodic abstinence.

- Programs that reach out to adolescent boys and young men teach them how to recognize symptoms of STIs can encourage them to go a clinic if they suspect they are infected.

- Working with men can redress women's disproportionate risk of contracting HIV. Programs with men can encourage them to address common misconceptions about HIV transmission (sex with a virgin can cure HIV infection, for example), and can also encourage delay of sexual debut, reduction in sexual partners, and consistent and correct use of condoms.

Working with Men is State of the Art

Male involvement is rooted in the Program of Action that was agreed to at the International Conference on Population and Development (ICPD, Cairo 1994) which included "male responsibilities and participation" as critical aspects for improving reproductive health (RH) outcomes, achieving gender equality, equity, and empowering women (Programme of Action, adopted at the ICPD, Cairo, 5-13 September 1994, paras 4-24 through 4-29). This mandate grounded male involvement programming. It contributed to broadening the concept of gender so that it now includes men.

The conference in Cairo catalyzed programs and studies that confirm the viability of involving men. Men's roles as sexual partners, fathers, decision-makers, actors in

preventing sexually transmitted infections (STIs) including HIV/AIDS and as allies in improving reproductive outcomes are summarized in the *Orientation Guide* that preceded this document.

Working with men can be done in a variety of sectors (e.g., employment, entertainment, community, market place) with a variety of collaborating program partners. For example, Trade unions can inform, educate and incorporate RH into existing health services provided by union benefits. The armed forces can integrate RH information and programs into their health service infrastructure. Schools and military academies can integrate RH education. Theatre groups, television and radio stations can develop dramas that address RH issues. Community members (barbers, taxi drivers, bartenders, coaches, and community, traditional and local leaders, for example) can be trained to become community-based promoters who inform their peers about RH.

GOs and NGOs skilled in specific areas (e.g., education, curriculum and/or development, training, outreach) can work together so that men can become informed consumers and allies in reducing maternal morbidity and mortality, unplanned pregnancies and the spread of STIs.

Working With Men Is Creative

The interventions presented at the Conference reflect an array of innovative approaches, including:

- The socialization of boys and supporting gender equitable boys (**Program H**, Promundo/Brazil; **Peer Advocates for Health**, US; **Better Life Options Program,** CEDPA/India);
- Fostering dialogues across generations and between genders (**Intergenerational Dialogue on Gender Roles and Reproductive Health,** a GTZ program in West and East Africa);
- Mobilizing communities to counter such harmful practices as female genital cutting (FGC) (**Community-Based Education: A Strategy for Engaging Men to Fight Female Genital Cutting (FGC)**, Mwangaza Action/Burkina Faso; **Mobilizing Men against Female Genital Cutting**, Center for Development Services/Egypt);
- Alerting men to support women's health to inform men about the actions they can take to promote safe motherhood (**An Intervention Study From Zimbabwe**; **Involving Husbands in Safe Motherhood: The *Suami Siaga* "Alert Husband" Campaign in Indonesia**, Directorate of Medical services; **Caring Men? Husbands' Involvement in Maternal Care Among Young Couples in Rural India**, ICRW; and several other programs were presented that addressed these issues; and
- Educating young people to respect the human rights of others (**Concientizing Nigerian Male Adolescents**, CMA, Nigeria).

Not all of the interventions described here have been formally evaluated. However, all of the interventions offer insight into innovative efforts to involve men in institutionalizing social change. Moreover, while intended changes (goals and objectives) may vary

significantly, the programs in this guide share many common features that are essential in implementing male involvement programs that promote gender equity. For example, broad involvement of **stakeholders** is critical to program success. This includes: policymakers from all governmental sectors (e.g., health, education, labor, family law); religious and traditional leaders; health care providers; and the target population and their families.

Other key factors include:

⇒ **Needs assessment** surveys and **formative research** completed *before* designing and implementing the program. The needs assessment shapes the program design while the base line study informs on progress achieved. A survey of men's knowledge, attitudes and practices (KAP) tests are commonly used to collect information about men's needs and are useful tools to assess program achievements by comparing base line studies with post intervention surveys. *Demographic and Health Surveys* (DHS), which are increasingly surveying men, are other tools that provide programmers with information about unmet needs.

⇒ Program design based on the needs to be addressed. The goal should be **quantifiable** (e.g., percent reduction in STIs, percent increase in condom use, number of men who are familiar with dual protection after the intervention compared to those who knew about it at baseline). The objectives should define the **target population** (e.g., in or out of school youth, married men, men in the armed forces), **specify what will be achieved** (e.g., change in knowledge and behavior, increase in condom use, reduction of violence), and **quantify the expected change within a defined period of time** (e.g., by the end of the three year project 50 youth peer leaders will have reached 2,000 youth; knowledge about STI prevention will increase by 50% among the 2,000 youth reached by the project).

⇒ **Advocacy** focused on all stakeholders (e.g., governmental officials for health, education, labor, and family law; religious and traditional leaders; care providers; target population and their families), using various media to target this diverse audience.

⇒ **Capacity building** to provide theoretical and practical on-going training for care providers, teachers and others who work with intended beneficiaries.

⇒ **Evidence-based approaches** that contribute to improving the reproductive health of men, women, and children by involving men, e.g., **community-based**, **employment-based, service deliver-based**.

⇒ **Monitoring** and **evaluation** is an integral part of every program with specific budget allocations reserved for these activities. **On-going monitoring** including supervising staff, trainers, peer educators, etc; tracking the number of clients served and types of services rendered or activities undertaken; tracking the number of boys, young men and/or men who participated; and tracking the requests for and distribution of condoms. Monitoring activities should include feedback from supervisors, clients, and care providers so as to make necessary adjustments. **Output indicators** should be time bound (short, mid and long-term) and should reflect changes in knowledge and behavior (e.g., 30 providers trained

in counseling men and women within the first three months of the project; increase in proportion of men attending counseling sessions either with their partner or alone at the completion of the project).

Working with Men: A New Vision

Abhijit Das, one of the keynote speakers at the conference, eloquently describes what male involvement programs with a gender perspective aim to achieve:

> "These programs embrace a vision where men define new roles for themselves, a new vision, where men are not limited to being passive participants or simply facilitative gatekeepers. This vision goes beyond ensuring reproductive health of women. It is a new vision where men can be described as being sensitive, emotional, concerned and creative; a new vision of reproductive health for all, which is based on equality and partnership between women and men. But this partnership goes beyond women and men in the community. It includes service providers, researchers, trainers, communicators and program managers, because we also share the same vision."
>
> Abhijit Das**,** Keynote Opening Address**,** *Reaching Men to Improve Reproductive Health for All,* Dulles, Virginia, September 2003.

Chapter I
Addressing Issues of Male Identity in Adolescent Men

KEY STEPS TO IMPLEMENTING PROJECTS THAT ADDRESS IDENTITY ISSUES in ADOLESCENT BOYS AND YOUNG MEN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Conduct a needs assessment	Survey adolescents, parents, teachers, community leaders and other adults that with work with youth to assess the needs of youth, for example, develop questionnaires and conduct focus group discussions that ask such questions as: What do they know about RH? How do young men make decisions about RH? How do they relate to and communicate with women? From whom/where do they get their RH information that they trust? Where do they learn about how to "be a man"? Examine other useful sources for needs assessment (e.g., national surveys from DHS, statistics from health department, studies on male identity and adolescents).
Develop project based on needs assessment	Determine what issues the project should address: • self identity/gender (e.g., how do boys and young men view themselves? What behaviors and practices do they adopt to identify as men?); • communication (e.g., how do they communicate with their families, friends, girl friends?); • decision-making (e.g., how do they decide if they will stay in school, work, have relationships?); • life cycle events (e.g., marriage/partnerships, parenthood, families). Determine to what extent efforts are needed to build capacity of local partner organizations (e.g., NGOs, FBOs, private groups). Projects that inform about RH issues such as prevention of STI/HIV/AIDS and unwanted pregnancies should provide information about men's and women's reproductive systems and address additional concerns of boys and young men, such as sexual performance and masturbation. Vocational training and career counseling should, whenever possible, be integrated into projects that work with young men.
Target project to specific audiences	Determine age, educational and income level of targeted audience. Take into consideration cultural values and religious beliefs.

KEY STEPS TO IMPLEMENTING PROJECTS THAT ADDRESS IDENTITY ISSUES in ADOLESCENT BOYS AND YOUNG MEN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Develop indicators to measure outcomes	Integrate monitoring and evaluation activities into project design. Determine quantifiable indicators (e.g., increase in number of young men who delay sexual relations, increase in number of young men who use condoms consistently, decrease of violence among men and against women, increase in number of young men who can talk about their needs and seek counseling). Develop pre- and post-tests that inquire about knowledge and attitudes (e.g., how is HIV transmitted? Name three STIs, and identify symptoms of STIs. Are boys and girls equal? Is it okay for men to show their emotions?). The pre-test informs on what needs are and the post-test measures what the intervention achieved. Partner with agency knowledgeable in evaluating projects to develop indicators and testing tools.
Determine monitoring activities and develop tools	Determine who will supervise staff and volunteers and the frequency of supervisory visits. Develop tools to monitor activities (e.g., number of workshops held, topics addressed, number health fairs run, number of participants attended, number of mentors at a given site, number of young men mentored, number and types of referrals made).
Develop evaluation tools	Determine indicators that will be used to evaluate the project, and develop tools to collect data (e.g., activity logs, profiles of participants, pre and post tests, focus group discussions, and interview guides).
Partner with other agencies knowledgeable about the issue the project addresses	Collaborate with NGOs experienced in working with adolescents, community centers, schools, and faith-based organizations to craft messages and house the project (e.g., provide space for the project, integrate RH into the curriculum, offer forum for reaching youth). Seek technical assistance in developing monitoring and evaluation tools, training trainers, facilitating delivery of the project into schools, community centers, and other organizations that work with youth from health, education and youth departments.

KEY STEPS TO IMPLEMENTING PROJECTS THAT ADDRESS IDENTITY ISSUES in ADOLESCENT BOYS AND YOUNG MEN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Build strategic alliances	Inform parents and religious, traditional and political leaders in the community about the project and the problems it aims to resolve. Empower stakeholders to be advocates for the project (e.g., share goals and objectives of the project and keep stakeholders informed of the progress).
Develop educational materials including dramas, theatre productions, Internet-based information, and experiential interactive exercises.	Determine the goal of the materials or media (e.g. determine topics to be addressed, targeted audience, how the materials, performances will be used and by whom). Encourage adolescent boys and young men to participate in developing materials and dramas, etc. Pre-test materials and make adjustments based on feedback.
Develop youth-friendly social marketing campaign (where applicable)	Involve youth in designing all aspects of the campaign including the design of condom packages. Pre-test messages and packaging and make adjustments based on feedback. See the IEC/BCC section in Chapter VI for more on how to develop programs that work with multi media.
Train trainers	Train teachers, youth leaders, youth advocates, peer leaders, and adults involved with implementing project activities.
Implement project	Develop partnerships with the ministry of health, departments of health, youth, and sports, etc. Select venues for locating projects. Potential sites include schools, vocational training centers, gyms, clubs, and correctional facilities. Work with advocates and their networks to find venues willing to house the project (e.g., parents associations in favor of integrating project into schools, correctional facilities working on rehabilitating troubled youth). Foster and encourage active support from parents and teachers (e.g., run workshops for them to keep them informed about what youth are learning). Facilitate accessibility of services through referrals to on-site or youth-friendly clinics in the community.

KEY STEPS TO IMPLEMENTING PROJECTS THAT ADDRESS IDENTITY ISSUES in ADOLESCENT BOYS AND YOUNG MEN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	Administer a pre-test on project participants.
Monitor activities	Implement monitoring activities (e.g., supervisory visits, staff meetings, quarterly reports, etc.) Administer a post-test to project participants when the project ends. Note the number of drop outs and the number of participants who joined the project once it was underway and did not take the pre test.
Evaluate project	Use monitoring tools (e.g., pre and post test results, data that tracks activities and number of participants, etc.) focus group discussions and interviews with trainers, teachers, youth, health care providers (where applicable) and other stakeholders to assess and quantify project achievements. Discussion groups and interviews should inquire about familiarity with project, its aims and activities, expectations, outcomes, strengths and weaknesses (e.g., did it achieve its objectives? What were your expectations and did it meet them? Are there any changes in your knowledge, attitudes or behaviors that you attribute to project?, etc.).

To access a presentation, click on the title of the presentation.

Identity, gender, reproductive health, and information about STIs including HIV and AIDS and how they are transmitted are themes commonly addressed by programs that involve adolescent boys and young men. Such programs promote healthy lifestyles by raising awareness about traditional norms of gender identity that contribute to adopting risky behaviors and aim to promote preventive health care.

The CEDPA Better Life Options program, **Enlightening Adolescent Boys in India on Gender and RSH,** and **Program H: Promoting Condom Use, Health Seeking Behavior, and Changes in Gender Norms Among Young Men**, both described below, as well as several other adolescent programs (e.g., **Peer Advocates for Health: A Community-Based Program to Improve Reproductive Health and Lifestyle Among Adolescent Males,** and **Seizing the Day - Right Time, Right Place, and Right Message for Adolescent RSH**) presented at the conference, are examples of programs that give adolescent boys the chance to explore their options during a critical developmental stage -- one during which they form their identity. These programs expose young men to lifestyle options and provide them with a space to reflect on the potential negative implications and costs of traditional views of manhood. They inform adolescent boys about alternative attitudes and behaviors while presenting them with different ways of conducting themselves.

Programs such as these tend to be implemented in schools, vocational training and community centers or other places where young men congregate or are a captive audience, such as food kitchens, homeless shelters, and prisons. They provide a safe environment, where boys are comfortable talking about such sensitive topics as gender-based violence. Here, trained facilitators can help young men explore alternative ways of relating to women and resolving conflicts.

Enlightening Adolescent Boys in India on Gender and RSH

Implementing agency: The Center for Development and Population Activities (CEDPA), a U.S.-based NGO, with the mission "to empower women at all levels of society to be full partners in development."

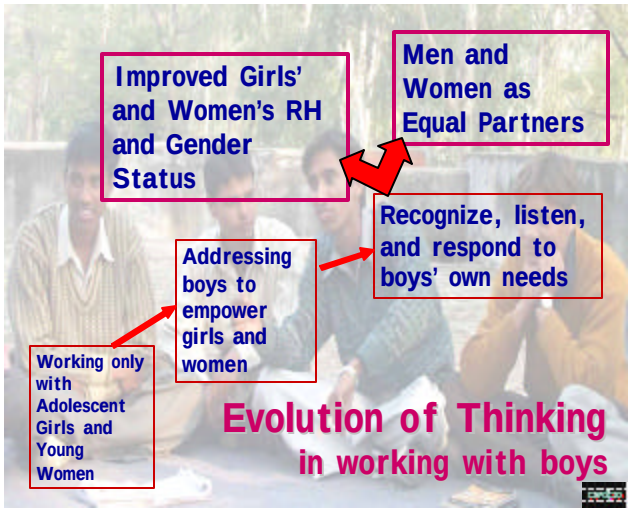
1. Background

There are over 1.05 billion people in India. More than 100 million are adolescent boys. Almost one percent of adults, approximately 4 million people, are infected with HIV; 25 % of them are women; half of all new cases of HIV/AIDS are among youth under 25. The maternal mortality rate is 540 per 1,000,000 live births. More than three quarters (78%) of pregnancies are unplanned and a quarter are unwanted. As a result 11 million pregnancies end in abortions. In this patriarchal society, there is a wide gender gap where son preference prevails. One out of every five boys between the ages of 10-19 is illiterate. About a fifth (19.8%) of rural boys and a third (34.8%) of urban male adolescents between the ages of 15-19 completed high school; 4 million of these adolescent boys are married.

2. Project Goals

In partnership with NGOs, the CEDPA program in India challenges gender inequities, expands life options, and uses an empowerment model through an integrated and holistic program for adolescent girls and boys aged 10-19 years.

3. Project design



Needs assessment: CEDPA initiated its Better Life Option Program for girls in India in 1989. Program personnel, adolescent boys, and community members expressed a need for a similar program for adolescent boys. The Enlightening Adolescent Boys program is an outcome of the needs assessment CEDPA undertook.

Focus group discussions are useful tools for assessing needs. Such discussions were conducted with 91 boys and 94 girls in peri-urban and rural areas. The major needs for boys identified through these discussions were:

- Career guidance and counseling;
- Educational and vocational skills development in such areas as: how to be self employed, where and how to obtain financial assistance, basic life skills, how to access and link up to existing resources; and
- Addressing such social issues as: gender equality, family norms, and building a trusting and supportive environment.

The program for girls aimed to improve the reproductive heath and gender status of women and girls by addressing men and women as equal partners. Shortly after the program with girls started, there was general agreement that boys needed to address the issue of empowering girls and women.

To reach boys, the program had to recognize, listen, and respond to the needs of young men.

Phases and Duration: This was a two-year project and had two separate phases, material development and implementation, each lasting one year. The project cost $100,000.

PHASE I: Development of training package, *Choose a Future!*

Goal: The goal of the manual is to help boys shape their own lives and create their own options especially for RH and gender issues. It is based on two principles: boys have the right to make choices to determine their future, and they can develop the skills to make them.

The package includes a training manual, a facilitator's handbook, posters, video cassettes, and supplementary materials: films, training aids, games, exercises, and anatomy models.

Issues addressed in the *Choose A Future!* training package are:

Self awareness	Values Identification	Gender Awareness
Feelings	Communication Skills	Interpersonal Relationships
Families	Community	The World of Work
Puberty	Reproduction	Health
Marriage, Partnership and Parenthood	Environment	Legal Rights
	Taking off from here (my life beyond)	

PHASE II: Implementation

The training materials were implemented in the second year. Ten NGOs across 11 states participated. They reached 8,387 boys at a total cost of $100,000.

The implementation phase relied on three approaches:

- A long term (3-6 months) approach during which the training package was integrated into vocational training classes, remedial tutoring classes, gyms, clubs, and other community organizations;
- The camp approach (10-14 days) where boys were intensively trained in camps for a short period of time; and
- The school approach where training package was integrated into the classroom curriculum.

Over half (56.9%) of the adolescent boys who participated were between the ages of 10-14. They were unmarried and most of them (86.7%) were in school and not working.

Stakeholders and their roles: Many stakeholders representing different levels of society supported the project by participating in it in different ways.

- Government ministries and agencies, NGOs, and INGOs (UNFPA, UNICEF, UNESCO) developed the training package with active participation of adolescents.
- Local NGOs, community members, and school teachers implemented it while parents and teachers actively supported it.
- Health care professionals provided services, whenever possible, on-site.

4. Measuring Outcomes

The study adopted a pre- and post-test design to assess knowledge before and after participation in the program. The assessment included 2,379 alumni boys who completed the pre- and post-test.

Examples of quantifiable indicators:

Knowledge about human reproduction (e.g. menstruation), and transmission of HIV and STIs: Among almost a third of participants, knowledge about menstruation increased. Other areas where knowledge increased significantly included the different ways that HIV/AIDS can be transmitted, and preventive care to assure healthy pregnancies. Graduates learned about the importance of antenatal care.

Knowledge about conflict resolution: There was a slight increase in how to resolve conflict through non-violence (11.9%), with almost half (45.3%) of the participants understanding that one can negotiate for a win-win situation.

Knowledge about gender equity: More than half (56.7%) of the students believed at the start of their training that boys and girls would be “more equal” if they both go to school;

by the end of the project, almost three quarters of the participants (71.5%) agreed with this statement.

Graduates expressed changes in attitude and behavior towards women. Several boys mentioned a shift from violence and aggression to negotiation and discussion. Married boys reported increasing communication with their wives on issues such as family planning, contraception, birth spacing, and number of children.

A comparison of the pre and post-assessment tests indicates that the program increased knowledge and affected attitudes related to gender and reproductive health.

Obstacles and strategies used to overcome them***:***

- Initially it was difficult to get boys to participate and it was difficult to convince school boards to allow the *Choose a Future!* training to be held in schools.

- Getting boys to participate was a challenge as their program was modeled on the girls program, which had a strong component of vocational skills training. The skills being offered to the boys at the village level were few in number and did not interest them. Furthermore, since mobility was not a problem for boys, career opportunities outside the village attracted them more than those offered at the autonomous centers. Therefore, in the boys programs, forums like sports clubs, gyms and health clubs were more popular. The short term camps were a greater success, in the boys' program, as they provided a forum for peer participation and interaction in a short amount of time (7-10 days).

- Numerous visits and meetings were held with principals and senior teachers, during which the training manuals were shared; however, in spite of such meetings, only a few schools agreed on the training but many schools decided against introducing the *Choose a Future!* curriculum.

- Monitoring was weak. NGOs that participated in the project should have monitored the implementation of project activities more closely. They should have also used the survey tools to supervise the program and ensure its quality.

- Limited resources constrained the duration of the project and its activities. There were not enough funds to implement a vocational skills training program.

- It was difficult to identify doctors willing to provide onsite services.

LESSONS LEARNED

- The training package can be used as an entry point for working with adolescent boys. It lends itself well to a broad age range, 15-24, and to a wide variety of boys: rural, urban, out of school, in school, employed, etc. The boys were open

"Earlier men wanted to prove their masculinity by being forceful. There is now realization that love is for life and lust is only for a short while." Sabir, 19years old.

and eager to learn about male and female reproductive health.

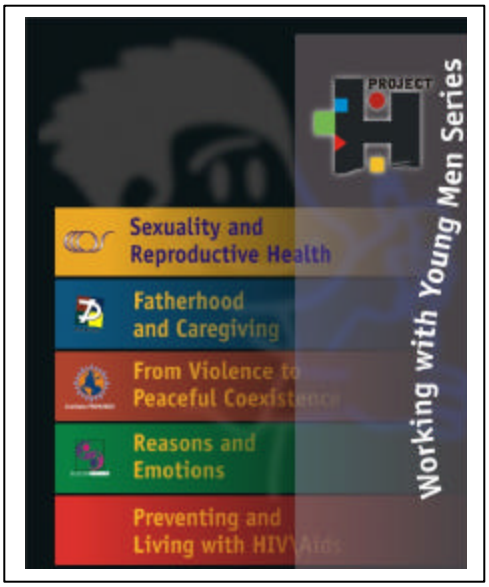
- Including stakeholders and youth in developing the training materials created a sense of ownership and facilitated the scaling-up process.

The Program H: Promoting Condom Use, Health Seeking Behavior, and Changes in Gender Norms Among Young Men (Brazil)

Phase I: Material Development

This is a portable program based on findings from extensive research that inquires as to what leads to young men being more gender-equitable and applies the findings to program development. Program H contains a video, "Once Upon a Boy" and four manuals on:

- Sexuality and Reproductive Health
- Fatherhood and Caregiving
- From Violence to Peaceful Coexistence
- Reasons and Emotions
- Preventing and Living with HIV/AIDS



Phase II: Implementation

The program works most effectively by using four integrated components:
1) Group workshops to promote changes in attitude addressed by the themes listed above;
2) Lifestyle social marketing that combines condom use with a more "gender-equitable" way of life;
3) Making health services more attractive to young men by simultaneously promoting health awareness among young men and their families and working with providers to sensitize them about the needs of young men; and
4.) Evaluating attitude and social norm change using a culturally relevant validated evaluation model. See presentation **Measuring Gender Equitability Among Men (Brazil),** *Horizons Program/PATH.*

Implementing a Youth-Friendly Socially Marketing Campaign:

Hora H – In the Heat of the Moment Campaign is a lifestyle social marketing component of Program H**.** The campaigns use famous cultural and youth personalities, including nationally-known rap singers, to promote messages to young men about gender equity. They also include messages about condom use, with a condom brand (Hora H condom) and marketing strategy designed by and for young men.

Next Steps: Scaling Up

The following activities were undertaken to scale up the project:

- Engaging ministries of health as partners and getting their logos on the Program H manuals (Mexico and Brazil);
- Engaging strategic partners that have wide-ranging networks of partners and counterpart organizations (e.g., IPPF/WHR, PAHO, WHO, UNFPA);
- Focusing on a training of trainers approach, identifying key partner NGOs in target countries and working with that partner NGO to take Program H to a broad segment, particularly in the case of countries where the Program H Coalition does not have a physical presence (e.g., India).

Measuring Outcomes

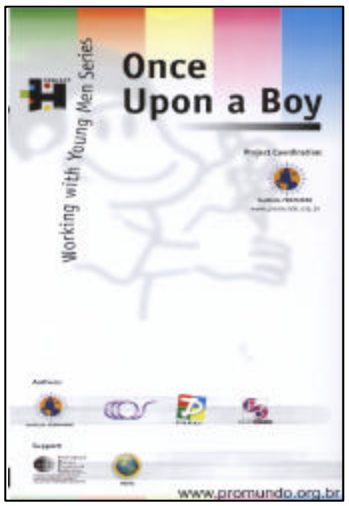
All aspects of Program H are being evaluated with support from Horizons. The evaluation model attempts to assess attitude change resulting from program activities. More importantly, this collaborative work has led to the development of the Gender-Equitable Men (GEM) Scale that is described in detail under **Measuring Gender-Equitability Amoung Men** in chapter VIII. Initial results from the evaluation found:

- Increased brand recognition and use of *Hora H* condom;
- Increased condom use with stable partner;
- Positive attitude change in 18 out of 24 measures on the GEM (Gender-Equitable Men) Scale.

Lessons Learned from field testing this package:

- This program appears to increase knowledge and affects attitudes related to gender and RH, including gender-based violence, and HIV/AIDS awareness. Boys expressed changes in attitude and behavior towards young women. Several participants spoke of a shift from violence and aggression to negotiation and discussion. Married boys appeared to increase communication with their wives on RH issues, family planning, contraception, birth spacing, and number of children.
- Boys are open and eager to learn information on both male and female RH.
- The participatory materials development approach created ownership and facilitated the scaling up process.

Program H materials are available in English, Portuguese, and Spanish from Promundo (m.nascimento@promundo.org.br). They have been widely field-tested in Latin America and the Caribbean, with initial training adaptation and training taking place in India, Thailand, and the U.S.



Chapter II
Policy Initiatives and Strategies for Advocating the Involvement of men in Reproductive Health

KEY STEPS FOR ADVOCATING MALE INVOLVEMENT IN RH AND FOR CHANGING POLICIES	
IMPLEMENTATION ACTIONS	EXAMPLES OF IMPLEMENTATION ACTIVITIES
Work in partnership across departments in the public sector with NGOs experienced in various aspects of RH and/or with faith-based organizations	Quality of Life Committee in Brazil includes representatives of 11 government departments, including labor and media, several NGOs and universities The advocacy program in Mexico included NGOs, academicians, and representatives from the public sector The Church of Christ in Nigeria participated in a program that integrates RH with democracy and governance
Determine policies to be targeted for change (e.g. reproductive health and rights, gender equity)	Conduct seminars to inform policy-makers about emerging issues (e.g., "Challenges of Contemporary Masculinities" seminars, Brazil) Disseminate and discuss current research findings, and share informational and educational materials through regularly scheduled meetings with policy-makers and program mangers.
Agree on target audience and on strategies to raise awareness about male involvement in RH	Hold seminars for professionals and decision-makers, and offer short-term annual campaigns such as Fatherhood Week for the general public.
Link male involvement to a broad spectrum of RH issues	Carry-through themes of male involvement in campaigns that address specific health issues such as 'breastfeeding week,' and 'say no to violence against women.'
Divide labor based on area of expertise	A country-wide advocacy project requires partners with various areas of expertise to implement aspects with which they are familiar (e.g., fatherhood, masculinities, socialization of boys, gender identity).
Monitor and evaluate activities and measure achievements	Assess indicators such as public statements about involving men in RH, capacity building and advocacy workshops with civil society,

	consensus building meetings with key stakeholders, political support using data on men, policies drafted, policies adopted, operational plans developed, and budgetary appropriations for men and RH activities.

To access a presentation, click on the title of the presentation.

Masculinities, Reproductive Rights, and Public Policies, a program initiated by the Municipal Secretary of Health of Rio de Janeiro, Brazil, is an example of a government and a policy program that targets a large and diverse group of people, from policymakers to children. In contrast, **Reaching Men to Improve RSH for All,** Mexico, is an advocacy program that is directed to highly educated professionals seeking to increase their knowledge and strengthen their skills to implement effective programs. Such initiatives give the issue visibility and encourage networking among local and country-wide organizations.

The third program described in this chapter**, Linkages between Democracy and Governance, RH, and GBV**, Nigeria, reports on the results of a study that found that women who participated in programs that link FP/RH and democracy and governance activities were more effective in increasing use of FP/RH programs than non-linked programs.

Masculinities, Reproductive Rights and Policies (Brazil)

Implementing agency: Municipal Secretary of Health, Rio de Janeiro in collaboration with Departments of Education, Social Welfare, Sports, Municipal Media, Social Works, and various NGOs.

1. Background

In 2002, there were close to 6 million people living in Rio de Janeiro, 47% male and 53% female. There were almost one million adolescents between the ages of 10 and 19. Adolescent mothers accounted for almost a fifth (19.26%) of all births. HIV/AIDS is spreading rapidly among women.

Rio de Janeiro has 1,040 municipal schools with 700,000 students, 155 municipal health facilities and 10 youth centers with 2,000 trained peer educators.

Identifying which issues to advocate: In 2001, the Municipal Government of Rio de Janeiro created a "Quality of Life" Committee which was coordinated by the Municipal Secretary of Health. The committee includes representatives from the departments of education, social welfare, sports, culture, labor, housing, publicity, communications, security, media and women's rights. Universities and NGOs such as Promundo, NOOS, CEDUS, NESC-UFRJ, Fiocruz, EICOS/UFRJ, and others were welcome to participate as well.

2. Program design

The objective is to raise awareness of the need to improve men's involvement in reproductive health and care of children and adolescents through several strategies, including two seminars on "Challenges of Contemporary Masculinities." One of the most important activities was a "Fatherhood Week," created officially in 2002, and repeated in 2003. This initiative was followed by partnerships with other campaigns such as the "International Breastfeeding Week" and the municipal campaign, "No to violence against women; world peace starts at home."

The health department coordinated these campaigns, and they were run by members of the Quality of Life Committee. During the two "Fatherhood Week" programs (2002 and 2003), committee members implemented activities in their area of expertise. For instance, research-based members conducted surveys about child-parent relationships and men's health needs. NGOs familiar with issues of fatherhood created public displays about fatherhood, identified and reduced institutional barriers to fathers' participation (in schools, community centers, health care facilities, etc.), adapted children's games to include fathers, and trained institutional staff on including issues of fatherhood and masculinities in training curricula. Members of the committee led discussions on diversity, inclusion (men who have sex with men, disabled people, other men, etc.), gender norms, socialization of adolescent boys, involving fathers in childcare, and men in family planning and STI/HIV prevention. Some committee members developed activities to enhance the father-child bond.

The program targeted all sectors of society, including professionals, children, adolescents and youth, men, women and families.

Duration: Initiated in 2001, and on-going. The activities included in this report are those that were carried out in 2002 and 2003. Activities for 2004 are being determined based on available resources.

Stakeholders and their roles: The Department of Health developed educational materials, hosted a web forum, seminars, and in 30 public health centers ran activities such as games, debates, making and distributing posters, conducting surveys, and hosting celebrations.

The Department of Education ran activities in 300-400 schools, similar to those run in the public health clinics. They also developed a newsletter for teachers with information about masculinities and suggested activities.

The Social Welfare Department trained 2,000 peer educators and ran activities in 10 youth centers, similar to those run by the health department. In addition, children of battered women were invited to participate in these activities.

The Sports Department conducted activities in five sports centers and 20 public parks.

The Municipal Media Institution ran eight television programs with themes such as the new man, fatherhood week, father's rights, fatherhood and health services, adolescent fathers, men and care, fatherhood and violence, and fatherhood and the media.

The Social Works Department/UFRJ conducted a survey on "What does it mean to be a father?"

NGOs and other institutions were involved in the activities described above, and ran seminars, lectures, and contributed to the development of educational materials including plays.

Activities planned for the two Fatherhood Week programs helped raise awareness about fatherhood and health services programs by emphasizing the father's role in contraception, pregnancy testing, antenatal care, delivery, pediatrics, school health programs, adolescent and young men's programs, STI/AIDS, clinical care, and care of the elderly.

3. Results

The initiative has strengthened partnerships between 400 different institutions (municipal departments, NGOs and universities) and thereby has fostered creative ideas. Running activities in different sites optimized opportunities and as well as helping to integrate working with men with activities already underway (e.g., a vaccination campaign encouraged the involvement of fathers and schools addressed such issues as the role of families in schools).

The program has led institutions, particularly health facilities, to review their routines to foster the participation of fathers. In other cases, the program gave visibility to activities that were already underway in health facilities but were not receiving the support they needed.

In terms of policy change, municipal departments in the health and education sectors are including masculinities and fatherhood topics in the training programs directed at peer educators, teachers, and health professionals.

Obstacles and strategies to overcome them: It is awkward to talk about fatherhood when many children don't have fathers. This was overcome by discussing "men and care" rather than fatherhood.

It was difficult to involve fathers of malnourished children. Health personnel had to be very careful when trying to involve fathers in group activities in order to avoid having them feel guilty for not being able to support their families.

The problem of discussing fatherhood with children and adolescent with a history of violence was addressed by giving children and adolescents the opportunity to talk among themselves about the fathers they have and the fathers they would like to have.

Remaining challenges include attracting media attention and having sufficient funds to assure the continuity of the program.

LESSONS LEARNED

Working with multiple partners requires careful planning and coordination and an on-going open dialogue among participating organizations.

Not knowing whether funds will be available to continue the program from year to year hampers the ability to do long-term cohesive planning and hinders efforts to scale up this initiative.

Creating a week of activities whose impact can be evaluated is very strategic to promote reflection among men and to mobilize institutions. Working with institutions generates new models of care.

Fatherhood motivates men to reflect about masculinities. However, one must recognize that it is a very sensitive issue, one that requires professionals to consider their own personal experiences.

Reaching Men to Improve Reproductive and Sexual Health for All (Mexico)

This program took a different approach to advocating and promoting men and RH. This project was initiated by two NGOs, MEXFAM and CORIAC, but also involved the public sector and academia.

The partnership between NGOs working on male involvement and academicians interested in male identity issues, in Mexico, is rooted in their close collaboration on this issue from its pioneer days. Theoretical research findings initially informed designs of male involvement programs. As the discipline evolved, with operational research findings indicating that working with men in RH was a viable strategy for addressing some of the countries' public health problems, representatives from the public sector were gradually invited to join meetings where such findings were discussed.

This male involvement advocacy project was designed to promote an interdisciplinary discussion of needs, problems, and ways to promote male involvement in sexual and reproductive health. Its objectives were to promote exchange of research and male involvement experiences in the field of sexual and reproductive health; promote collaboration and operational strategies for working with men and give technical assistance to the state groups; provide interdisciplinary training in gender and in sexual and reproductive health from a male involvement perspective; and to develop action plans.

Implementation: monthly meetings held in five cities: Mexico City, Hermosillo, Jalapa, Morelia, and Oaxaca, with set syllabi and invited speakers. Participants received materials on masculinity and related theories.

LESSONS LEARNED

- Institutional support is critical for implementing ideas developed by program professionals, as are the commitment and leadership skills of the local leader.
- Buy-in from key stakeholders such as the participants themselves and beneficiaries has to be obtained from the beginning of the project. Convincing stakeholders to support advocacy activities may take time and resources. In this case, it took three years and three separate conferences (regional, Oaxaca 1998; national, Mexico 1999; and theme based, NGOs in Mexico that work with men 2000) to convince stakeholders of the need to undertake a national advocacy program.
- Experiential workshops in which participants have a chance to role play or practice other interactive skills were among the activities participants consistently cited as the most useful. Participatory activities helped increase their understanding of male involvement issues and how to change attitudes.

Linkages between Women's Political Participation and Reproductive Health: The Male Influence (Nigeria)

Implementing agency: The Enabling Change for Women's Reproductive Health (ENABLE) Project implemented RH and Democracy and Governance activities. CEDPA evaluated the effectiveness of the integrated intervention.

1. Background

The Church of Christ in Nigeria participated in Democracy and Governance (DG) activities run by the ENABLE project in 1998. In 1999 RH was integrated into the Democracy and Governance project at the request of the Church of Christ.

Activities implemented in Democracy and Governance program:

- Grassroots mobilization for women's participation in political processes
- Formation of coalitions and networks by women-focused organizations
- Advocacy visits to opinion leaders on women's issues
- Women's leadership training

Activities implemented in Reproductive Health program:

- Training community and clinical health workers
- Distribution of family planning commodities and IEC materials

2. Study Design

The hypothesis tested by CEDPA is that women exposed to both DG and RH activities will have more favorable reproductive health practices than those who are not exposed to both, particularly those women whose spouses are supportive of women's empowerment

The experimental study compared the level of women's empowerment, political participation, and use of modern contraception in four local government areas of Plateau State. ENABLE, in partnership with the Church of Christ in Nigeria, implemented both RH and DG activities in only one of the local areas; participants in two of these locations

received either RH services alone or DG interventions alone; and the fourth local area was the control group, with no RH or DG activities. Data for the study is from a representative survey of 2,000 reproductive-age women conducted in Plateau State in December 2002 and January 2003.

The information presented focuses on the types of influence that husbands have on women's empowerment, which in turn affects the relationship between women's political participation and contraceptive use. Women's empowerment was measured on four scales: freedom of physical movement, decision-making on household purchases, situations in which a wife can refuse sex, and justification for wife-beating. In this traditional, male-dominated culture, male approval is generally needed for nearly all actions that women take, including going to the market, attending a health clinic or visiting friends.

3. Results

The results of the study indicate that:

- Women in the RH/DG-combined intervention area scored highest on all of the women's empowerment and RH indicators, compared with other women.
- Modern contraceptive use was low overall (8.6%), but highest in the RH/DG combined area (12.0%), as is the percentage of women who intend to use contraceptives in the future (45.6%).
- Intention to use family planning was 56% greater among women exposed to DG activities than those not exposed.
- Among women with little or no education, current use of modern contraceptives was 10 times higher among those whose husband approved of FP than among those whose husband did not approve. The intervention only measured the impact of husbands' approval of FP on contraceptive use among women. It did not try to increase husband's approval of FP.
- Similarly, among women with little or no education, those with permissive physical mobility scores were twice as likely to say they intend to use FP compared with women with lower mobility scores. The intervention did not attempt to increase women's physical mobility.
- Group affiliation (e.g., church membership) has a strong independent influence on current contraceptive use, while the effect of political involvement operates through other background characteristics (education, socio-economic status, age).

LESSONS LEARNED

The project demonstrates that linking health programs with non-health programs leads to women's informed and autonomous decision making, particularly for the allocation of women's time and resources. These linkages promote greater acceptance of family planning and the participation of women in the democratic process, particularly if husbands are supportive and permissive. In a traditional, male-dominated society, husbands who permit greater physical mobility faciliatate exposure to new ideas and other social networks that can be conducive to improved reproductive health behavior. A husband's positive attitude on family planning and greater communication on reproductive issues are highly related to his wife's use of modern contraceptives.

The implications of linked programs are that political involvement through group affiliation of women leads to better reproductive health outcomes and is enhanced when men are supportive of the economic, cultural, social, and sexual dimensions of women's empowerment.

Chapter III
Involving Men in Reproductive Health through Maternal and Child Health

KEY STEPS TO IMPLEMENTING PROJECTS that INVOLVE MEN in RH through MCH	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Assess infrastructure of clinics and maternity wards in hospitals and their accessibility to men	Conduct a facility-based analysis to understand how clinic functions, services offered, patient flow, and time spent with each patient. Consider if privacy and confidentiality is assured (e.g., rooms with closed doors, curtains between beds). Conduct focus groups with providers to assess their attitudes about treating men and couples. Assess if clinics have waiting rooms and if so. are they gender neutral and male-friendly? Review guidelines and protocols, available equipment, drugs and commodities that provide quality MCH care.
Assess attitudes among women and men in the community	Conduct focus group discussions with women, or surveys to find out if they want to involve their partners in FP, MCH, HIV/AIDS prevention, and/or addressing issues of violence. Assure women that they decide as to whether or not to involve their partner. They must give consent for him to be involved. Conduct separate focus groups or surveys with men to find out if they want to be involved.
Advocate and buy in activities with decision-makers and local leaders	Host meetings with department of health officials at national, provincial, and regional level to inform, promote, and encourage buy-in to male involvement programs. Where appropriate, include traditional and local leaders or have separate meetings with them. Use these meetings to get feedback and agree on windows of opportunity for initiating male involvement programs.
Promote and advertise male involvement program	Advertise that clinics welcome men. Dispel the notion that clinics are for women only.

KEY STEPS TO IMPLEMENTING PROJECTS that INVOLVE MEN in RH through MCH	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	Partner with community leaders, media organizations, churches, and community centers to let people know that men are welcome at clinics.
Develop plans of actions	Action plans should consider how involving men affects every aspect of service delivery (e.g., scheduling, time spent per client, patient flow, tracking and monitoring client visits, costs, décor and upkeep of waiting rooms and rest rooms). Action plans should include adjustments to infrastructure to assure privacy and confidentiality (e.g., rooms with doors, curtains between beds).
Adjust or develop monitoring tools and management information systems to track services provided to men and women	Establish systems that disaggregate data by gender and services provision (e.g., number of counseling sessions provided and issues addressed, number of men and women that visit the clinic and services they receive).
Training	Train all staff from doctor to maintenance staff about working with men; provide on-going technician training to nurses and counselors who will be working with men.
Develop and disseminate training materials for in-service training and IEC materials geared for couples	This may require setting up a technical working group to develop materials or outsourcing this activity to an experienced NGO or governmental department. Discuss and distribute IEC materials to women and men in couple counseling sessions. Encourage couples to tell their friends that clinics are not for women only but also welcome men.
Introduce couple counseling	Offer couple counseling as an alternative to individual counseling based on women's consent. Consider flexible hours for couple counseling taking into account men's work schedule.

KEY STEPS TO IMPLEMENTING PROJECTS that INVOLVE MEN in RH through MCH	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	Consider group counseling as an alternative to couple counseling to facilitate scheduling.
Evaluate project	Use monitoring tools, interviews, and focus group discussions with providers, clients, and community leaders.

To access a presentation, click on the title of the presentation.

Maternal and child health (MCH) presents many opportunities for involving men in reproductive health, whether through pregnancy or through the health of the baby. Research findings and program experience concur that "pregnancy is a time when both parents have similar interests in the survival and health of their babies. However pregnancy presents a time of vulnerability for women and their babies with respect to sexually transmitted infections (STIs) including HIV" (Marindo et al., 2003). Furthermore, in patriarchal societies, where men hold the decision making power in matters including use of family income, access to health care, and reproductive and contraceptive choices, involvement of male partners in RH services may have a crucial impact on women's and families' reproductive health. Yet, public health services still tend to exclude men when counseling women about childbearing, contraception, and STI protective behaviors, even though many service providers feel the need to involve and educate men about reproductive health. Research in North India confirms that men want to know more about reproductive health and that couples are uncomfortable discussing family planning and STI related issues (Singh et al., 1998).

The seven projects presented herein illustrate opportunities to include men in maternal and child health programming. Many of the presentations are operations research projects that provide information on how to replicate and scale up similar types of programs. The ***Mira Newako* project: Involving men in pregnancy and ANC in Zimbabwe** described in depth below addresses themes covered by most maternal and child health programs that welcome men. Their IEC and couple counseling sessions inform about the male and female anatomy, how a healthy pregnancy should progress, what symptoms indicate an abnormal pregnancy, and the actions men can take to seek emergency medical care for their partners. These programs promote antenatal and postnatal care, or what is also commonly referred to as maternity care or safe motherhood; programs such as these reach out to men by focusing on ways to encourage positive male involvement in caring for their partners during pregnancy and postpartum. They integrate STI prevention, including HIV, family planning, and preventive health care.

To access a presentation, click on the title of the presentation.

- **Involving Men in Antenatal and Postnatal Care: The Men in Maternity Project in South Africa.** Despite such obstacles as staff reluctance to include men in maternal health services and an infrastructure that was unwelcoming to men because of lack of privacy and inflexible clinic hours, this project found that men are interested and willing to be involved and women want such involvement.
- **Successfully Involving Men in Maternity Care: The Men in Maternity Project in India**. This project successfully overcame health care workers' discomfort in doing demonstrations of proper condom use by having male doctors initiate such demonstrations.
- **Involving Husbands in Safe Motherhood: The *Suami Siaga* ("Alert Husband") Campaign in Indonesia.** The project aims to involve men in MCH through a mass media campaign. Aspects of this project are highlighted in Chapter VII under Media Approaches.
- **Supporting Married Adolescent Girls: Encouraging Positive Partner Involvement (India).** This project sought to better understand the social context and health seeking behavior of young couples experiencing the first birth. The project assessed how a the first pregnancy affects a young woman's position and prospects within the household and with her husband. Based on their findings, project managers developed and tested interventions that increase young women's social support and designed services to first-time mothers in a manner attentive to the role of fathers. Thus, the project focused on the special opportunity that a first birth provides to establish health care behavior for future births.
- **Promotion of Male Involvement in Adolescent Married Women's Reproductive Health through Reproductive Health Education in Rural Area in Maharashtra, India.** This community-based intervention trained peer educators to impart knowledge about reproductive and sexual anatomy and physiology, menstruation, pregnancy and delivery, contraception, infertility, RTIs and STIs, HIV and AIDS.
- **Caring Men? Husbands' Involvement in Maternal Care among Young Couples in Rural India.** This operations research project inquired about what men with young wives know about maternal care. It also asked: "How does the socio-cultural context influence husbands' participation in maternal care among young couples? What other factors are associated with husbands' participation in maternal care for young wives?"

Involving Men in Antenatal and Postnatal Care: The Men in Maternity Project in South Africa.

Based on a paper submitted by Busisiwe Kunene, Involving Men in Antenatal and Postnatal Care: The Men in Maturity Project in South Africa, September 2003.

Implementing Agencies: Reproductive Health Services Unit (RHSU)/Durban; Department of Obstetrics and Gynecology, University of Witwatersrand; and Population Council, FRONTIERS in Reproductive Health Program and Family Health International.

1. Background

KwaZulu-Natal (KZN) Province in South Africa has a population of 9.1 million people, with fifty-seven percent living in rural areas. Men are traditionally not expected to be involved in maternity related issues with some believing that a man will become weak if he is present at the birth of his baby. The HIV prevalence among antenatal clients in KZN was 33.5% in 2001, and maternal mortality increased from 188 in 1998 to 243 in 2001, with 23% of these deaths HIV related. Although HIV/AIDS is known due to national IEC campaigns, sexually transmitted infections (STIs) are another major public health problem and are less well known. Reproductive health information including STIs and condom use, if ever given, is primarily aimed at women who are not financially and culturally enabled to make decisions on many of these issues. In addition, women are not in a position to talk about sex or condom use with their partners while men, as partners and decision makers, have very little knowledge of reproductive health issues.

Sources: Department of Health, 1997; Editors Inc., 2001; National HIV Survey, 2001; Saving Mothers, 1999-2001

2. Project Goal

The goals and objectives were to:

- Develop an expanded, acceptable antenatal and postpartum care program which includes both men and women and aims to improve reproductive health and pregnancy outcomes;
- Assess the impact of involving men in two pre and one post-delivery counseling sessions conducted in couple groups.

Exposure to the intervention was expected to result in:

- Improved male involvement and intra-couple communication
- Improved family planning knowledge and use at six months postpartum
- Improved STI preventive behaviors
- Improved knowledge of dual protection offered by condom use
- Improved syphilis testing and management
- Improved infant health, feeding, and immunization
- Greater providers' satisfaction

3. Project Design

Duration: June 2000 – March 2003

Needs assessment: As this was an operations research assessment the study was not based on a needs assessment, though formative research (see below) was carried out to understand how the clinics functions.

Surveys were conducted prior to clinic interventions and at a six months post-due date in women's and men's homes in both control and intervention sites. At baseline a total of 2,082 women, (1,087 control and 995 interventions) were interviewed using a structured questionnaire. Males were only interviewed in intervention sites at baseline if the female participant agreed to have her partner involved. Ninety nine percent of women who qualified to participate in the study consented to have their partners involved. However,

only 59% of the 995 men eligible to participate in the study were interviewed, mainly due to difficulties in tracing them as most participants were not married and cohabitation was low among those who were not married. A follow-up rate of 66% (n=712) of the control women and 75% (n=745) of the intervention women was achieved and 604 control and 652 intervention male partners were also interviewed at six months postpartum. Towards the end of the project, focus group discussions were conducted with health care providers to evaluate their satisfaction.

Research design: Two clusters of 6 clinics each matched for a range of characteristics were randomly assigned to either treatment (intervention) or control. Six clinics implemented the intervention and another six control clinics continued to provide services following the current practices and guidelines of the Department of Health.Both rural and urban clinics were included. The size of the clinics varied considerably with some clinics seeing 185 first time antenatal care (ANC) clients and some as few as 20 clients per month. All study sites were in the catchment area of Prince Mshiyeni Memorial Hospital, a tertiary hospital with 22 clinics under its administration; almost all providing antenatal care services. It is located in Umlazi Township which, with a population of about two million, is the largest township in the Durban metropolitan area and the second largest township in South Africa.

Strategies: The intervention was clinic based and included two broad strategies:

- Improving antenatal care services by improving counseling and providing basic essential equipment, as well as strengthening service monitoring and supervision;
- Introducing couple counseling by providing training to health care providers and inviting partners of antenatal women to attend couple counseling twice during pregnancy and once post-delivery. Couple counseling was conducted in small groups. In addition to this, a booklet called Ukuba umzali (*Being a Parent*) was newly produced, provided to all women during their antenatal care; they, in turn, were encouraged to share these with their partners.

Various activities were implemented to achieve the goals and objectives. These included:

- **Advocacy and buy-in activities** - With existing cultural beliefs that discourage male involvement in maternity, there was a need for extensive and intensive buy-in activities among health care providers, clients, and relevant non-governmental organizations. Several meetings were held with different groups and individual representatives at all levels of the department of health (national, provincial, regional district) as well as in each clinic. Clinics' committee members, where available, were also approached to sell the idea to the community and get feedback from policy makers and the community. They also helped inform project designers with suggestions on where to start to assure cooperation and ownership of the program. (Most of this was done during the Syphilis case study involving primarily the policy makers.)

Formative research to inform the planned intervention as there was a need to understand how the clinics functioned. The research included a facility-based analysis, a case study on syphilis screening and management in antenatal clients, client flow analysis, and time spent by provider per client, focus group discussions and reviews of records.

Formative research findings revealed a lack of ANC guidelines and protocols, inadequate basic essential equipment, and shortage of drugs required for routine pregnancy care and STI management. The management information was inadequate and IEC materials focusing on pregnancy were lacking. Most clinics were not assessing, educating or counseling clients on STI and HIV/AIDS. In most clinics, congestion was compromising clients' privacy during consultations.

Tools development - Several technical working groups were established to develop IEC materials and a training package for in-service training, identify relevant trainers, and make recommendations for a couple-friendly environment. They also designed a supervisory tool to monitor the intervention, drafted and sent out invitation letters, and distributed attendance certificates that men who participated in couple counseling sessions during their working hours could show to their employers. The Department of Health made trainers and staff available to develop IEC and training modules.

Training - Two types of training were conducted. Initially, whole site overview training was given to all staff in intervention clinics including support staff such as general assistants and clerks to inform them of the study and its components. The second training was more intensive and involved all nurses working in the intervention clinics; training not only updated and expanded existing antenatal care curricula but also included counseling skills and information on how to address men and couples. Sixty-five professional nurses working in the intervention clinics attended the workshops between February and March 2001 at Prince Mshiyeni Hospital.

Implementation - Each clinic developed its own plan on how to conduct their couple counseling. Four clinics chose to utilize less busy afternoons, one clinic preferred two mornings per week and one that was already conducting antenatal care daily chose to introduce couple counseling during this period. The counseling sessions included the following topics: antenatal care procedures, physiological and emotional changes, pregnancy danger signs and care seeking, delivery plan, post delivery care for mother and baby, prevention and management of sexually transmitted infections and HIV/AIDS, and family planning and exclusive infant feeding.

Continuous support and mentoring was given by both the district trainer and staff of the reproductive health services unit to ensure that participants adapted to their new practices at their facilities until competency was gained and at least a minimum quality of service was achieved.

Monitoring activities included:
Supportive supervision - A supervisory tool was used to continuously monitor practice and record keeping and facilitate follow-up and supportive supervision. Intervention

clinics were visited monthly for the first six months, bimonthly for the second six months, and every three months thereafter through the completion of the study. Monitors observed clinic structures, service provision, and couple counseling sessions during their visits. Progress made and problems identified were discussed with the clinic staff. Supervisors from all the clinics participating in the study met regularly to share lessons learned and foster peer support.

Management information system – Newly developed and improved registers for antenatal care and counseling sessions recorded data on the number of clients counseled, topics discussed, and the job title or position of the person who conducted the counseling session.

Surveys **(**see **needs assessment** above**)**

Cost and client flow analysis and time motion studies – Family Health International, a FRONTIERS partner, provided technical assistance to calculate intervention costs, client flow analysis, and helped conduct time motion studies at two points in the study in the intervention clinics.

Stakeholders and their roles**:** The KZN Department of Health, Maternal and Child Health Unit provided support and guidance in developing the curriculum and IEC materials. The Regional Department of Health provided trainers and support to ensure that supplies such as drugs were always available in the clinics. The Provincial STI Advisory Committee and Provincial Maternal Task Team provided guidance on how to best run the intervention. Hospital management, especially the maternity and community health sections, provided the facilities, training venue and trainers, and supported and motivated the staff to implement the project. The Henry J. Kaiser Family Foundation and Department for International Development (DID UK) provided financial support for the production of the booklet on becoming a parent. The United States Agency for International Development (USAID), through FRONTIERS, provided funds for the project including essential equipment. FRONTIERS also provided technical assistance. The Reproductive Health Research Unit of the University of Witwatersrand, based in Durban, KwaZulu-Natal managed the program and conducted the research component.

Target population: All women who attended the antenatal care clinics for one of their early prenatal visits from June to September 2001 in the control clinics and from October 2001 to February 2002 in the intervention clinics were approached for permission to be enrolled. Eligibility criteria included: consent to be interviewed and to have their partner interviewed; 10 to 30 weeks of gestation; living with their partner or having regular visiting relationship for at least one year; and expecting the partner to be present during and after the pregnancy. These women had to have been resident in the area for at least one year prior to recruitment and who plan to stay in the study area for at least six months post delivery.

Obstacles and strategies used to overcome them: Involving men in maternity was a process that required several stages of implementation, and each one required health

professionals to take on different roles, as trainees, motivators, and counselors. Nurses needed continuous motivation and support while in turn motivating and encouraging the women. Women have traditionally experienced pregnancies and childbirth without their partners; thus, it was a challenge for these women to start involving partners in their maternity care.

Although men were interested in being involved in their partners' maternity care, participating was not always possible because public health clinic services in South Africa are only open during working hours. This poses a problem for men who may not be able to leave work to attend couple counseling.

Traditionally men have not been involved in any aspect of their partners' maternity care. This posed challenges for both the nursing staff and the ANC clients. Nurses had to become the primary motivators of the clients, to encourage them to bring their partners to participate in counseling and other maternity care visits. Both nurses and clients were initially unsure if men would be interested in being involved in an area that has traditionally been a woman's domain. Some clients felt they needed a letter from the clinic to get their partners to participate as this formalized the process and the man would see that it was not just the woman wanting them to participate. There was also some confusion with the parallel introduction in some clinics of a mother to child transmission (MTCT) program, leading some clients to think these projects were related.

Staff rotations, which ranged from one to three months in each clinic section, posed another challenge as changes in personnel assigned to the maternity ward did not consider the interests of health workers. This had implications on the trained and experienced staff that left their jobs and newly arriving staff that had no previous experience working in maternity care. Rotations also affected clients who became familiar and comfortable with certain staff members and had to reacquaint themselves with new personnel.

Although the referral hospital was not part of the project, hospital staff were concerned about the shortage of linen and lack of privacy in the labor ward. These were obstacles that would make it difficult for men wanting to accompany their partner during delivery. The hospital solved this challenge by allocating a waiting room next to the delivery room, which was furnished by the project. In addition, hospital management put curtains between beds to provide visual privacy.

Loss of staff due to emigration was an issue for some of the clinics. Supportive supervision was particularly affected, in that three supervisors left within the first two years of the project. Those who were left had no cars to visit the clinics due to problems with administrative logistics. The same situation prevails in the clinics with skilled and motivated staff becoming highly marketable in the private sector as well as overseas. A number of nurses left while the project was underway. This was an on-going challenge, though provisions were made to orientate new staff who joined the intervention clinics.

Clinics are commonly congested in the morning so no space was available for couple counseling at this time of the day. To overcome this obstacle and accommodate the new and time consuming couple counseling sessions, the sessions were scheduled later in the day when the clinic was not as busy.

4. Results

Is the intervention acceptable to clients and providers?

Men were willing to be involved and also admitted that they lacked knowledge in reproductive health. Women felt they would benefit by having nurses give health education messages directly to their partners: *"Men will learn how to treat us. They will treat us like ladies,"* said one woman. Most women were excited*: "Nurses will stop harassing us when men get involved in maternity care,"* said one woman. Not all of them were enthusiastic *"…he is going to say why now…I've had babies without him,"* said one participant.

The majority of women (84%) expressed a desire for men to be involved to provide them with comfort and support. About half of the men said they wanted to be involved in all aspects of maternity care. Seventy-seven percent of the interviewed men and eighty percent of the women would like their partners to be present at clinic visits and group discussions. The lowest level of interest in men's presence was for the actual delivery (females 66-72%, males 53%). Only two men did not want to be involved in any aspect of maternity care.

Opinions on male involvement differed among health providers. Some of them were concerned about involving men based on cultural beliefs. Others were convinced this was a good practice. Some were also concerned that men might not come for couple counseling.

Is the intervention feasible?

A total of 524 couples were counseled and all women attending antenatal care were given the same information that was given during couple counseling.

Clinic services were rearranged to accommodate couple counseling. Every clinic managed to make its own schedule for couple counseling at the time that suited the clinic best. When individual counseling became obviously impractical, intervention clinics were able to arrange group couple counseling sessions. These changes were accomplished without increasing clinic staffing. Ideally, low male attendance could be overcome by offering couple counseling at times when men are not involved in income producing activities. However, this may not be possible for providers and clinics due to restricted hours when the clinic is open.

Is the intervention effective?

All participants were followed up six months post-due date of delivery to assess if the intervention was effective.

Table 2 shows topics discussed with partners post delivery reported by control and intervention women and men.

Table 2: RH topics discussed with partner (end-line survey)

	Intervention %		Control %	
Topics discussed with partner	Women (n=589)	Men (n=589)	Women (n=526)	Men (n=526)
Sexual relations	86**	88	74	84
Baby feeding	83*	86	76	83
STI/HIV	81**	85*	67	76
Family planning	82**	84	74	81

*p=0.001; ** p=0.000

The differences in couple communication on RH topics between intervention and control groups were significant when comparing the women in the intervention and the control group, particularly in terms of women discussing STI/HIV and FP with their partners. When intervention women were compared with control women, changes remained significantly high (p=0.000). However, when intervention men were compared with control men only STI/HIV communication was significantly improved in the intervention group (p=0.001); the rest were not significant.

Table 3 shows differences in family planning and condom use comparing control and intervention women pre- and post-intervention. In addition it includes data on self-risk perception of contracting HIV.

Family planning and condom use (p=0.000) improved significantly in the intervention compared to the control groups even though condom use remains low. However, a high percentage at baseline in both groups said they had no chance or did not know whether they had a chance of contracting HIV. This did not change much with the intervention, although the tendency is in the right direction. These results should be viewed with caution since this preliminary analysis has not taken the cluster design into consideration. Analysis was based on individuals.

Table 3: Family planning, condom use and HIV risk-perception

	Intervention Women %		Control Women%	
	Pre (n=995)	Post (n=728)	Pre (n=1081)	Post (n=694)
FP use postpartum	-	59*	-	49
Condom use with current partner	34	55*	34	47
Condom use last sex	4	22*	6	14
Dual protection ever use	13	24*	16	17
Don't know/no chance of getting HIV	65	53	58	46

* p=0.000

The knowledge of women in the intervention group improved more than those in the control group. The pre-intervention figure is lower than the post figure for "do not know or chance of getting HIV" which is to be expected.

Table 4 indicates knowledge of danger signs before and after the intervention. Although the control women had better knowledge of obstetric danger signs before the intervention, intervention women had more knowledge than their control counterparts at endline Those who did not know any danger sign in the intervention dropped from 11% to 3%. The changes were significant (p=0.000)

Table 4: Women's knowledge of danger signs (baseline and end-line surveys)

	Intervention Women %		Control women %	
Danger signs	Pre (n=994)	Post (n=729)	Pre (n=1081)	Post (n=694)
Bleeding	44	51*	59	50
High blood pressure	26	57*	33	38
Fever	27	35*	30	20
Swelling of hands and face	5	11*	6	15
Don't know any	11	3*	8	5

* p=0.000

LESSONS LEARNED

The lessons learned pertain to adjusting institutional structures to welcome men and women and to outreach and dissemination strategies that target men.

- Public services have to adjust their institutional structures to accommodate working men and women and provide career opportunities to health care professionals interested in involving men in MCH. Structural adjustments should consider revisiting rotations, scheduling flexible hours for couple counseling, strengthening monitoring, and supportive supervision. Hospital management and staff should be involved at the outset of couple-service interventions to accommodate couples that wish to be together during delivery.
- Outreach to communities needs strengthening to inform larger numbers of men that they are welcome to participate in their partner's maternity care, based on their partners consent, and to disseminate information targeted at sub-groups of men and women (e.g., adolescents, at risk, illiterate, employed, unemployed, urban, rural).
- Health care providers need additional training on how to serve couples and how to conduct couple counseling.
- New strategies need to be designed to address remaining challenges in HIV/VCT (Voluntary Counseling and Testing) and integration of other services into maternal services.

Chapter III
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Chapter IV
Men's Rights and Empowerment in Improving Women's Reproductive Health

KEY STEPS FOR IMPLEMENTING PROGRAMS THAT RAISE AWARENESS ABOUT GENDER and RH AMONG MEN	
Implementation Actions	Examples of Implementation Activities
Needs assessment	Use focus group discussions, surveys, or self-assessment with women in the community to find out what their partners should know about RH and why.
Adapt educational materials	Adapt materials used to inform women about RH to include issues that concern men (prostate cancer, urethritis, sexual performance, pleasure and enjoyment, etc.) Share materials adapted for men with women to facilitate communication about issues that are important to individuals regardless of gender. IEC should address gender roles, equity, the rights of individuals to determine the spacing and number of children they want, male and female anatomy and reproductive physiology, safe pregnancy, and violence.
Train trainers to work with men	Training should include practicing self-reflection, and exercises through which individuals explore, analyze, and discuss their self identity: --drawings that illustrate one's strengths and weaknesses -- questionnaires that query men about their attitudes and beliefs on violence, wage earning, and household responsibilities.
Work in partnership with departments and/or organizations that have experience in adapting educational materials, talking with men and/or addressing specific rights or RH issues with men.	Local authorities can be helpful in providing funds, convening men, and providing legitimacy to the program. Health care providers at the local and regional levels may help facilitate workshops.
Monitor	Make supervisory visits to community promoters and staff trainers on an on-going basis during which supervisors observe trainers training and promoters extending information to men in their communities.

KEY STEPS FOR IMPLEMENTING PROGRAMS THAT RAISE AWARENESS ABOUT GENDER and RH AMONG MEN	
Implementation Actions	Examples of Implementation Activities
Evaluation	Develop tools to assess achievements based on change in knowledge and behaviors, number of men reached, and degree of client satisfaction.
Diversify approaches to reach men	Consider radio programs, radio spots of personal stories, house-to-house visits, and employment-based outreach programs to reach men.

To access a presentation, click on the title of the presentation.

The programs presented at the conference raised gender awareness within the guiding principles of ICPD (International Conference on Population and Development, Cairo 1994). The ReproSalud (Peru) experience in working with men, **Involving Men in a Project Based on Women's Empowerment (Peru),** described below, captures the intricate connections between the goal of improving women's RH by empowering women to take control of their health and the numerous actions vital to achieving such a goal – among these the need to reach out to men as informed allies, aware of gender inequities. This project along with others, such as **Challenging Inequities: The Story of an Anti-Sexist and Rights-Based Program for Nigerian Adolescent Males** and **Human Rights-Based Interventions Are Crucial to Changing Attitudes Toward RSH Issues (Malawi)** undertake reproductive health programming by embracing men as partners with the understanding that they have been ignored even though they are essential to human reproduction and a key audience to reach in the efforts to stop the spread of AIDS. Such projects teach adolescent boys and men about men's and women's reproductive health systems and provide them with alternative gender models that foster more gender- equitable relations. They inform men and women about ways to improve communications about such personal matters as contraceptive use, family planning, and protecting themselves from STIs including HIV. As health providers become increasingly involved in efforts to reduce violence against women, RH programs that include men tend to address gender-based violence by presenting alternative behaviors to resolve conflicts. The program in Nigeria that targets adolescent males was highlighted in *Quality/Calidad/Qualité* (issue No. 14, 2003); the ReproSalud Project is described in issue No. 10 (2000). Both of these are available from the Population Council.

The session on raising men's awareness about gender, empowerment, and rights was prefaced with an overview of the challenges in collecting RH data on men**, Collecting RH Data From Men: A View From the Demographic and Health Surveys (Global).** Surveys undertaken in 40 countries found men difficult to reach, a challenge faced by programs that are designed to respond to men's unmet needs. The men were less easily available during the day and the length of the questionnaire was more problematic for

them than for women. As a result, men only completed a third to a quarter of the household surveys completed by women.

Involving Men in a Project Based on Women's Empowerment (Peru)

The ReproSalud Project (Brems, 2003; Leau, 2003)

Implementing institution: ReproSalud, a reproductive health project, is being implemented by Movimiento Manuela Ramos Movement, a Peruvian feminist organization with a long and rich history of championing women's rights and gender equity from a participatory, community-based approach and assistance from various CBOs. USAID-Peru provides technical and financial resources.

1. Background

Peru is a South American country characterized by large inequities among urban, peri-urban and rural populations. Many of the targeted social indicators for urban areas have already reached or are close to acceptable levels, while similar indicators for rural areas are currently at the level where urban area indicators were more than 25 years ago.

As in many places throughout the world, differences in social indicators between urban and rural women are remarkable because, in addition to socio-economic exclusion and ethnic discrimination, they suffer gender inequities. For example, the illiteracy rate of rural women is 38%. This is 2.6 times higher than that of rural men and almost 5 times higher than that of urban women (ENNIV, 2002).

Rural women are less likely to achieve their fertility preferences. They average almost twice the number of children (4.3) as urban women, even though their desired fertility is very similar (2.5). The national maternal mortality ratio is 185/10,000 live births, one of the highest in Latin America. Only 29% of deliveries in rural areas are assisted by a professional, while 85% of women in urban areas receive professional assistance (ENDES, 2000).

Furthermore, rural and peri-urban women who completed self-assessments identified reproductive tract infections (RTI) as the most important reproductive health problem.

2. Project goals and objectives

The ReproSalud project aims to improve the reproductive health status of low-income, rural, urban, and marginalized women by increasing their use of interventions to protect their reproductive health. These range from adopting health preventive behaviors to increasing their use of health services.

The project aims to establish relationships that are more gender equitable, specifically to enable women to overcome their subordination and reach a more equitable place in their community.

The work with men, introduced two years after the project was designed (1997), aims to increase men's awareness about gender equity and human rights--particularly women's

ability to access RH care and live healthier lives--and to involve men in preventing and dealing with reproductive health problems which affect women and men.

Objectives include involving men as partners in preventing sexually transmitted infections, unwanted pregnancies, and maternal mortality and morbidity. Activities implemented by ReproSalud to achieve these objectives include promoting men's reflection (i,e., exploration, analysis, discussion) about gender roles, responsibilities and rights; and giving them the information they need to prevent these health problems. As with the women, the men learn about consistent and correct use of contraceptives, including condoms; the causes of RTIs and STIs, their symptoms and medical treatments; and the importance of antenatal care and the identification of alarm signs during pregnancy or after child birth.

Duration of program: nine years and six months. The project's duration included a six month pre-project phase to design and test methodologies and strategies that had little precedent in conventional health and population programs, and to train staff to implement them.

PHASE ONE: lasted four years (1996-2000) and involved 2-3 cycles of providing sub-grants to women's community-based organizations in eight regions. Each sub-grant supported participatory educational and community-based interventions addressing specific reproductive-health problems identified by women.

PHASE TWO: extended the project for five additional years (2000 – 2005). This phase focuses on increasing educational activities and strengthening advocacy in local communities. The intent is to scale up and expand the impact of ReproSalud to create a critical mass which will ensure its sustainability.

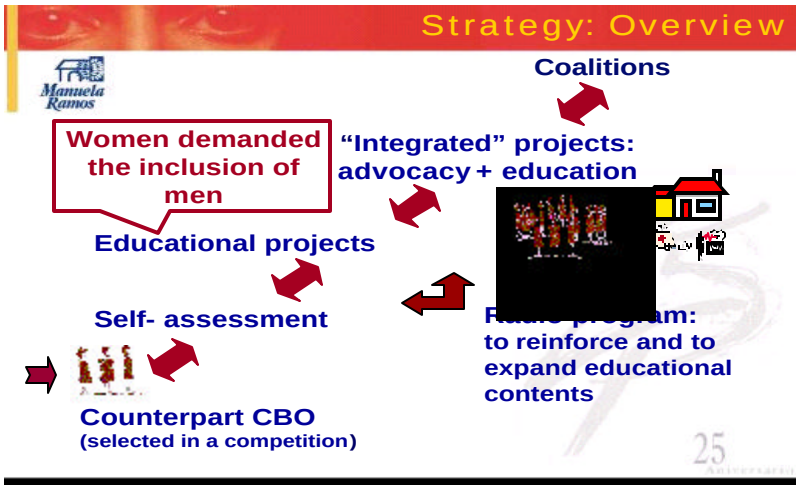
Needs Assessment: ReproSalud designed its project to address the under-utilization of health services provided by the ministry of health in marginalized urban and remote rural areas. The project design took into account relationships between health care providers and low-income women by focusing on the demand side of the reproductive health equation, and by addressing, at the community level, those structural barriers related to gender, ethnicity, and class that prevent poor and marginalized women from exercising their reproductive and sexual rights.

3. Project Design

Rather than delivering health care, ReproSalud works to empower women and their communities to overcome gender-based, social, cultural, and economic barriers to reproductive health. It aims to enable women to become informed consumers of reproductive health care, to practice healthy behaviors, and to advocate for changes in the health care system to meet their needs. In other words, ReproSalud aims to empower women to reach full citizenship.

Early during the design phase of the first community projects, many community-based organizations (CBO) identified the need to reach out and work with men in their

communities. They cited both pragmatic and strategic reasons. Pragmatically, it was necessary to engage men so that they would not oppose women's involvement in ReproSalud's meetings and related activities. Strategically, it was vital to involve men because they were continually identified as an important factor in women's reproductive health problems. In view of the women's sound arguments, ReproSalud decided to respond to their request.



The need for more equitable-gender relations is stressed with male as well as female audiences so that couples, for instance, learn to talk more openly about sexually transmitted infections, family planning, and domestic violence.

Communication Strategies: A radio-based communications program is being implemented to reinforce the face-to-face program and to expand educational contents about reproductive health and gender in places not yet reached by ReproSalud. A radio soap-opera was produced based on women's and men's true stories gathered in the field. However, the characters also exhibit alternative gender roles as one of the objectives of these shows is to expose viewers to different types of men's and women's roles and relationships.

Educational Activities: Educational strategies and training modules were adapted to work with men, taking into account the same participatory and reflexive methodology that ReproSalud uses with women. Specific issues or interest for men, like STIs, prostate cancer, and urethritis, were included in the training materials for men.

Men do not participate in the self-assessments, instead they talk about their needs and worries at the beginning of each module, as part of the methodology. Workshop discussions include myths related to sexual performance and concerns about mutual enjoyment and pleasure. These tend to surface toward the end of the sessions on women's and men's anatomy, and birth spacing, and improving their health. Issues of interest and concern to men were concurrently included in training materials that address

women's issues so that women could understand and help men with their problems. This promotes communication between men and women on topics that are important to individuals, regardless of gender, and to couples. Finally, this strategy enhanced men's and women's ability to recognize the interdependent cause and effect of many sexual and reproductive problems and how they affect the life of the couple and family life in general.

Project staff selected and trained male trainers. The training required self-reflections by the trainers. A Mexican consultant specializing in work with men was in charge of the training process because there were no precedents of working with men, in particular with rural men, in Peru. Following training, project staff led educational activities with male community promoters selected by their communities, and set up educational programs for interested men. Prior to conducting workshops, promoters adapted guidelines and organized educational workshops.

Educational methodology of ReproSalud: Training is based on the processes of self-reflection and building an integrated knowledge base that combines what men know with their experiences and biomedical information.

The curriculum includes an introductory module on gender roles and equity, human rights (focused on sexual and reproductive rights), male and female anatomy, and reproductive physiology. Three modules focus on sexual and reproductive health problems and one addresses violence against women. Rights and violence are covered in all the modules including to the two dedicated to these topics. The curriculum is covered in approximately 48 hours of class time.

Men are encouraged to exercise their right to know and care about their bodies, specifically their sexual organs. In this context, they are encouraged to take care of their own sexual and reproductive health, for example, by practicing hygiene as well as making more use of the government health care facilities for sexually transmitted infections (STIs) and prostate cancer screenings. At the same time they are encouraged to help women to care for their bodies, and prevent and deal with sexual and reproductive problems.

Each module concludes by asking participants to make specific voluntary and spontaneous commitments. For instance, some men have committed to sharing with other men their knowledge and new perspectives; others make it a habit to practice preventive health care to avoid STIs and unwanted pregnancies, thus implementing what they have learned.

Stakeholders and their roles: several key local stakeholders are involved in making ReproSalud successful. There are local ones, such as:

- Women leaders of CBOs--the main actors--manage projects, involve CBO members, advocate, and negotiate with health care providers;
- Local male authorities provide legitimacy to the program and community resources, and help to convene men;

- Health care providers at the local and regional levels incorporate some of the women's needs and carry out agreements negotiated with community leaders and promoters. An example of such agreements is making professional health care providers accessible to women who may want or need them regardless of the fact they give birth at home with the help of traditional birth attendants, as is customary.

Other actors are:

- NGO Coordinators responsible for advocating at national and regional levels in favor of policies and programs that ensure that poor women and men are able to exercise their rights to determine the number of children they want, their spacing, and whether or not they want to engage in sexual relations. Their primary audiences are the Ministry of Health (MOH), the Ministry of Social Development, some sectors of civil society's stakeholders, members of the Medical Association and mass media communication reporters.
- Donors through technical and financial support.

The intended beneficiaries are 290,000 women and 130,000 men of reproductive age, who live in rural and marginalized urban areas of the highlands and jungle. The rural women and men in the regions participating in the project are largely indigenous, approximately 75%-95% speak Quechua or Aymara (in Puno), as a first language.

4. Evaluation of expected outcomes

The evaluation of ReproSalud involves a quantitative impact study and a scaled down ethnographic study to review expected outcomes. These will be carried out before, during, and after the project is implemented. In addition the evaluation includes a cost-effectiveness analysis.

In accordance with the principal goal, the primary expected results are to increase women's use of reproductive health interventions (the strategic objective); increase equity in gender relations; improve women's abilities to access reproductive health programs; and include grass-roots women's organizations in all aspects of RH programming, from developing proposals to adapting and overseeing programs.

The quantitative study seeks to evaluate changes in knowledge, opinions, values, attitudes, and practices relating to the expected results through a survey administered to women and men.

The qualitative study gathers in-depth data on key issues in the results framework of the ReproSalud project, data for which the quantitative impact study is not appropriate. It aims to learn and understand patterns of social relationships (between men and women but also between provider and client and vice versa) and processes relevant to the expected changes. The study also seeks to identify paths toward change and empowerment. The data is collected with different qualitative techniques such as in-depth interviews with each woman and her partner, participant observations, and information gathered on paradigmatic events that are significant to people in the community. For

example, the study will look closely at relations between rural women and health service providers by examining a case in which medical assistance was considered successful and one in which it was not. Violence against women and women's empowerment will be used as indicators to assess changes in gender relations.

Examples of indicators: indicators that are used to assess the program's success related to women's reproductive health are:

- % of men who can recognize some alarm signs during pregnancy or after child birth
- % of men who agree that their partners should attend a health care facility for the delivery.

Indicators related to men's sexual health:

- % of men with STI's who went to a health care facility
- % of men who have used the condom in order to protect them and/or their partner against STI's.

Indicators related to enhancing men's awareness about gender equity and women's rights:

- % of men who believe that it is never right to hit a women
- % of men who believe that men are entitled to demand sex even when the woman does not want it.

Examples of changes

Manuela Ramos

Some indicators	Intervention*			Control
	BL	MTE	Dif	Dif
% of men who agree that their couples should attend a health care facility at delivery	40.6	74.0	33.4	18.8
% of men who can recognize some alarm signs during pregnancy or after child birth	16.5	45.0	28.5	15.8
% of men with STI's who went to a health care facility	15.8	38.5	22.7	2.6
% of men who have used condom in order to protect them and/or their couple against STI's	10.1	24.0	13.9	4.2
% of men who believe that it is never right to hit a women	58.1	66.3	8.2	4.2
% of men who believe that men are entitled to demand sex when the woman does not want it	13.6	6.4	-7.2	-0.9

BL=Base Line. MTE=Midterm evaluation, taking in account the same people who was interviewed in BL.
Dif.=Difference in percentage points. *Men who participated in at least one educational module.

Monitoring activities: Monitoring activities include supervisory visits of staff trainers to community promoters at least twice per workshop. During these visits, trainers review materials with promoters to refresh their knowledge before the workshop starts, and observe some sessions conducted by promoters to identify strengths and challenges in introducing new knowledge and perspectives or address problems with the training

methodology itself. Trainers reinforce the promoters' knowledge and skills based on information gathered through their observations.

At the end of each activity promoters complete a report, taking into account achievements, difficulties, and the number of participants. In addition, they complete a report with information such as an overview of the educational background, age range, and occupations of the participants.

Evaluation: Participants are evaluated at the beginning and at the end of the workshops through a test that is graded by promoters. The levels of achievement and increase in knowledge are registered as indicators of the effectiveness of community educational projects.

Promoters and the steering committee of community-based women's organizations with one or two members of ReproSalud's staff evaluate the community-based projects. The goal is to know if these projects have made the anticipated progress and to reflect on the difficulties and opportunities encountered during the project's implementation. The project is evaluated based on the level of knowledge and it's increase, the number of beneficiaries, and the degree of satisfaction of beneficiaries and authorities, which is measured through a survey conducted by ReproSalud Project's regional staff. The degree of complexity of the next community project depends mostly on the results of the evaluation.

Obstacles and strategies to overcome them: Some obstacles that constrain ReproSalud's ability to achieve their goals are related to MOH policies and health providers' attitudes. Strategies that Reprosalud has used to overcome them are as follows:

- Advocacy and lobbying to effect changes in MOH policies regarding sexual and reproductive rights;
- Empowering a critical mass of users and raising cultural awareness to achieve more equitable relationships with health providers;
- Sensitizing providers on gender issues and user's rights.

Other constraints are men's negative attitudes about participating in educational activities and difficulties in organizing meetings with them. Strategies to resolve this issue are as follows:

- Reflexive-participatory education, which takes into account fears, rights, benefits for all, to address men's reluctance to sanction women's participation;
- Convening participants through house-to-house visits by a male promoter and community authority;
- Radio programs to reach men (especially young men) who are displaced from their communities in search of work or have no access to higher levels of formal education in better educational institutions.

LESSONS LEARNED

- Before starting a new program, managers should consult the community about their sexual and reproductive health and gender needs and problems. Women in

communities with few resources have taught us that we need to work not only with women but also with men. As gender, sexuality, and health are socially constructed, women and men in communities with few resources are more able to identify their needs related to RH than program managers. It is important to consider a "cross analysis" of women's assessments and men's assessments of their reproductive health, taking into account power relations based on gender and a lack of communication about sexual and gender issues.

- Taking into account that power is a key issue in understanding gender relations and many aspects of women's reproductive and sexual health problems, empowering women and involving men simultaneously in reproductive health programs is highly advantageous, and even indispensable, in conditions of marked female inequality for women. This approach avoids the reinforcement of oppressive gender norms that result in oppressive relations between men and women.

- Designers of reproductive health programs need to think more about how to change meanings and values associated with masculinity which are contrary to gender equity. Designers should achieve a balance in power as well as broadening existing social norms attributed to men and women and emphasizing the diverse ways that currently exist or can be created and which are valued in being male and female.

- Men need involvement in community activities to deepen their understanding about their health problems and relations with women and other men. Thus, training workshops help men express their own concerns and discover the importance of relationships and discussions about reproductive health, even when they talk about reproductive health problems identified by women. In addition, men, including community-based promoters, are changing the way they relate to men and women. This in itself is creating and strengthening alternative models of femininity and masculinity.

Chapter IV
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Chapter V
Impact of gender on men's health: sexual risk and sexual dysfunction

KEY STEPS TOWARDS FORMATIVE RESEARCH TO BETTER UNDERSTAND MEN'S SEXUAL RISK AND SEXUAL DYSFUNCTION	
Determine characteristics (e.g., gender, educational level, age range, location, income level, professional level) of population that will participate in the baseline survey	Choose target audience to survey based on national or local demographic data for project area (e.g., men and women, age rate, employed/unemployed, rural/urban, married/unmarried).
Research national and local demographic data on issues the study addresses (e.g., drug abuse, alcoholism, violence)	Study the demographics of populations who tend to exhibit risky behaviors (e.g., employment status, age range, literacy rate, geographical location, religion). If data are available, study the rates of alcoholism and drug abuse in light of STI and HIV/AIDS infection rates and prevalence. Inquire about the source of distribution of alcohol and illegal drugs.
Segment target audience into subpopulations of interest. Develop qualitative and/or quantitative instruments for focus group discussions, surveys, and individual interviews targeted at specific audiences	Address life styles, behaviors and attitudes, for example: • Alcohol consumption (frequency, location, feelings about drinking, attitudes towards consuming alcohol and sexual performance/enjoyment) • Nature of marriage (age of man and partner at marriage, length of marriage, was marriage arranged) • Nature of extramarital relations, if reported (frequency of condom use, use of condom during last sex, alcohol consumption during sex) • HIV/AIDS (experience with HIV testing, awareness of HIV serostatus, knowledge about HIV transmission and ways to protect self and partner from infection, communication with partner about HIV/AIDS) • Gender-based violence (justification, if any, of violence, past instances of hitting a woman, nature of alcohol consumption--if relevant--during such occasions, reasons for hitting a woman).
Train staff in research methodology and assessing research results	Determine capacity needs among staff. Inquire about professional organizations and

KEY STEPS TOWARDS FORMATIVE RESEARCH TO BETTER UNDERSTAND MEN'S SEXUAL RISK AND SEXUAL DYSFUNCTION	
	universities familiar with conducting such research and/or training staff in research methodology. Decide if staff will be trained or if survey will be conducted by technical experts. Provide supportive supervision for research staff. Include ethics and informed consent training if staff will implement research.
Use research findings to evaluate project success	Develop post-test assessments based on baseline survey and compare changes.

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Becoming a man and living up to the traditional or hegemonic model of masculinity is challenge that takes a toll on men's health and impacts women's well being when the traditional norms associated with manhood encourage behaviors that put men and women at risk. Socially reinforced assumptions that men know everything and that masculinity is synonymous with virility pose significant challenges for men, especially regarding their sexual performance. Such assumptions contribute to sexual dysfunctions and misinformation about what constitutes normal biological functions. For example, a study on sexual health problems among men in India found that Indian men spend large amounts of money seeking treatment "for symptoms such as wet dreams and masturbation. One estimate is that one out of every 10 Indian men is impotent and that almost two-thirds of cases of impotence stem from psychological causes" (Raju, 2000).

Assumptions about traditional models of masculinities also may lead to stigma and discrimination against men who do not conform to such models. Challenges remain in reaching boys who live on the street, men who migrate for work, and men who have sex with men. These men are often marginalized because of their lower socioeconomic status or non-traditional behaviors, and may engage in behaviors that confer a high risk of contracting STIs and HIV.

The project **Reaching Marginalized Populations: a Project on HIV/AIDS Prevention Among Men who have Sex with Men in the City of Lahore, Pakistan** describes a population alienated because of the sexual orientation of its members, which conflicts with rigidly upheld cultural norms. Through in-depth research that attempts to characterize the community, this project provides a wealth of information about the *Zenana* (men who identify themselves as women and wear mostly women's clothing) community in Bangladesh, India, and Pakistan. It exposes the violence *Zenana* suffer and the conditions under which they are willing to live rather than seek health care and

thereby risk revealing their sexual orientation. These men are powerless, a reminder that women do not have a monopoly in the struggle for equal power.

The **lessons learned** from this project are that:

- HIV/AIDS prevention in marginalized communities can never be effective in isolation;
- marginalized communities have inherent strengths as they learn to survive under adverse circumstance and these strengths can serve as guidelines and frameworks for designing holistic interventions
- a complete knowledge of the dynamics of the community is essential before undertaking a program intervention.

The three other intervention studies presented here summarize research that explores how drugs and alcohol affect men's and women's health, highlight the need to recognize marital sex as a dyadic event in HIV prevention programs, and look at the symptoms for which men seek health care. These three studies represent sub-sections of a larger Population Council-New Delhi study on sexual risk.

The research interventions described in this chapter were the only papers submitted on sexual dysfunctions, thus the Guide does not include examples of how this issue is addressed in other countries.

Research and Training Program on Alcohol and Sex Risk Behavior among Male Migrants to Mumbai summarizes aspects of the study that links the use of alcohol and drug use to sexually risky behaviors. Its goals and objectives were to:

- provide faculty and students of the International Institute of Population Services (IPPS) with background on migration, drug, and alcohol use and HIV in India;
- accumulate literature on this topic;
- train faculty and students in ethnographic research methods to identify patterns and processes of alcohol and drug use related to sexual risk taking;
- present results to interested public and private sector institutions and plan for community interventions.

To achieve these objectives, researchers used three approaches. They trained faculty and students in ethnographic research methods for assessing young men's attitudes about alcohol, their beliefs about sexuality, and expectations and behaviors. They conducted community-based research and assessments through pilot studies and disseminated their findings nationally in fora where they discussed the implications for research, practice, interventions, and policies.

Some research results that pertain to men and their health found that alcohol is associated with physical abuse and forced sex and that men believe alcohol and opiate use enhances their sexual performance. Furthermore, men who participated in the study reported that alcohol justifies the need for immediate sexual satisfaction. Such findings highlight the need for health professionals working with men to address the issue of substance use and abuse with their clientele. They should talk to men about men's and women's rights and

provide them with alternative means for enhancing their sexual performance. This includes developing meaningful and trusting relationships with their partners and communicating with their partners to find out what they enjoy. Discussions about alcohol and drug abuse are opportunities to talk to men about why they drink and what pleasures alcohol and drugs provide, and to explore how they can achieve these pleasures while being sober.

The **Gender Concepts, Marital Relationships, and Sexual Risk Behavior in Mumbai, India** intervention study worked with couples to reduce risky behaviors that contribute to spreading STIs including HIV.

The **goals and objectives** of this study were to:

- Describe sexual risk from the perspective of both married women and men in slum communities in Mumbai;
- Assess the risk of HIV/STI for married, monogamous women;
- Delineate the dynamics of the marital relationship that increase or reduce risk for HIV/STI transmission;
- Assess the potential of the husband-wife dyad as a unit for intervention for sexual risk reduction through a pilot intervention;
- Conduct community health education focused on risk reduction for the marital dyad;
- Determine the feasibility of developing a marital intervention resource network.

The study, which relied on in-depth interviews and surveys, found that even in the poorest communities, couples' intervention can be a viable approach to risk reduction. Although further research is necessary to identify the key factors that contribute to reproductive and sexual risk for wives and husbands, study results indicated that the marital relationship in both sexual and non-sexual manifestations has a significant impact on the reproductive health of women and men.

Men's Secret Illnesses (*Gupt Rog*) and its Relationship to Sexual Risk: A Case from India

Based on a paper submitted by Ravi K. Verma et al, *Men's Secret Illnesses (Gupt Rog) and its Relationship to Sexual Risk: A Case from India*, September 2003.

Implementing agencies: Population Council, New Delhi; Institute of Community Research, Hartford, CT; International Institute for Population Sciences, Mumbai (Bombay), India.

Background: India, with a population of 1.07 billion, has about 4 million adults living with HIV. According to the data of the National AIDS Control Surveillance, 83 % of the cases are transmitted sexually. More significantly, the epidemic is quickly reaching the general population. The sentinel data from the antenatal clinics suggest HIV prevalence rate among pregnant mothers is well over 3%. Yet another feature of the epidemic is that

the sex-ratio among AIDS cases is rapidly changing to favor women. The current sex-ratio is 3:1 in favor of men which about a year ago was 5:1.

It is evident that any effort to arrest the growth of the epidemic has to rely primarily upon changing men's risky sexual behavior. However, reaching men is a major challenge given the fact that India is predominantly a patriarchal society where men are not as easily accessible to interventions as women. They are the bread winners and therefore spend a significant portion of their time outside and away from home. Men enjoy greater freedom in terms of mobility and have access to resources; these two factors provide them with greater opportunities to engage in risky behaviors. Yet another important feature of the Indian society is that men mature and develop within a male dominated context, with little contact in the post-pubertal period with female peers and virtually no sex education. Under these circumstances, it is not surprising that most growing boys develop a misdirected sense of masculinity characterized by male sexual dominance, and unequal gender attitudes and behavior. It is not uncommon to find young men seeking to prove their manhood through visits to sex workers and other willing partners in the community.

A closely linked feature of this sense of masculinity among your men is the widespread presence of sexual health anxieties popularly known as '*gupt rog*' in India (DCT, 1999; Verma et al 2000, Pelto, Joshi and Verma 1999). Independent surveys completed by men and their women partners revealed a widespread presence of sexual health problems among men in the community. The survey forms submitted by men (44.3%) and by women (49.4%) reported on at least one of 12 symptoms of male sexual health problems (Verma et al 2003).

Pelto (1999) and later Verma and his colleagues (2001, 2003) classified various '*gupt rogs*' into two broad categories:

1) 'Non-contact' (e.g., involuntary loss of semen while urinating, lessening or thining of semen, nocturnal emission, premature ejaculation, masturbation, and problems with erections);

2) 'Contact' problems (e.g., STIs-like problems such as pus discharge, burning urination, gonorrhea, and syphilis).

These studies provided initial empirical evidence on the conceptual link between non-contact problems, contact problems, and sexually risky behaviors.

The results of these studies showed that men who are single or not living with their wives are close to two and a half times more likely to have non-contact problems than married men or those men who have had first sex with a women other than their wife. These studies also revealed that a large proportion of those who reported non-contact problems also sought treatment from various care providers. Among respondents reporting at least one non-contact problem, 25.5% said they had sought treatment. Of the 65 respondents that reported at least one contact problem, 61.5% sought treatment.

The present intervention research finds its rationale in these initial studies and outlines a study design that uses *gupt rog*--and sexual health providers who treat the *gupt rog*--as entry points to change risky sexual behaviors among men and reduce the incidence of STIs. The present intervention research is a collaborative effort among various agencies. The International Institute for Population Sciences (IIPS), Deonar, Mumbai, India, an apex demography research and training institution is carrying out the implementation of the intervention and related research. The other collaborators include: the Center for International Community Health Studies (CICHS) of the University of Connecticut School of Medicine, Farmington, CT USA; The Institute for Community Research (ICR), Hartford, CT; Population Council, New Delhi, India; The Department of Community Medicine, Nair Medical College, Mumbai; Committee of Resource Organizations (CORO), a community based NGO; National AIDS Research Institute (NARI), India; and OSB Diagnostics, Mumbai, India. The study has been carried out in different phases and funds were raised from various sources. Preliminary research (1999-2001) was supported by the Ford Foundation, New Delhi. The National Institute of Mental Health (NIMH), USA is supporting the current intervention research on men (RISHTA acronym for Research and Intervention in Sexual Health: Theory to Action 2002-2006) and on women; Population Council, New Delhi is supporting a nested study on youth risk behavior in the same communities.

Goals and objectives: The study aims to achieve the following major goals and objectives:

- Test the proposition that *gupt rog* is associated with higher rates of HIV/STI;
- Develop an intervention utilizing culturally based sexual health concerns that can attract men into HIV/STI education, sexual risk reduction and early identification of HIV/STIs;
- Further develop, test, and evaluate a culturally-based therapeutic approach to male sexual health problems termed “Narrative Intervention Model" (NIM) that can result in positive social, psychological, and health outcomes;
- Assess the relative efficacy of developing the NIM with the allopathic providers versus the Indian System of Medicine (ISM) doctors serving men with sexual health problems.

The Study Community: The present intervention research is set up in three large slum pockets in the north-eastern part of Mumbai. These slum pockets are also characterized by the presence of a large number of untrained health providers including sexual health providers. One can easily locate hoardings/wall-paintings and a range of advertisements claiming treatment for a variety of *gupt rog* in these communities.

Intervention approach: This approach involves implementing a treatment process called a ‘narrative intervention model’ by the sexual health providers, allopaths, and non-allopaths. Initial findings suggest that allopaths and non-allopaths use the practices listed in the table below while providing care to men suffering from sexual health problems (SHP).

Focus/component of care

	Allopaths	Non-Allopaths
Use patient "language"	No	**Yes**
Assess sexual health problem	No	**Yes**
Cultural aspects of SHPs	No	**Yes**
Psychological aspects of SHPs	No	No
Relationships aspects of SHPs	No	No
Syndromic recognition of symptoms	**Yes**	No
Referral-STI testing, medical treatment	**Yes**	No
Referral-psychological/social services	No	No
Education and risk reduction	No	No

Given the cultural underpinning of sexual health problems, this intervention proposes to shift the practices among allopaths and non-allopaths by converting all 'no's to 'yes'es in the table above.

The hypothesis is that changing the practices of health providers will lead to a greater change in risk behavior and thus reduce the incidence of STI among men in the community.

The study uses a three-arm intervention design as described below:

1. Establishment of an allopathic "male health clinic" in the public health facility in one experimental community plus positive sexual health messages to be disseminated through multi-media approaches;
2. Train Indian System of Medicine (ISM) providers on the use of Narrative Intervention Model in the other experimental community plus positive sexual health messages to be disseminated through multi-media approaches,
3. Control community with only positive sexual health messages to be disseminated through multi-media approaches.

Research design: The research design is characterized by the following major stages:

- Formative research that involved in-depth interviews with men in the community and providers and assessing the capacity of community-based organizations;
- Quantitative survey that involved conducting a baseline survey of 2,400 randomly selected men in the three study communities on KAP and STI testing for syphilis, HSV-2 (using blood samples) and chlamydia and gonorrhea (using urine and PCR analysis) for a subset of 640 men;
- Intervention phase that involved training providers, establishing referral networks, community based educational programs and pre-post treatment and six-month follow-up survey and STI testing for 640 patients drawn randomly from the male health clinic, the trained ISM providers and the untrained allopathic and ISM providers in the control community; observation and interviews with providers and patient exit interviews to establish integrity and acceptability of provider

approaches; data on men treated, service statistics; focus group and interviews with key informants on community health education;
- End-line KAP survey of 2,400 randomly selected men in the three study communities and STI testing of a sub-sample.

Indicators: Researchers used the following set of indicators:
- Reduction in the prevalence of STIs;
- Reduction in HIV/STI risk behaviors including an increase in condom use;
- Increased capacity (efficacy of treatment, referral, perceived skills) on the part of providers to treat sexual health problems;
- Increase in treatment-seeking among men with sexual health problems;
- Reduction in the consequences of sexual health problems including domestic violence, coercive sex, and marital discord;
- Increased utilization of available referral resources by providers and men in the community.

Preliminary results on the prevalence of sexual health problems and treatment-seeking from the men in community: The baseline survey of 2,400 married men inquired about their sexual health concerns, treatment seeking behaviors, and presence of STIs. Researchers also undertook a situational assessment of 245 providers in the community on the practices that they follow while treating sexual health problems. Reiterating earlier results, the preliminary results from the baseline survey revealed a significantly large presence of sexual health problems in the community with a considerably larger proportion of men reporting non-contact problems. About 69% reported having experienced wet-dreams as a problem and 18% said they had experienced involuntary loss of semen. There were distinct treatment seeking behaviors for the contact and the non-contact problems. About 53% of those who had non-contact problems went to allopathic doctors, 25.9 % to ayurvedic specialists, 18 % to chemists, and 2.8% to homeopathic doctors. While more than one-third of the respondents received zadibutty (local herbs and plants) as the medication for treatment, almost 59% of the respondents received English medicine. A much larger proportion of those who received zadibutti reported complete relief from the non-contact problems than those who received English medicine.

Among those who reported contact problems about 55% went to the allopathic doctors, 9.8% to ayurvedic specialists, 33.5% to chemists, and 1.4% to homeopathic doctors. While more than four-fifths of the respondents received English medication, one-fifths received other medicines or zadibutti.

Preliminary results reported by providers: A total of 245 providers belonging to various types of treatment systems (allopathic, ayurvedic, homeopathic, and unani) were interviewed to assess the patient load for sexual health problems, treatment practices, and willingness to participate in the intervention. Allopaths and non-allopaths saw on an average 13 (10 by allopaths, 7 by non-allopaths) patients with sexual health problems per month.

Practices used by the non-allopaths in treating patients with sexual health problems

- Non-allopathic providers use lab tests for diagnosis and allopathic medicines for treatment; however, these providers are not necessarily using the test and treatment in the correct contexts.
- The non-allopathic providers do not pay as much attention as originally thought to counseling and psychological/emotional issues.
- They usually refer clients for treatment after the treatment they are providing is failing.
- The most common non-contact problems were nocturnal emission, premature ejaculation, and masturbation. Masturbation is seen as an expression of losing sexual control and if not treated on time may lead to compulsive behavior and cause perpetual loss of semen which is considered a vital source of energy and strength. Men seek treatment for masturbation if they think that they are masturbating compulsively. In qualitative interviews, men mentioned different range of the frequency of masturbation that they considered as normal or abnormal. For some, anything more than three times a week was a problematic behavior and needed treatment. They also believe that excessive masturbation leads to the thinning of semen.
- The most common contact problems were gonorrhea, syphilis, HIV/AIDS, and cancroids.

Practices used by allopath providers in treating patients with sexual health problems

- The allopath providers saw the same problems as non-allopathic providers.
- They did not do much counseling (as with non-allopathic providers).
- They used primarily allopathic treatment for contact and non-contact problems and appeared to be using a lot of lab tests.

Activities undertaken: On the basis of the treatment practices, results researchers carried out the following activities:

- Developed a training module on treating contact and non-contact sexual health problems and on sexual risk behavior change;
- Developed a male health clinic and trained staff in association with Nair Medical College;
- Trained providers from the Indian System of Medicine (ISM) providers (on-going);
- Trained literacy staff from the Community of Resource Organization (CORO) in community education;
- Developed a referral network of service resources;
- Distributed condoms through male health clinics and ISM providers.

Stakeholders and their roles:

- As part of the Indian Council of Medical Research (ICMR) Committee, The National AIDS Control Organization (NACO) provided the approval for the study. The state level societies of NACO were kept informed about the progress.

- As a parent body of the institute, The Ministry of Health and Family Welfare approved the study.
- The Mumbai Municipal Corporation (BMC), Health Division was extremely helpful in providing community-based services. Its health outreach workers, working as key informants collected important clues about the community. In addition, its medical school, Nair Madical College, provided services to the male health clinic.
- The International Institute of Population Sciences (IIPS) provided infrastructure, manpower, and technical resources.
- The National Institute for Mental Health (NIMH) provided financial support.
- Community-based providers acted as key informants and helped enroll clients.
- Community-based organizations were key informants and provided the local infrastructure to carry out the study.

Obstacles and how they were addressed: The novelty of sexuality research and intervention at the Indian organizational base could have been problematic, but researchers addressed this by holding a series of preparatory meetings where they talked with all the stakeholders about the programmatic implications of the research. They also made sure that the rigor of the research and ethical considerations were highlighted in all the discussions. In addition, the participatory approach used in these meetings reduced apprehensions and encouraged constructive inputs.

Research conducted by an international group of researchers is difficult to undertake as they are likely to face skepticism while working on a local issue. Partner research organizations (ICMR, IIPS, and NIMH) had to be convinced that this study was a worthwhile undertaking.

The informed consent and ethical review process also had to be addressed. Major obstacles came from groups of researchers who were apprehensive in that by imposing the process of informed consent they would not get the cooperation from respondents; they also feared that most participants would avoid talking about personal issues. Rigorous training and field testing of the informed consent and relevant ethical processes removed all apprehensions, however, and the study was carried out with full ethical protocols.

Attracting men to complete the baseline survey was another challenge which researchers overcame by adjusting the timing of interviews according to times that were convenient to men. Hence, to reduce the refusal rate, the baseline survey had to be monitored and followed very carefully.

Drawing blood and urine for STI testing was addressed by first holding community meetings and talking with community leaders who in turn advocated for the need to participate in the study. Samples were collected in the communit, often in places of worship (Masjid or temples) or community centers. This increased the accessibility and also removed apprehensions.

Opportunities

- The current male focus of the HIV epidemic in India;
- The opportunity to link *gupt rog* concerns with HIV/STI;
- The concern that public health services do not address men's needs and need to be restructured;
- The importance of ISM providers in addressing men's health;
- The emphasis on HIV/STI prevention in Indian public policy sectors.

Lessons Learned

1. Launching such a study requires several steps to inform the community and its leaders and to train researchers from local institutions to undertake the research. Leaders of this study held a series of meetings with health officials from Mumbai Municipal Corporation (BMC) and opinion leaders at the local community level. Community surveys that preceded the intervention study made it visible and prepared the community to accept the intervention. A careful selection of sensitive and experienced field investigators and their thorough training also formed part of the ground work.
2. Complete transparency and strict adherence of ethical protocols enhances credibility. These principles were an integral component of the training extended to local researchers.
3. Apprehensions about sexuality research are not necessarily based on experiences, and if the research is carried out with sensitivity, people are willing to share their personal lives.
4. Providing feedback on research findings to important stakeholders at regular interval fosters their support and builds good rapport.

Chapter V
References

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Chapter VI
Successful Strategies in Reaching Men

This chapter highlights various strategies for reaching men, particularly young men, and for informing them about a number of reproductive health related topics, such as prevention of unwanted pregnancies, STIs and HIV/AIDS. Including men in information, education and communication (IEC) or behavioral change communication (BCC) programs is an effective way to inform them about their bodies and give them a comfortable environment to talk about their sexuality, to express their concerns, and to ask questions. Community wide awareness-raising campaigns or counseling sessions are other means to encourage men and women to discuss sensitive issues such as family planning and birth spacing.

This chapter is divided into three sections:

- IEC/BCC
- Peer education
- Communication and counseling

Each section is self-contained and summarizes programs that have been implemented using these strategies.

IEC/BCC	
KEY STEPS TO IMPLEMENTING a BEHAVIOR CHANGE CAMPAIGN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Needs assessment	Conduct knowledge, attitudes and practices (KAP) survey to identify issues to be addressed by the campaign. The survey should inquire about men's attitudes toward FP, men's involvement in MCH sexual behavior, their knowledge about how AIDS is spread, practices regarding communication and decision-making in their family, beliefs about gender equality, etc.
Develop campaign based on KAP results	Based on results of the needs assessment, choose themes to be addressed (e.g., use of FP is consistent with Islamic teachings).
Determine clear goals for the campaign	Based on results of the needs assessment, target audience and specify behavior change goals (e.g., enable married men to make informed FP decisions, enable men to limit their sexual partners, encourage married men to initiate discussions with their spouses on FP).
Design a campaign with multiple channels of communication	Create ads for radio, TV, and newspapers. Facilitate community mobilization sessions with religious, community leaders, and health

IEC/BCC	
KEY STEPS TO IMPLEMENTING a BEHAVIOR CHANGE CAMPAIGN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	professionals. Run national contests to test people's knowledge about an RH issues (e.g., FP, maternal care, AIDS, violence).
Monitoring and supervision	Monitor activities and their outcomes (e.g., number of radio programs, themes addressed, number of call-ins to radio station or to hot lines following a given program, number of men participating in contest, their knowledge, attitudes and practices based on answers to questions on entry forms). Supervise activities by undertaking focus group discussions with target community members and with health providers. This can provide necessary feedback on the quantity and quality of the campaign (e.g., if there enough posters visible, if the message clear and not offensive).
Evaluation	Develop and implement evaluation tools to measure program success. For example, conduct surveys of viewers and listeners that ask them about issues addressed in the campaign, what they learned from it, and the behaviors they have changed in response to the campaign. Conduct another KAP at the end of the campaign to measure changes in knowledge, attitudes and practices.
Get celebrities or popular political leaders to endorse the campaign	Enlist personalities that tend to raise the visibility of such campaigns, including musicians, actors, member of a royal family, television celebrities, etc.
Pre-test messages and materials associated with the campaign	Assure that messages are culturally appropriate and/or religiously acceptable. Test them with religious and community leaders.
Involve the private sector	Involve private companies to increase visibility and share costs. Companies are often willing to contribute prizes for contests.

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IEC is evolving into BCC in response to studies that consistently point to the wide gap between knowledge and action. RH programs have succeeded in informing people about how to protect themselves from STIs and avoid unintended pregnancies but have been less successful in turning knowledge into action. The following program aims to address this dilemma by including actions individuals and couples can take to plan their families and avoid STIs.

Men Win with Contests, Reaching Men through Entertainment Education (Jordan)

Implementing agencies: Johns Hopkins Bloomberg School of Public Heath/Center for Communication Programs (JHU/CCP), Idea International Center, and the National Population Commission, Jordan.

1. Background

Jordan's population growth is very high (TFR 3.8), compared with other Arab and Muslim countries (TFR is 3.5 in Egypt, 2.1 in Tunsia, and 2.6 in Indonesia), consequently burdening the economy and social service sector. Frequent multiple births are also taking a toll on the health of mothers and children.

Islam is a crucial force in Jordanian society. It shapes attitudes, impacts behaviors of Jordanians, and directly influences their decisions regarding all aspects of life including those related to FP and RH. Religious leaders are intimately involved as opinion leaders in the social networks that influence the decisions and actions of Jordanians at the local level.

Knowledge, Attitudes and Practices (KAP) survey: The Department of Statistics (DOS) conducted a national population-based study throughout Jordan on a representative sample in which 1,000 married women in reproductive age and 1,000 men married to women in reproductive age were surveyed. The results concluded that a lack of knowledge about Islam's position regarding the use of modern FP methods, their safety, reversibility, and effectiveness are barriers to their use. Furthermore, the study also identified two deeply rooted social norms that influence men's reluctance to use modern contraceptive methods: the preference for male children and large family size (The mean ideal number of children is 3.8).

The survey was crucial in identifying the concepts that the campaign should address and the most appropriate channels for conveying information about RH to men. It also identified geographical locations best suited for initiating such interventions. The first national family planning communication strategy was developed based on these findings. Its aim was to increase the participation of husbands in making RH/FP decisions and using modern contraceptives. The slogan by which the different communication interventions were identified was ***"Together for a Happy Family."***

2. Goals and objectives of the campaign

The main purpose of the campaign was to improve the results of the 1996 KAP survey. In addition, the campaign emphasized the idea that FP improves the quality of life of families and that a female child is as precious as a male child. The messages conveyed to emphasize the latter were: male and female children are god's gift and are of equal value; men are biologically responsible for determining the sex of the child; parents should treat their male and female children equally; and females have important roles to play in society. The objectives of the campaign were to:

- Provide married men with the necessary health, social, and religious information to enable them to make informed FP decisions;
- Encourage men to initiate discussions with their spouses on this issue.

Themes addressed: The following five themes were discussed and promoted during the campaign. Each theme was selected and designed based on the KAP study.

The use of modern FP methods is consistent with Islamic teachings. Clarifying Islam's position regarding the use of modern contraceptive methods is crucial to the acceptance of these methods by the people in Jordan. Furthermore, communicating that Islam allows birth spacing and that it is different from birth limitation was an important part of the message. Birth limitation is not allowed by Islam while spacing is. It was important to stress the fact that the campaign was promoting birth spacing and not limitation. Children are viewed by Islam as a gift from God and the main reason of happiness in life. Another important reason behind this differentiation is the political situation in the region that makes people in Jordan view children as an asset for the future and an important factor in social positioning of their family in the society.

*Modern FP methods are effective, safe and reversible***.** Health concerns were identified as one of the barriers to using modern FP methods. The campaign recommended couples consult with a health provider before starting to use a method.

Spousal communication on FP. Previous studies demonstrated the percentages of couples that discussed family planning issues was double among users of modern family planning methods compared to non-users.

Female children are as precious as male children. Preference for boys drives couples to have children until they reached their desired number of male children. The male child is considered a continuation of the man's name. A common belief is that the greater the number of male children, the greater the social support and position of the family in society. The messages relayed in the campaign conveyed the ideas that: parents should treat male and female children equally; Islam asks parents to treat their female child with the same respect and love as their male child; and girls have the same intellectual capabilities and rights as boys.

Family planning enhances the quality of life. Approximately 44% of men and 37% of women surveyed mentioned that FP improves the quality of life (representative sample of 1,000 married women in reproductive age and 1,000 men married to women in

reproductive stage). Emphasizing the message of planning a family is important to create social norms about the relation of family planning to the quality of life of the Jordanian family. In addition, this message may lay the groundwork to promote the idea of smaller family size in the future

3. Campaign Strategy and Design

The National FP/RH Contest was a part of the *"**Together for a Happy Family"*** campaign. The campaign used multiple communication channels and approaches: mass media, community mobilization sessions (CMS), and a national contest.

- ***Mass Media***: Five television and radio spots were specifically designed to convey the different themes of the campaign. They aired during prime time on Jordanian TV and radio. All the campaign themes were integrated into different related TV and radio programs.
- ***Community Mobilization Sessions***: 40 triadic teams conducted community mobilization sessions in five governorates (provinces or states). Each triad team consisted of a social worker, a Moslem religious leader, and either a trained gynecological or obstetric specialist. The Men's Involvement in Reproductive Health Survey (MIRHS) showed that 2% of respondents in these governorates reported having participated in such meetings. This was an achievement considering the challenge of organizing and conducting sessions that reached 20,000 men.
- ***National RH/FP Contest***: In addition to the above-mentioned channels, the National RH/FP Contest was designed using the entertainment-education (enter-educate) approach. This approach uses entertainment to educate people about specific topics and offers many advantages for health communication, as it has been used for educational purposes throughout history. Greek tragedies, parables in the Bible, songs and stories in every religion and culture present the conflicts and values of different societies in vivid, dramatic, and, above all, entertaining terms. Modern mass media carries on this tradition, reaching millions with popular radio and television shows that entertain and educate simultaneously. Johns Hopkins has used this approach for more than a decade to make health messages more appealing. Enter-educate has many advantages in promoting different health messages as it is persuasive, popular, and stirs emotion.

The National RH/FP Contest:

Stakeholders and their roles: The National RH/FP Contest was crafted carefully in partnership with Idea International Center and all the parties involved in the campaign with an endorsement from the Royal Family. Idea International Center is the private advertising agency that developed , conducted and monitored this campaign. Its design, content, and methodology took into account the personality of Jordanians, their sensitivity to these topics, and at that time, the absence of entertainment-educational approaches used in promoting health and social messages.

Themes of the RH/FP contest:

- Male and female children are of equal value;

- Spousal communication is important in making decisions about FP;
- Using modern family planning methods is consistent with Islamic teachings;
- Modern family planning methods are safe, effective, and their effects are reversible;
- Using modern FP methods enhances quality of life for the entire family as:
  - It allows more time for mothers to take care of their children's and their husband's health;
  - Smaller families enhances the economic status of the family, so parents are able to provide better education and care when pregnancies are sufficiently spaced.

In one of the community mobilization sessions, a father of 10 children talked about the problems his family faced in caring for such a large family and advised his peers to think carefully about having so many children.

Strategic design: The contest was designed to enhance and maximize the impact of the campaign and work in synergy with its other components. To participate, entrants had to complete four entry forms; each form included a paragraph with information about one of the campaign themes which were the basis for the answers to the four multiple choice questions contestants had to answer.

The contest distributed messages through four channels: advertisements in four daily local newspapers, mailings to all post office boxes (135,000) in the country, direct distribution through outreach teams, and e-mails.

Several promotional and public relation activities, such as teasers on TV, newspapers, posters, and give-aways contributed to increasing the visibility of the contest. It was launched in a well promoted, highly publicized ceremony attended by representatives of all the sponsors, media professionals, and representatives from other relevant national organizations. Over 100 prizes were awarded in a national ceremony under the patronage of Her Royal Highness Princess Basma. The prizes included 100 household electronics, five accounts at the National Bank of Jordan with an opening balance of 100JD, and two round trip tickets, one from Amman to Vienna and another to the Gulf. The winners' names were advertised in daily newspapers.

Throughout the life span of the contest, various pre-testing, monitoring, and supervision activities and techniques were held to maintain the momentum, to solve problems that might arise, and to analyze results on a regular basis. All the campaigns were field-tested on targeted audiences before an materials were produced. Religious leaders, media professionals, and selected policy makers pre-tested the materials and were consulted to assure that their content was culturally appropriate and religiously acceptable. The management team held weekly meetings to address and resolve problems. Community mobilization sessions were carefully coached and supervised.

The contest was fully sponsored by the private sector. Four private companies donated 107 prizes with a value of approximately US$32,000. Gatekeepers and stakeholders such as religious leaders, media professionals, health and social professionals, and private sector representatives were involved in its planning and implementation. This

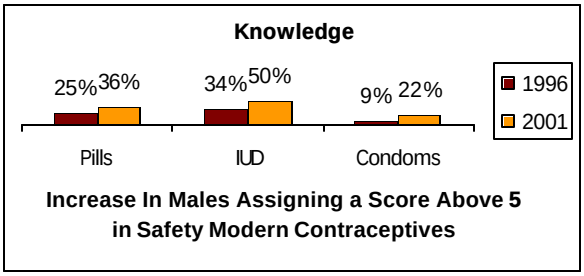
partnership, combined with endorsements, created the enabling environment required for the contest to achieve its objectives.

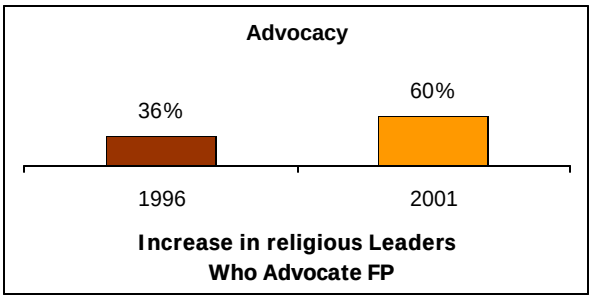
4. Results

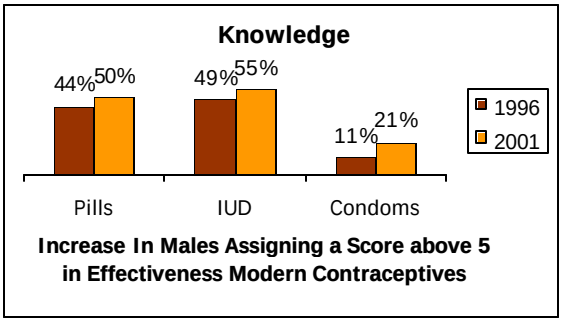
Two percent of the Jordanian population participated in the contest (around 100,000 contestants). Of the participants 60% were male and 40% were female. The largest age group that participated were 24-38 years olds (43%) followed by youth, those under the age of 24 (32%). More than half of the contestants were married (58%) but a large number of them were single (42%). Three quarters of the participants responded to the direct mailing and 92% of all contestants answered the multiple choice questions correctly.

Impact of the campaign:

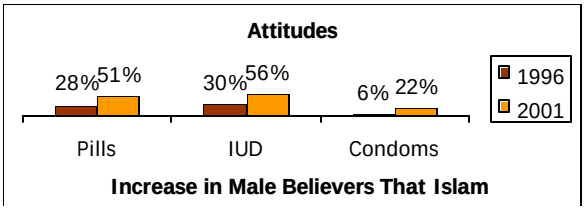
The ***"Together for a Happy Family"*** campaign markedly improved the knowledge and attitudes of Jordanian men and women regarding specific modern family planning methods. The 2001 Men's Involvement in Reproductive Health impact assessment Survey (MIRHS) shows that a significantly higher proportion of men considered the use modern family planning methods as safe, effective, reversible, and permitted by Islam. Accordingly, the number of men who cited the use of specific modern methods as forbidden by Islam and those who did not know the religious stance of specific methods decreased from 1996 to 2001.

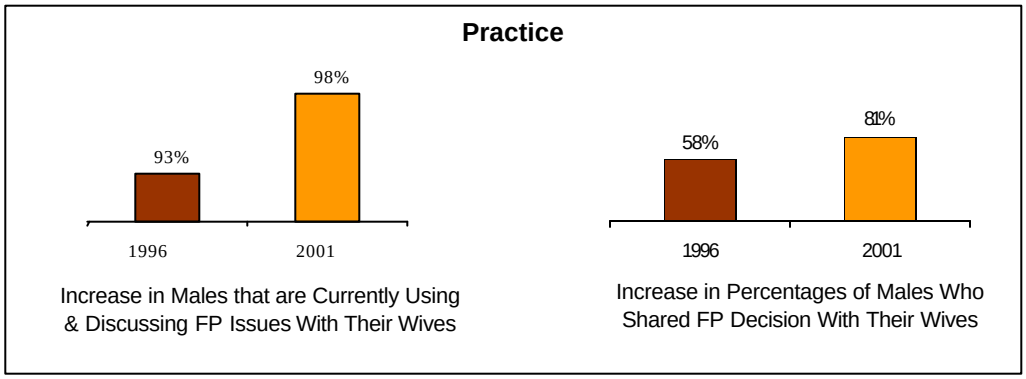






The proportion of men who used a family planning method and discussed it with their wives significantly increased from 93% to 98% ($P < .05$) between 1996 and 2001. Among women, however, the difference was not significant.





MIRHS survey respondents received a list of actions taken as a result of exposure to the campaign. Respondents ranked discussing issues with spouses and sharing decision-making as the top actions taken. Other actions included treating sons and daughters equitably and initiating the use of a family planning method.

Although the campaign did not directly promote smaller family size, it did promote the use of family planning to improve the quality of life of Jordanian families. Nevertheless, a comparison of the KAP survey with the MIRHS data indicate that the ideal family size declined from 4.3 in 1996 to 3.8 in 2001.

Gender preferences: More than 70% of respondents of the MIRHS survey said that the sex did not matter or said they wanted an equal number of boys and girls. However, men tend to prefer male children more than women do: 24% of the men said they wanted more boys than girls, compared to 16% of the women. A very small minority of men and women expressed a stronger preference for girls than for boys.

Youth Contest: The success of the enter-educate approach in promoting different health/social messages within the men's campaign prompted the National Population Council, with technical assistance from JHU/CCP, to offer another contest, on a larger scale, in the National Youth Program (*Youth 21*). The *Youth 21* program provided adolescents and young adults with information on reproductive and sexual health and life planning skills. The contest was designed and implemented by Idea International Center with technical assistance from JHU/CCP.

The enabling environment that was created during the National RH/FP Contest for men broke the culture of silence about such sensitive issues in the Jordanian society. This allowed the new contest targeting youth to be designed and implemented on a larger scale. The youth contest used more innovative channels to promote approximately 15 messages, many more than the four relayed in the men's contest. The youth campaign attracted more private sector involvement and participation (table 1 highlights the differences between the two contests).

LESSONS LEARNED

The findings described above demonstrate that, even in a country with strong traditional and religious beliefs, a well-coordinated large-scale reproductive health communication campaign supported by political and religious leaders, endorsed by the royal family, supported by the private sector, and designed in partnership with all parties can increase knowledge and positively change attitudes.

Table 1

Together for a Happy Family Men's Contest	National Youth Program Youth Contest
Total Budget	
80. 000 US $	145. 000 US $
Prizes	
107 Prizes ⟶ 25.000 US $	180 Prizes ⟶ 70. 000 US
Messages	
4	15
Channels	
- Newspapers - Internet E-mail - Post office boxes - Direct distribution	- Direct distribution (Promotional Distribution Points) - Web site/Internet - Newspapers - TV Spot - Youth 21 Radio show - Youth 21 TV show
Promotion	
- Posters - Teasing ads	- 3 Posters - T-Shirt - Caps - Bookmarkers - Pens - Promotion Distribution Points - TV teasers - Radio Teasers
Number of Participants	
94802	631042

PEER EDUCATION	
KEY STEPS TO IMPLEMENTING PEER EDUCATION PROJECTS	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Needs assessment	Conduct focus group discussions with youth, youth advocates, community leaders, teachers, and parents. Another useful tool is a Participatory Rapid Assessment (an intensive team-based qualitative inquiry to quickly develop a preliminary understanding of a situation). The needs assessment should also look at indicators such as pregnancy rates among young unmarried women, STI/HIV/AIDS prevalence, unemployment statistics among young men, etc.
Determine clear goals based on needs assessment	Based on needs assessment, target audience and specify behavior change goals (e.g., increase among in-and-out-of-school youth regarding RH, improve the capacity of Youth Unions to implement peer education.)
Involve youth in all aspects of the project	Involve youth in developing, implementing, and analyzing the results of the needs assessment.
Measure outcomes	Develop and administer pre- and post-tests with quantifiable indicators to measure change in knowledge and behaviors (e.g., do young ment consistently use condoms? Can they identify symptoms of syphilis, chlamydia, herpes, and HIV? How many and which modern contraceptive methods can they name? Do they think that men and women are equal? How many partners have they had in the last six months?) Develop and use management tools that track the number of youth served and specify the activities in which they participate.
Evaluation	Develop and use tools that measure outcomes so as to evaluate the project. Conduct focus group discussions and/or interviews with youth served, peer educators, and stakeholders to assess project achievements.

PEER EDUCATION	
KEY STEPS TO IMPLEMENTING PEER EDUCATION PROJECTS	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Work in partnership with other organizations who are working with youth, have experience developing programs for them, and involve parents and teachers.	Collaborate with NGOs working with youth and sub groups of youth (vulnerable, illiterate, in school, out of school, employed, unemployed, etc.). Partner with agencies knowledgeable about materials development and the audience targeted (e.g., NGOs that work with youth, NGOs that specialize in technical publications, MOH, MOE) international donors that can offer financial assistance and technical assistance (e.g., USAID, UNFPA, UNICEF, private foundations). Work with MOH if applicable and feasible. In some cases MOH may have material available. Keep parents and teachers informed of what youth are learning (e.g., adult ed workshops on RH).
Training	Train youth leaders about RH issues including puberty, conception, safer sex, sexuality, and AIDS. Expose and train youth leaders in the use of various media to inform about RH such as interactive exercises, films, dramas, and IEC/BCC campaigns.
Monitor	Conduct on-site, on-going supervision of peer leaders. Give peer leaders constructive feedback to strengthen their skills. Meet regularly with project staff to exchange feedback and make needed adjustments.

To access a presentation, click on the title of the presentation.

Peer education is particularly popular in adolescent RH programs. There are clear indications that youth are more willing to listen and share experiences with peer leaders who speak their language and share a common culture than with adults. The following two programs emphasize peer education.

Addressing Adolescent Males' SRH Needs Through the Creation of Male Peer-educator Groups, Belarus. The **lessons learned** from this program suggest that such programs could benefit from the participation of health specialists such as psychologists and medical professionals who could meet with young people, alongside their peer leaders, to address specific issues related to physiology, psychology, and sexuality.

Impact of a Peer Education Intervention on Gender and Reproductive Health among Vietnamese Youth.

Implementing agencies: Population and Development International, Family Planning Australia, Academy for Educational Development (AED), and Consultation of Investment in Health Promotion (CIHP).

1. Background

The project was conducted in Cualo in the Nghe, a coastal area in central Vietnam during a period of urbanization triggered by tourism. Most of the people in the province are classified as having an average socio-economic status (49%), another major sector of the population is better off (39.2%), while 7.9% is poor and 3.9% is rich. (Ministry of Labor, Invalid and Social Affairs (MOLISA), Vietnam: people earning less than 10$ per month are classified as poor.)

Boys have a higher level of education: 65.7% finished high school and went on to higher education compared to 52.5% of the girls. The first case of HIV was detected in Vietnam in 1989. By July 2003 there were 63,361 HIV positive cases; 9,802 people living with AIDS, and 5,349 deaths from AIDS. The rate of induced abortions among single women was 21% (about 150,000/year).

2. Project goals

The goal was to reduce the health and social consequences of risk behavior among Vietnamese youth in the intervention area. The two main objectives were to:

- Increase knowledge among youth regarding reproductive health and other health matters, and increase their ability to make positive decisions affecting their health and lives;
- Improve the capacity of the Vietnam Youth's Union (VYU) to manage and implement peer educations RH programs to facilitate expanding the project throughout the national VYU network.

3. Project Design

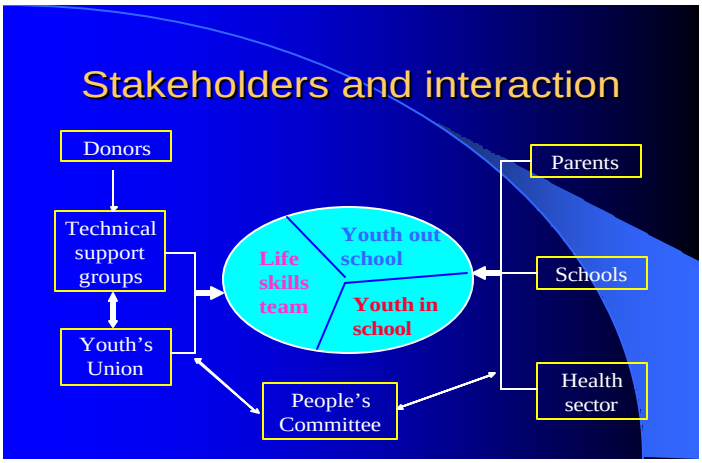
The needs assessment informed the design, planning, implementation, and evaluation phases of the project. A Participatory Rapid Assessment was used to collect data on the socio-economic situation and reproductive health of young people aged 14 – 25, and identify issues they face and their needs in terms of life skills, reproductive health, and HIV/AIDS prevention. Results of the assessment were the basis for defining young people's roles in community development programs and building an appropriate model of group activities for effective reproductive health communication. Staff of the Youth

Union, representatives from different organizations and agencies, and youth participated in the needs assessment.

This project relied on a peer education strategy, using a participatory approach in working with its target audience, in-and-out-of-school youth. The project had four main components: IEC development and training of trainers; training team leaders; life skill team meetings; and life skill teams carrying out their activities (e.g., peer education and IEC campaigns).

Stakeholders and their roles: There were many stakeholders participating in this project and the coordination was not always easy.

- The technical groups worked closely with local Youth's Union to help them implement the project step by step. Youth's Union is a nation wide association centrally organized with networks at the provincial, district, and commune level. Its membership includes youth who are interested in joining and who fulfill the criteria.
- The local People's Committee coordinated different sectors to work with the youth. This is a governmental organization which works at the provincial, district, and commune level.
- The life skill teams, with the support from the health sector, teachers, and parents worked directly with youth in and out of school.



Training: Youth leaders at the commune, district, and provincial level received training on project management, gender issues, IEC development, and training of trainers. Initially, gender issues were addressed as a separate topic in training sessions, but due to limited time and resources, this unit was dropped. This is a common problem not only in this project but in other intervention projects in Vietnam. However, gender issues were mentioned in relation to other topics like FP or prevention of STIs.

Team leaders were trained in ten topics which include: friendships and relationships; love and interaction skills; physical changes at puberty; psychological changes at puberty; conception and unwanted pregnancy; sexuality; safe sex; contraceptive methods;

STIs and HIV/AIDS; composing songs and dramas for IEC campaigns; and IEC campaign organizational skills.

Activities: Three main activities are carried out by the life skill teams:
- Educating team members on 10 topics through team meetings;
- Conducting IEC campaigns: outdoor performances with songs, dances and dramas;
- Counseling other youth by team members.

4. Results

The data from pre- and post-surveys show that boys' and girls' knowledge improved across many topics. However, as gender issues (joint decision-making, open communications, and conflict resolution, for example) were not clearly emphasized, the surveys respondents' attitude about some general issues of gender remained unchanged. Though some life skills were taught, both boys and girls continue to be embarrassed about asking for or buying condoms. It is worth noting that there was a slight increase in the percentage of girls who approved of premarital sex. This may be due to the fact that in the first survey--before trust had been completely established--some girls hid their opinions. Other significant results were:
- 14 new cases of HIV were identified in the last year, in comparison to 22 the previous year;
- Local health centres reported that termination of pregnancy among young women decreased by 20% over the past year;
- Effective planning and management systems were established and run by Vietnam Youth's Union, including financial management;
- The project profited from an enabling environment in which the MOH has integrated adolescent RH (ARH) as a component of RH strategies.

Obstacles and strategies used to overcome them	
Obstacle	***Strategy to overcome it***
The age range of 15 to 24 year olds is too large and difficult for group discussions	Break into smaller groups with different focuses
Girls feel it is difficult to talk to boys about some topics	Give girls more practice to talk in smaller groups
Some topics such as gender and sexuality are still sensitive to youth and their parents	Develop campaigns on specific issues to build common awareness

LESSONS LEARNED:
- Participatory needs assessment and planning increase the ownership of youth.
- Community support from parents, community leaders, and local agencies is essential to ensure the participation of youth.
- Selecting team leaders is important to maintain the life skills team and its quality of activities.
- Gender issues, such as joint communication, decision-making, and conflict resolution should be explicitly introduced in the training contents.

- Involving the Youth's Union was beneficial for several reasons: a) it has a large network that extends from the central to the commune level; b) its young staff tends to be enthusiastic and is capable in carrying out social activities; c) it is effective in reaching youth and implementing a peer-education strategy due to its familiarity with the skills and needs of its members.

COMMUNICATION AND COUNSELING

This section does not include a chart summarizing key actions for projects that focus on communication and counseling as these methods tend to be integral components of IEC and service delivery programs. Please refer to the IEC/BCC chart at the beginning of this chapter.

The studies summarized below conclude that:
- The right to privacy is a major challenge in male involvement programs. Providers should ask the client for consent, privately, before including the client's partner.
- Men will attend counseling sessions regardless of whether they are for men only or for couples.

Addressing Gender Issues with Men and Couples in a Reproductive Health Service in Ecuador: a Case Study in Organizational Change

This case study looks at the program implications of adapting clinic-based services to include men. One of the **lessons learned** is that the right to privacy is a major challenge in the male involvement strategy. APROFE (Asociacion Pro Bienestar de la Familia Ecuatoriana) achieved universal compliance with procedures that ask, privately, for the female client's consent before including her male partner. Another lesson pertains to the "gendered dynamics that affect health" in that discrimination, power imbalances, and gendered norms about sex are some of the root causes that put men and women at risk of STIs.

Involving the Men: Condom Promotion among Groups of Men vs. Couples: A Randomized Study in Zimbabwe)

Based on a paper presented by Margaret Mlingo, *Involving the Men: Condom Promotion among Groups of Men vs. Couples: A Randomized Study in Zimbabwe,* September 2003.

*Implementing agencies, stakeholders and their roles***:** University of Zimbabwe and the University of California, San Francisco (UZ-UCSF) Research Program provided the human and material resources needed to design and implement the study; the Chitungwiza and Harare Municipalities, with whom the UZ-UCSF Program has enjoyed a long-standing collaboration, granted permission to recruit participants from their clinics; the Zimbabwe National Family Planning Council (ZNFPC) provided support and a facility where the study was conducted; the UZ-UCSF Community Advisory Boards (CABs) in Harare and Chitungwiza represented the communities where the study was conducted. These CABs were involved in protocol development and implementation, and

communicated the concerns of people in the community to the researchers in the UZ-UCSF Program. Family Health International assisted with protocol development, monitoring, data analysis, and preparing reports.

1. Background

The study was conducted in Zimbabwe; the research sites were in the peri-urban and urban communities of Harare and Chitungwiza. The combined population of the two settings is 3.5 million.

According to the latest Zimbabwe Demographic Health Survey (1999), the adult literacy rates are estimated at 91% for males and 82% for females. Maternal mortality rate for Harare is 331/100,000 live births; however, this estimate is not very reliable because of incomplete notification of maternal deaths, especially for women who die at home (Majoko, 2001). The rate of unwanted pregnancies is 86% for youth and 34% for adults (Phiri, 2000; Johnson, 2002).

HIV/AIDS is one of the most serious public health challenges in Sub Saharan Africa. According to the most recent report from UNAIDS on HIV in Zimbabwe, approximately 25% of 18-49 year olds are HIV +; 33% of pregnant women are HIV +; 72% of persons with STIs are HIV +; 65% of hospital admissions are HIV-related. Life expectancy in Zimbabwe is estimated to be 35 (UNDP, 2003); this is down from a life expectancy of 60 in 1998.

As in most cultures, gender norms in Zimbabwe are deeply rooted in Zimbabwean culture. This society is patriarchal and the boy child is considered more important than the girl child as he symbolizes family continuity. The boy child is socialized toward decision-making processes, while the girl child is brought up to be subservient and a conduit of the society's values. Because men are ascribed with power over women, men decide on the size of the family, the method of family planning, and when to have sex. A husband can refuse to have sexual relations without any consequences and yet such refusal by a wife results in divorce. In 1990, the ZNFPC began targeting their campaigns towards men, rather than women (Zimbabwe, 1999), after realizing that men had a greater role to play with regard to contraception and family size (Zimbabwe, 1999).

Culturally, female ignorance of sexual issues is considered a sign of purity, and women are not socialized to discuss sexual issues (Zimbabwe National HIV/AIDS Policy, 1999). Girls should remain virgins until marriage whereas men are expected to enter into marriage with requisite experience acquired through multiple sex partners. Zimbabweans are taught that men should dominate during the sex act, and women should please men sexually and bear children. Women have gone to the extent of using herbs and other products that are meant to dry and tighten their vaginas in order to please men (Braunstein, 2003). In addition, and despite legal prohibitions, women are entrenched in customary practices that have consequences on their sexual freedom, such as pledging a young woman to marriage with a partner not of her choice, offering a young girl as compensatory payment in inter-family disputes, or forcing a widow to marry a late husband's brother.

Violence against women, especially wife beating, is very common in Zimbabwe. Domestic violence accounted for more than 60 % of murder cases tried in the Harare High Court in1998 and in Zimbabwe, as a whole, one woman in every four suffers some form of violence (Musasa Project, 1997). Some aspects of gender violence are culturally condoned in that they are perceived as within the bounds of what is culturally expected of men (National HIV/AIDS Policy, Republic of Zimbabwe, 1999; 31).

There are also gender inequalities in education. If a family is unable to pay fees, it is most often the female child who does not go to school. According to the 1998 UN Development Programme's Human Development Report, fewer girls than boys attended secondary education.

UZ-UCSF Research Program: The UZ-UCSF Research Program is a collaborative research program between the University of Zimbabwe and the University of California, San Francisco. Researchers from several departments have been collaborating on reproductive health research for the past eight years. The program also collaborates with CABs, in each community where research takes place.

2. Objective

The overall objective of the UZ-UCSF Research Program is to conduct clinic-based and community-based, qualitative, and quantitative research projects on RH and HIV prevention among adult women, men, and adolescents in Zimbabwe.

Rationale and history of the Study: The Condom Promotion and Counseling Study were initially slated to be a microbicide preparedness study for Nonoxynol–9 (N-9). However, following the release of preliminary results indicating that N-9 did not protect against HIV, the N-9 trial was cancelled and converted to a condom promotion study in which 551 HIV-uninfected women were enrolled and counseled to use condoms with their male partners. Participants in the study were followed for 14 months. The female study participants and the CABs requested that the men be involved in the research as it is difficult for a woman to bring up RH issues with a man without threatening his superior status. Male partners of female study participants were added to the ancillary study.

For just under US$28,550, granted by USAID through FHI (Family Health International), UZ-UCSF added this ancillary study on male involvement. The project was implemented in four phases. The four month preparatory phase entailed obtaining regulatory board approvals, sensitizing communities and CAB members, hiring staff, developing data collection forms and counseling materials, and conducting three two-day training workshops for the staff. The second phase involved recruitment and data collection followed by data entry and clearing. The last phase involved data analysis (which is on-going). The study was monitored internally by study coordinators and externally by FHI study monitors.

Objectives of the Ancillary Study: The ancillary study proposed to evaluate:

- Whether the male partners of the female study participants would come to the clinic for condom counseling if invited by their female partner;
- Whether male-group counseling *or* couples counseling was more acceptable to the men and women;
- What effect the male-group counseling and couples counseling would have on condom use.

3. Design

343 HIV-uninfected reproductive age women attending postnatal clinics and participating in the Condom Promotion and Counseling Study were enrolled into this ancillary study and randomized to invite their male partner to attend either one male group condom counseling session, *or* one couples condom counseling session. This number was reduced from 551, in the original study, as some of the women had exited the Condom Promotion and Counseling Study by the time the ancillary study was conducted and 59 women refused to participate. Women received an invitation letter that they took home to their partner.

Male and female participants completed standardized questionnaires before and after the male groups and couples counseling sessions which included information on socio-demographic background, sexual behavior, contraception, pregnancy, STI history, condom use, and attitudes about the counseling session.

Key outcome indicators:

- number of women who thought that their partner would attend the counseling session;
- proportion of invited men who attended a counseling session;
- men's attitudes after the counseling session;
- women's actual condom use, reported before and after the counseling session.

4. Preliminary Results

Socio-demographic and behavioral characteristic at baseline in the two randomization groups were compared to determine if randomization was successful. There were no significant differences between women randomized to the couples counseling session and those randomized to male group counseling. Similarly, the men in each randomization group did not differ.

Demographics and Sexual Behavior

Baseline socio-demographic characteristics and sexual behavior are summarized by sex. The median age among women was 28 years, and among men 32 years. Less than half of the women were employed, compared to over 90% of the men. This included both formal and informal forms of employment. About two-thirds of the men and two-thirds of women reported using condoms during the seven days prior to their baseline interview.

Attendance and Attitudes

Overall attendance by men was surprisingly high, with 141 men, or approximately 41% of invited men, attending a condom promotion session. Researchers expected men to

have a preference for one kind of counseling session over another; thus, it was surprising to find that the men were evenly split between their attendance for the male group and the couples' condom counseling sessions. All of the men, regardless of the intervention group, indicated that the counseling would increase their condom use.

	Group	**Couples**
Percent of men attending	42%	40%
Percent of men who thought counseling would increase their condom use	100%	100%

Impact of Intervention

Both before and after the male counseling intervention, researchers interviewed women about their condom use over the last seven days and the last time they had sex. Although there was an increase in condom use following the couples counseling session, these increases are statistically non-significant.

	Group	**Couples**
100% condom use, last 7 days: – Baseline – Follow-up	67% 66%	68% 79%
Condom use, last act: – Baseline – Follow-up	81% 77%	77% 87%

CONCLUSIONS and LESSONS LEARNED

Call from community to involve men in research: the community and participants supported the program objectives. The only complaint received was that the ancillary study was based on men's desire to be involved rather than being an integral component of the original study design.

Men want to be involved in HIV prevention efforts: additional research is needed to determine how to increase the involvement of men in reproductive health and HIV prevention efforts.

A flexible schedule is needed to accommodate men and their schedules (e.g., evening and weekend clinics): as men are less available during the weekdays, a varied schedule could potentially improve their participation in reproductive health and HIV prevention programs.

*Group assignment did not influence male participation: t*he study shows that group assignment (male group counseling vs. couples counseling) had little impact on men's interest and involvement. Both groups had similarly high levels of participation.

*Couples counseling modestly increased condom us; h*owever, participating in condom counseling and promotion activities did not necessarily equate to increased condom use, which could be due to the small sample size and/or already high baseline rates.

*More research is needed to demonstrate impact of increased condom promotion: a*dditional studies are needed to examine ways to harness men's enthusiasm and increase their envolvement.

Chapter VI
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Chapter VII
Successful Approaches in Educating or Changing Men's Attitudes

This chapter describes different approaches to reach men:

- Approaches to reduce gender-based violence among men
- Community-based approaches
- Employment-based approaches
- Military services
- Service delivery-based approaches
- Sports-based and other youth-based delivery approaches
- Media approaches

Each section is self-contained and summarizes programs that have been implemented using these strategies.

APPROACHES TO REDUCE GENDER-BASED VIOLENCE (GBV) AMONG MEN	
KEY STEPS TO IMPLEMENTING PROJECTS THAT AIM TO REDUCE GENDER-BASED VIOLENCE AMONG MEN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Needs assessment	As gender-based violence is a sensitive topic, and one that puts women at risk, data on this public health issue is only beginning to emerge (see *World Report on Violence and Health*, WHO 2002). Conduct well structured focus group discussions (e.g., clearly define the objectives of the inquiry and how the information obtained will be used) and assure participants that all the information obtained is confidential. A useful tool for designing a needs assessment is *Putting Women First: ethical and safety recommendations for research on domestic violence* (WHO, 2001) www.who.int/docstore/frh-whd/PDFfiles/Ethical%20Guidelines2.pdf

APPROACHES TO REDUCE GENDER-BASED VIOLENCE (GBV) AMONG MEN	
KEY STEPS TO IMPLEMENTING PROJECTS THAT AIM TO REDUCE GENDER-BASED VIOLENCE AMONG MEN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Design project based on needs assessment	Determine the **audience**(s) to be addressed (e.g., young men, married men, men only, couples, police force, men in the military, sports teams, prisoners, faith-based groups). Determine the **approach** (e.g., discussion groups, training workshops, community mobilization activities, inter-generational discussions, media campaigns). Determine the **issues to address** (e.g., socialization of boys, challenge existing norms of masculinity, raise awareness of difference between aggressive and assertive behavior and their consequences, explore issues of power dynamics). Projects can be single or multi-faceted. For example, address single or multiple audiences or use one or several approaches.
Determine project goals	Project can aim to **change behaviors** among individuals (e.g., reduce the rate of GBV among married men); change societal and/or institutional **norms** (e.g., hold men accountable for sexual harassment, train police force to understand gender dynamics and not to blame the victim, integrate gender-based violence in RH services); and/or change **policies** (e.g. recognize rape in marriage, penalize men who are violent against women).
Design training materials	Training materials should focus on issues addressed in the project (e.g., inform on different types of violence—psychological, physical and sexual—anger management, conflict resolution) and target specific audience(s) (e.g., adolescent boys, married men, community leaders, policymakers).
Train trainers	Include refresher courses in project design for trainers.
IEC/BCC and media campaigns	See table in chapter VI (under IEC/BCC)
Monitoring	Conduct supervisory visits to observe staff

APPROACHES TO REDUCE GENDER-BASED VIOLENCE (GBV) AMONG MEN	
KEY STEPS TO IMPLEMENTING PROJECTS THAT AIM TO REDUCE GENDER-BASED VIOLENCE AMONG MEN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	implementing activities. Hold regularly scheduled meetings with staff to collect feedback. Track number of workshops, discussions groups, training sessions held, and number of men who attended and topics discussed.
Evaluation	Conduct pre- and post-tests that inquire about men's attitudes toward women (e.g., under what circumstances is violence against women acceptable? Are rape victims "asking for it"? Does rape in marriage exist? Is sexual coercion a form of violence against women?) Conduct focus groups with project participants to assess impact of project on them. Survey partners of men who participated in the project to find out the partners they see changes in behaviors. Interview policymakers of organizations participating in the project to assess changes in policies among organizations involved in the project (e.g., police department, armed forces, schools, clinics, youth centers).

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Intergenerational Dialogue on Gender Roles and Reproductive Health

The German Technical Cooperation (GTZ) project is a multi-country program to discourage female genital mutilation that fosters dialogues between older and younger men and in turn catalyzes discussion among men and women on various gender related topics, including violence against women. This presentation describes the GTZ program in Guinea, West Africa.

Implementing agency: *Deutsche Gesellschaft für Technische Zusammenarbeit* (German Technical Co-operation, GTZ) commissioned by the German Federal Ministry for Economic Cooperation and Development (BMZ), www.gtz.de/FGC

1. Background

The project started in 1999 in response to requests from several partner countries of the German government in West and East Africa. In Guinea, a small country in West Africa, the intergenerational dialogue was initiated and piloted in 2002 as an innovative approach to open a constructive dialogue on this sensitive issue between the younger and older generations. Here, partner organizations and community groups expressed the need to better take into account the fact that people link female genital cutting (FGC) with other reproductive health matters, such as gender and power issues, the threat of HIV/AIDS, and adolescent sexuality. Slogans like "communication rather than information," "dialogue, not lecturing," "participation rather than confrontation" not only characterize the situation the anti-FGC or anti-HIV/AIDS campaign found itself in, they became guiding principles in the development and design of the intergenerational dialogue. However, this approach does not happen in isolation. It is part of a more comprehensive behavior change communication strategy which addresses community groups at different levels, with different approaches and differing intensity.

Stakeholders and their roles: GTZ NGO partners including *Fraternité Medical de Guinée* (FMG), the *Association des Femmes pour l'Avenir des Femmes*, the *Cellule de Coordination sur les Pratique Nefaste (CPTAFE Labé and Faranah)* or the *Association Aide pour la promotion des Femmes* are grass root initiatives working at the community level to address a broad range of topics around health, education, empowerment, and community participation.

2. Objectives

The multi-country project *Promotion of Initiatives to End Female Genital Mutilation (FGM)* supports governmental as well as non-governmental organizations working to end FGM in West and East African countries. It provides technical assistance to its partners in implementing their programs and activities. This project also helps identify promising approaches and practices that stimulate a process of rethinking traditional attitudes about this issue and changing relevant behaviors.

3. Project Design

Initial work on FGC in different communities in Guinea found that condemning FGM did not affect attitudes, behaviors, or practices either in communities or among “anti-FGM activists.” Thus, it emerged that initiatives that center on public outcries may threaten the long-term measures of efforts to abandon this traditional practice. As a consequence, the community asked for a dialogue-centered, interpersonal approach which would enable them to discuss these sensitive matters in more depth.

The intergenerational dialogue first began with a four-day workshop in Guinea's capital, Conakry, where young and elderly women met together to discuss topics and problems that are important to them. Participants were selected by the organizations that either already knew them from their work or they were recommended by their communities. The young women were unmarried, between the ages of 16-20, whereas the older women were married and were over 60 years old. Some of them were already grandmothers with

teenage grandchildren. This criteria for selecting participants was also adopted for the later workshops with young and elderly men. Most of the elderly men had key positions of respect and power in their communities.

Trained local staff members moderated the process and promoted understanding between the two age groups. The generation dialogue was conducted in the local language of a given area. Written training materials were not used, as most of the older women and men cannot read or write and are not used to workshop settings. The dialogues were held in local facilities which were close to the communities and did not isolate participants from the context of everyday life.

The following main steps characterize the method:

"Get to know each other": Similarities and differences between generations are initially identified and discussed in small peer groups. Participants then engage in private, two person talks to stimulate curiosity and give both parties something to think about. In a next step, exchanges between generations--using proverbs, music and songs, religious metaphors, and role-play--facilitate the sharing of information about the course of their lives.

"The road of life": Everyday objects illustrate the life style of the two generations: traditional objects (items used in life-cycle rituals) represent important stages in the life of each generation.

Traditional customs and religion are seen by the older generation as the regulating and stabilizing frame of a life that is intact and value-oriented. In contrast, modern music and dance as well as other items from modern life (e.g., condoms, cigarettes, alcohol) represent the stages of life of the younger generation. These customs and life rituals are used in dramatization and role playing. For example, the use of drugs and alcohol as well as premarital sex, contact with sex workers, or a lack of a perspective for the future lead to the young male hero ultimately dying from AIDS.

As the discussion between the young and the older generation unfolds and controversial subjects arise, moderators and participants work on practicing the new forms of appreciative dialogue and ways of talking to one another. Moderators encourage participants to seek common solutions to resolving conflicts.

"Practising intergenerational dialogue in the community": Accompanied by the moderators, the participants try out the new forms of dialogue with their families and in their neighborhoods. The older men talk about their experience with the dialogue and the issues covered in school or at the mosque; for instance, a participant reported that HIV/AIDS and condom use was raised at a Friday prayer.

After *"trial dialogues"* between the generations, the process continues: participants meet again after one month in a two day workshop setting to discuss their experience with their newly-gained information and skills. The issues most commonly addressed are:

- Did they succeed in starting up a dialogue in their own surroundings?
- What problems cropped up in the process?
- What changes have come about for them?

"The gender dialogue": After initial experiences with the intergenerational dialogue, participants feel a strong desire to discuss important issues with the other sex. The second day of the workshop provides men and women of the same age group the opportunity to begin a dialogue. The floor is then open for topics that were discussed in the intergenerational, same sex groups held before. The older women, in particular. question male behavior and insist on a more positive attitude towards women. But the young women also demand that:

- Married older men stop buying young women for sexual services;
- Men cease to exercise violence against women and girls;
- The practice of forced marriage or marriage by abduction be abandoned;
- Young men marry girls who did not undergo excision (FGM);
- Fathers care more about their children and their education;
- Men accept condom use in order to protect their female partners from HIV/AIDS.

By exchanging their views and perspectives, men and women of the two generations experience for the first time the value of appreciative communication across the boundaries of age and sex. Agreement is obtained about the need to further reflect on the issues that were addressed and to continue dialogue within one's family and among peer groups. The "gender dialogue" initiates a process of rethinking gender relations and fosters understanding between men and women of both age groups.

"Continuing the dialogue": same sex intergenerational groups meet again on a regular monthly basis to continue the dialogue and encourage a process of exchange and understanding. The aim of the intergenerational dialogue: increase communication and appreciative dialogue in the families and personal lives of participants on issues around sexuality, gender, and reproductive health.

4. Results

At times, the process emerges the fact that the generations are "worlds apart". For instance, young men depicted their lives in upsetting or dismaying terms which were in sharp contrast to the harmonious pictures presented by the older men. Young men expressed their disappointment and a sense of hopelessness inferring an increase in their risk-taking, fatalism, and violence. They accused the older generation of having "double standards," that is, a "moralist" religious orientation coupled with the practice of extramarital relations with young, unmarried girls. Young women expressed the need for education of the girl child; expressed their disapproval of traditional practices like FGM or arranged or forced marriage; question the high social value attributed to female obedience to the male partner; and resent the pressure they feel when submitting themselves to the sexual demands of their boyfriend in order not to lose him to another girl.

Differences in the thinking of the two generations arose with regard to:

- Premarital and extramarital sexual relationships;
- The threat of HIV/AIDS and the necessity versus condemnation of condom use;
- Polygamy and the sexual desires of old men;
- The role and presence or felt absence of fathers;
- The value of female subjugation to spouse;
- Intra-family, partner violence.

Initial results of this pilot approach are visible in Guinea and indicate that some impact will most likely occur over time. Participants stated that they felt some positive effects right after the first introductory round of the generation dialogue. For example they stated that:

1. Silence in the face of differences and conflict became obvious;
2. Old and young became aware of the need for and benefit of more open communication;
3. Old and young together arrived at possible solutions;
4. Dialogue within one's own family was easier.

As a consequence, further generation dialogues were demanded by the population:

- Participants of the first female intergenerational dialogue, who were enthusiastic about the experience, also wanted their partners or key male family members to undergo the experience. Hence, the male generational dialogue setting was conducted.
- Female participants also stressed the need to discuss sensitive issues with their male counterparts in order to be able to successfully change matters in private and public life. Thus, the gender dialogue came into life.
- Older male participants were especially concerned about the obvious disorientation and frustration of the young men whose perception of life did not at all correspond to their idealistic view of religion or traditional customs as the frame of life. They realized the need for improved and more frequent communication between the age groups.
- Ministries and partner NGOs in Guinea are asking GTZ to integrate this approach of interpersonal, intergenerational communication into the HIV/AIDS campaign and in the education sector.

Preliminary results on the impact of the approach are expected from a survey which was conducted among the families and peer groups of those who participated in the intergenerational dialogues.

LESSONS LEARNED

- This pilot approach developed from an unmet need which was channeled into a demand. The approach was conceptualized, tested, redesigned, and adapted in response to the need for more intimate and personal communication in the sensitization campaign on FGM.
- Crucial to the success of the workshops are the communication skills of the moderator. The moderator must encourage an atmosphere of appreciation and respect, and room for listening and understanding between individuals and

between generations even at times of confrontation and dissent. In addition, the moderator attends the monthly groups sessions that are organized as follow-up and as a continuation of the initial moderator-led intergenerational dialogues.

- Ideally, the members of the groups, by their example, become positive role models within their communities, so it is important to not only gain, but keep the momentum going. The newly acquired skills of this intergenerational dialogue will hopefully enable the generations to practice and thereby multiply the new form of appreciative, intergenerational communication.

The intergenerational dialogue method has been documented in a video that is available from the GTZ project in French and German language (contact: www.gtz.de/FGM)

Other programs that work with men on reducing gender-based violence are:

- **Giving Men Choices: A Rozen Project with the Police Force in Pakistan,** a project that aimed to reduce the ineffectual and insensitive handling of victims of gender-based violence by the police and the violence it commits against women and children. Training workshops focused on understanding of GBV by focusing on self-awareness, expression of feelings, anger management, power and stress management along with raising awareness on gender and sensitizing them to issues of violence against women and children.
- **MAVA's Efforts Toward Changing Men's Attitudes (India),** MAVA (Men Against Violence and Abuse) is a pioneer organization that advocates against gender-based violence, uses an "enter-educate" approach to raise awareness among youth about gender issues including violence against women, and provides counseling in conflict resolution.
- **Taking a Stand for Gender Equity and Positive Male Involvement (South Africa),** a program that integrated gender-based violence into its RH program for men after finding the problem so widespread. The challenges or next steps in this program are to "eroticize safe sex workshops," address the silence surrounding HIV and GBV in White, "Colored," and Indian communities, and mobilize communities around these issues.
- **Reaching Men: Educating, Mobilizing, and Organizing Men to Confront Sexist Violence and Improve Reproductive Health (USA),** uses an IEC/BCC approach to empower and educate men about sexist violence. It motivates men to examine the issues and attitutes of sexist violence and provides them with the knowledge and basic skills to address such violence both personally and politically.
- **Mobilizing Men against Female Genital Mutilation (Egypt),** a project that informs men about the possible complications from FGC, corrects misconception that FGC is based on religious traditions or is medically warranted and thus works to create a social norm that opposes this harmful practice while emphasizing the role of men in combating it.
- **Piloting a Men-Centered Domestic Violence Research Intervention: Strategies and Effects (Philippines),** aims to explore men's gender and violence-related knowledge, values, beliefs and behavior, and assists men in changing violent behavior. One of the lessons learned from this study is that men also possess values

and beliefs that are useful building blocks to promote personal change and gender equity.

- **Addressing Domestic Violence in Northern Jamaica 1999-2000,** described in this chapter under "Service Delivery-Based Approached."

COMMUNITY-BASED APPROACHES	
KEY STEPS TO IMPLEMENTING COMMUNITY-BASED RH PROJECTS THAT INVOLVE MEN AND ARE GENDER SENSITIVE	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Needs assessment	Base the message to be relayed to the community on population and health statistics (e.g., DHS, national health data, UNDP, UNAIDS, World Bank data).
Build partnerships with religious, traditional, and community leaders	Inform and educate religious, traditional, and community leaders about the issue the project plans to address.
Develop clear goals	Work with community, religious, and traditional leaders to develop goals (e.g., dissipate misconceptions about FP and to encourage FP). Increase the community's capacity to organize public meetings and discussions on women's health through awareness-raising workshops.
Measure outcomes	Develop quantifiable indicators to measure changes resulting from project activities (e.g., increase in number of condoms distributed, reduction in FGC, contraceptive prevalence rate (CPR), increase in number of men accompanying partners on maternal health visits, increase in number of men seeking RH services and counseling).
Evaluation	Develop and conduct pre- and post-tests to assess change in knowledge and attitudes. Form focus groups with project participants and community leaders on issues addressed in the project to collect feedback on strengths and weaknesses of the project. Use quantifiable indicators to evaluate project.

COMMUNITY-BASED APPROACHES	
KEY STEPS TO IMPLEMENTING COMMUNITY-BASED RH PROJECTS THAT INVOLVE MEN AND ARE GENDER SENSITIVE	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Partner with other organizations	Partner with MOH, other government organizations, international donors, local NGOs, FBOs, and municipalities (health, education, youth, departments, etc.) to inform on local needs and messages that are appropriate and effective.
Develop clear goals	Examples: dissipate misconceptions about FP; encourage FP; increase the community's capacity to organize public meetings and discussions on women's health and the dangers of FGC; and inform men on what they can do to plan their families' reproductive health.
Develop, test and disseminate RH message	Keep community leaders informed of the messages that are being designed. Involve community in developing and testing messages.
Train volunteers	Train members of the community to lead community meetings on RH topics the project aims to address. Involve men in project activities through advisory groups or committees.
Use various strategies to relay messages to the community about RH	Lead round table discussions, distribute IEC materials where men congregate (cafes, barbers, factories, and other work places), host radio programs, present dramas, etc.
Monitor	Conduct supervisory visits to observe staff and volunteers implementing project activities. Track number of round table discussions and number of men who attended them, number of IEC materials distributed, number of listeners and call-ins, and number of men seeking services during the duration of the project. Track topics covered in discussions and messages relayed in IEC materials.

COMMUNITY-BASED APPROACHES	
KEY STEPS TO IMPLEMENTING COMMUNITY-BASED RH PROJECTS THAT INVOLVE MEN AND ARE GENDER SENSITIVE	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	Hold regularly scheduled meetings with staff to collect feedback and make needed adjustments.

To access a presentation, click on the title of the presentation.

Community-based approaches to inform men about reproductive health can be an effective method of reaching men as men are less likely to attend reproductive health programs offered at clinics. ***Planificando Juntos* (Planning Together): Consequences of Involving Men in Family Planning through Water and Sanitation Programs** in El Salvador is described at length below as an example of how to integrate reproductive health into economic development programs. In addition, eight other programs listed below focus on this type of approach, a testament to its popularity, effectiveness, and adaptability to reach a wide audience and address diverse topics.

- **MAVA's Efforts Toward Changing Men's Attitudes (India)**, MAVA (Men Against Violence and Abuse) is a pioneer organization that advocates against gender-based violence, uses an "enter-educate" approach to raise awareness among youth about gender issues including violence against women, and provides counseling in conflict resolution.
- **Involving Men to Abandon Female Genital Cutting (FGC): A Community-Based Education Program in Burkina Faso**, this project underlines the importance of involving community leaders and decision-makers as advocates in projects that disseminate information through public meetings about issues such as FGC in an effort to abandon this ritual.
- **The Importantce of Male Involvement in Reducing Barriers to Safe Motherhood (Ghana and India)**, a study conducted in Ghana and India that engages communities in safe motherhood. It uses a participatory learning approach that empowers men to help their partners avoid delays in obtaining prenatal care; assures that they are properly nourished; and encourages men to help reduce women's pre and postpartum workload.
- **Addressing Men's Concerns About Reproductive Health Services in a Rural Community Mobilization Program (Ghana**), the Navrongo Project in Northern Ghana addresses men's opposition to family planning and gender equality by undertaking dialogues with chiefs, bringing in trusted outsiders as advisors, and reaching out to men and women to talk about these issues. Including RH as a topic openly discussed in community meetings (*durbars*) mostly attended by men is an important aspect of this project.
- **Involving Village Men in Health Issues (Armenia)**, a dual protection project to empower men to make knowledge-based decisions about reproductive and sexual health which faced such obstacles as: men not wanting to be involved in the

educational process because they think they know enough; cultural norms that made it difficult for women providers to train men on topics such as sexual health; local physicians' unwillingness to train project coordinators on a volunteer basis; and fear of sharing personal information, a vestige of the Soviet era.

- **Reducing Reproductive Health Vulnerabilities of Male Adolescents Involved With Justice Conflicts in Brazil**, this project targeted young men who are in trouble with the law. It aims to increase their knowledge about sexuality and STIs/HIV and change their attitudes by increasing access to RH clinical services and condoms and by strengthening educational activities with parent involvement. One of the outcomes was that *Sociedade Civil Bem-Estar Familiar no Brazil* (BEMFAM) broadened its range of activities and developed partnerships with organizations knowledgeable about working with troubled youth. Project managers attribute its success to the integration of educational activities and clinic services and the involvement of youth in several phases of the project.
- **How to Reach Men With a Gender Perspective of Southeast Asia, Pakistan**, a comprehensive program that aims to inform men about RH by reaching out to all sectors of society from political and religious leaders to teachers and health care providers using various approaches including peer education, advocacy, and outreach through the media and places where men tend to congregate (barbers, cafes, factories, etc.) Among some of the valuable lessons learned from this project are a) that the project design needs to include gender-sensitive strategies to ensure program focus on men and b) that strong advocacy helps men realize their strategic role in RH programs.
- **Talking Man-to-Man Conversations: Reflexive Group Methodology (Brazil)**, a project that works with groups of men with diverse backgrounds and various social situations in Rio de Janeiro. Participants include street children, ex-street children, students of public and private institutions, military policemen, residents, leaders and social agents from *favelas* (slums), universities, liberal professionals, and men who are perpetrators of domestic violence. It aims to reduce violence among its clients.

Planificando Juntos (Planning Together): Consequences of Involving Men in Family Planning through Water and Sanitation Programs

Implementing agencies Project Concern International (PCI), Institute for Reproductive Health at Georgetown University.

1. Background

PCI integrated family planning (FP) into its water and sanitation program as a way to increase male involvement in family planning decision making and use. This activity followed the integration of women into water committees, a domain that had previously been reserved for men. PCI was well positioned to reach out to men, given its "male friendly" culture, especially in comparison to most FP organizations. PCI staff was relatively free of the biases held by many health workers related to men's roles in family planning. PCI staff and volunteers were comfortable and experienced working with men, and about two-thirds of the staff was male. PCI has developed on-going, positive relationships with men while providing support for building water systems contributed to

a male friendly culture.

2. Design

PCI called the model "Planning Together" to emphasize gender equity in decision making. The strategy included integration of FP messages into water and sanitation education; community-based provision of condoms and the Standard Days Method, a fertility-awareness based method the couple can use together; and referrals for other methods. The Standard Days Method (SDM) was introduced to expand family planning options for men.

> The Standard Days Methode (SDM) is a new, fertility awareness-based method of family planning developed by the Institute for Reproductive Health at Georgetown University. Women with menstrual cycles between 26 and 32 days long can use the SDM to prevent pregnancy by avoiding unprotected sex on days 8-19 of their cycles. A color-coded string of beads, called CycleBeads, helps couples identify the fertile days. The method is 95% effective when used correctly.

After obtaining a go-ahead from community development committees, water, and sanitation volunteers were trained to incorporate FP into group talks and home visits. Couples interested in obtaining a FP method were referred to the community volunteer, Ministry of Health promoter, or health center for counseling. The topics discussed in group talks and home visits centered on couples making decisions--as a couple--for the welfare of the family. The key family planning messages included were: 1) the relationship between the protection of natural resources and the protection of family health; 2) gender equity in making decisions about family and community resources; and 3) the availability of a range of family planning methods to meet the particular needs of each couple.

Strategies used to reach men: male and female volunteers provided information and services in their communities. Trained staff and volunteers were monitored and rewarded for their efforts to reach men and couples. The rewards included public recognition in meetings and trainings of staff and volunteers who made an extra effort. In addition, staff who were especially effective in reaching men were extended opportunities to participate in cross-trainings and other meetings, such as, a training of trainers for SDM trainers held in Washington, D.C. and a regional dissemination meeting in Honduras.

Project staff had flexible working hours which allowed them to support volunteers on evenings and weekends, thus, making it possible to plan visits according to men's schedules. In addition, they made surprise or unscheduled home visits and reached men during meetings of community associations, where men tend to be well represented. If men were unavailable, volunteers encouraged wives to share the information with their husbands. The project also used the print media to relay messages on client cards, calendars, and posters.

Evaluation design: The evaluation used several strategies to assess the success of the project. These included baseline and endline community surveys to measure changes in knowledge, attitudes and behavior. PCI also conducted focus groups with men, women, and providers to assess the feasibility and acceptability of the strategy. Men and women using the SDM were interviewed quarterly for up to thirteen cycles to assess satisfaction, correct use, and male participation.

3. Results

Almost half (45%) of men and 51% of women participated in a home visit, group talk, or both. About 27% of the people who had participated in a discussion reported that their partners had also participated in a group talk. Although volunteers tried to conduct the home visits with both members of the couple, only 18% of the respondents reported that they and their partner had both been present during the visit. When asked about the PCI water and sanitation project, almost three quarters (73%) of the respondents knew that it included FP. Almost all of them (92%) stated that including FP in a water and sanitation project is beneficial and even necessary.

Men who used the SDM received instruction from their wives (43%) and from community health workers (48%). Most of them (82%) reported that they discussed when to have sex and were able to reach agreement about whether to abstain or use a condom during the fertile days. Most (83%) of the SDM users were not using any method at they time they began using the method, and the majority were first time users of a modern method. This intervention helped change men's attitudes about decision-making regarding contraceptive methods and male participation in family health, and increased couple communication. FP prevalence increased from 45% to 58%, primarily through use of the Standard Days Method and other methods which involve men, which increased from 20 to 28% of the method mix. Indicators used to measure changes included couple communication, decision-making, and use of contraceptive method involving the man.

The study also concluded that FP is more acceptable when it is discussed in the context of partner communication. Ministry of Health staff reported that PCI's efforts paved the way for continued discussion of family planning use with men and women previously opposed to the topic. Lastly, PCI is scaling up this model and other NGOs are now interested in replicating it.

Obstacles and strategies used to overcome them: The major obstacle to successful implementation of this project was staff overload. Staff found it difficult to balance competing priorities, especially when dealing with natural disasters. Close collaboration with Ministry of Health staff provided ongoing support to newly trained community volunteers which PCI's overcommitted staff sometimes found difficult to provide. Flexible hours were critical to the ability of PCI staff to reach men.

LESSONS LEARNED

Integrating FP into resource programs is feasible, but requires work and changes within the implementing organization. Strategies that insure success include organizing the program plan so that activities happen simultaneously, for instance including FP at the

outset of the project. On-going coordination with community members and leaders, including the MOH, is also critical. Such programs are effective in reaching men with both information and services and succeed in teaching men about FP. They are also well received by communities.

EMPLOYMENT-BASED APPROACHES	
KEY STEPS TO IMPLEMENTING EMPLOYMENT-BASED RH PROJECTS THAT INVOLVE MEN AND ARE GENDER SENSITIVE	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Identify places of work that have existing health or RH services	Survey employers and trade unions that provide health services to their workers (e.g., how many men and women are employed/are members? What types of health services are available at the company run clinic? Which services are covered in the health benefit package? Are HIV/AIDS and MCH integrated into the health services? Are condoms and other contraceptives available?) Inform employers and union leadership about the advantages of integrating RH for men and women (e.g., reduce absenteeism, improve health of workers and their productivity by providing needed health services on site).
Develop clear goals for the program and share them with management, union leaders, etc.	Develop realistic and quantifiable goals (e.g., promote greater male participation in RH care among trade unions, increase use of condoms, improve the provision of RH services, extend IEC and counseling services to men, integrate RH into the health benefit package). Awareness-raising workshops may be needed to inform and educate employers and union leaders about RH and the importance of involving men.
Design projects that can be integrated into existing infrastructure or added where none exist, and consider introducing IEC activities.	If clinic services are available, project can integrate family planning, MCH, and HIV/AIDS prevention into existing services. IEC activities can be introduced as a component of an integrated RH program or as a stand-alone educational project (e.g., STI/HIV/AIDS prevention with condom distribution).
Train peer promoters among employees or union members	Train a group of male peer educators who can lead workshops on RH for union members and workers.

EMPLOYMENT-BASED APPROACHES	
KEY STEPS TO IMPLEMENTING EMPLOYMENT-BASED RH PROJECTS THAT INVOLVE MEN AND ARE GENDER SENSITIVE	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	Training should include providing peer promoters with literature and IEC materials to distribute during training sessions.
Monitoring and evaluation	Use strategies and tools as in other projects to involve men in RH (e.g., pre and post test, focus groups, quantifiable indicators, KAP survey, monitor peer educators/promoters to collect feedback and make needed adjustments).

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As male-involvement programming requires outreach to those places frequented by men, the workplace presents an ideal site of intervention. Increasingly, employer-based health services are integrating reproductive health into their programs. Of the four programs described here, two focused on men in the military and are included in the following section, "Military Services."

Preventing Truck Drivers from Risk Behavior: Observation from an Operations Research in India, the study assesses truckers' knowledge of STIs/AIDS and its preventions, document their sexual behavior, and test the usefulness of an education-cum-service model to promote safe sex among the truckers. The study found that men do not like to use condoms and that condoms are not readily available at truck stops or wherever "the truck is parked and the act is hurriedly done – who would take the trouble to use condom?" During the project period, when condoms were readily available at gas stations where men could receive information about STIs and how to prevent them, the number of condoms dispensed quickly increased. However, once the main interventions --the clinic and counseling session-- were withdrawn the use of condoms declined. The study concludes that simple availability of condoms at petrol pumps is helpful to truckers and many continue to use them even when counseling and clinic services are not available

Male Participation in the Trade Union Way (Philippines)

Implementing agency: Trade Union Congress of the Philippines (TUCP).

1. Background

In the Philippines, trade unions are a force for social, economic, and political change and development. They are increasingly resorting to social and political advocacy, using their infrastructure to reach a large number of men in wide ranging jobs. Unions are also becoming more service oriented and are promoting social development programs by

taking active roles in protecting the welfare of their members, by helping them find jobs and affordable housing, and increasing their access to proper health care. It is under its health care services that the TUCP pioneered the project, *Enhancing Male Participation among Male Trade Union Members*. More recently, it broadened its FP/Family Welfare (FW) program to include RH.

More than 60% of union members are men. They are significant partners in workers' households. Targeting them would significantly increase the client base for family welfare clinics (FWC) and male union members have requested an expansion of FP services to include a wider spectrum of reproductive health services.

Workplaces, the domain of most unions, are a convenient and fertile ground for educating and influencing workers, and RH has become part of the worker's welfare program.

2. Goals and Objectives

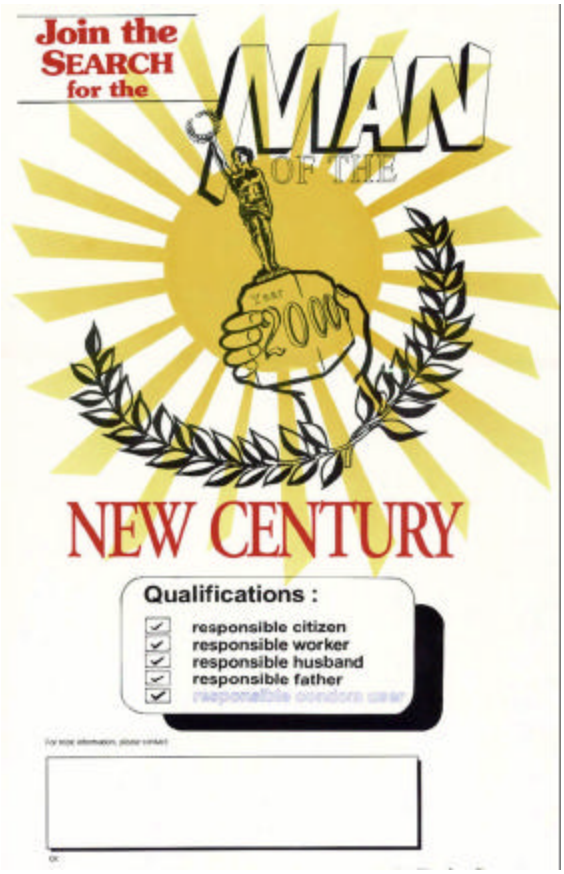
The goal is to improve RH care of TUCP union members and their families, thus, enhancing workers' productivity in the workplace. To achieve this, the objectives are to:

- Promote greater male participation in RH care among trade unions by training peer educators/motivators and strengthening IEC activities.
- Improve the provision of gender-responsive quality of RH services and IEC/counseling.
- Integrate RH care as part of the welfare and services benefits package under the collective bargaining agreement.

3. Project Design

Strategies: Seven provinces where the union has a large membership were involved in the project which focused on integrating gender responsive RH services while targeting IEC to male union members. The activities included developing a training guide on men's involvement in RH which used a life cycle approach in addressing such topics as healthy life style, MCH, sexuality, prevention and management of abortion complications, menopause/andropause, violence against women, STIs, FP, and ARH. This guide was used to train a network of male peer educators who in turn lead weekend seminars on RH for union members and workers.

IEC campaign: The project also developed an IEC campaign on male involvement in RH that used posters, stickers, buttons, mugs, and t-shirts. Messages promote and encourage shared responsibility and active male involvement. They frame sexual harassment and domestic violence as unacceptable behaviors that are contrary to the rights of individuals. The campaign also advocated the respect for reproductive health; the ability of men and women to resolve conflicts through non-violence; increased awareness about safer sex practices; and vasectomy as a permanent FP method.



Poster from the Trade Union Congress of the Philippines.

4. Results

Health workers were trained to provide gender responsive services, including violence against women, emergency contraception, and quality of care. Ten of the family welfare clinics scheduled male-only hours. Almost 30,000 clients received RH services; 55% of them were men and 45% were women. The family welfare clinics introduced digital rectal and self testicular examinations. Seven collective bargaining agreements included RH services.

Remaining obstacles:

- Men are still tied to their time sheets and can not devote their time to RH activities as much as they feel they need to;
- Management support for RH programs needs improvement;
- Lack of supportive government policies on RH in the workplace in general and Men's RH in particular;
- Lack of access to resources for men's RH activities;
- Need for more innovative and aggressive social marketing;
- Discomfort of men addressing RH issues with female care providers. This is being addressed by training male peer educators to assist in increasing the comfort level between male clients and female nurses.

- Establish male-only service day in RH clinics or male-only clinics. This addresses the stigma that RH clinics are women-oriented. This strategy was partly responsible for motivating men to come to the clinics on specific hours and days. However, it is premature, at this point, to determine the sustainability of male-only clinics run by the trade union. Moreoever, early indications show while it may be worthwhile experimenting with such a model, it may not be feasible as it might further contribute to widening the gender gap.

LESSONS LEARNED

- Trade unions are effective networks and partners in providing information and education on population, RH, and sustainable development.
- Informing union members about RH increased the demand for RH services and union members' interest in having these included in their benefit package.
- Peer educators/motivators are effective agents for expanding men's understanding of RH.
- Union leaders and workers' communities need to be engaged in advocating for RH, particularly FP, prostate cancer, gender-based violence, and MCH.
- Men's RH services and issues need to be addressed in a more collaborative manner involving their partners and even their children.

MILITARY SERVICES	
KEY STEPS TO IMPLEMENTING RH PROGRAMS FOR MEN AND WOMEN IN THE MILITARY	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Become familiar with military establishment in country of program	Assess which departments are responsible for health, education and training.
Identify and build relations with advocates of RH among high ranking officers	Assess what aspects of RH interest the military. Traditionally the military has been very active in preventing STIs and more recently HIV/AIDS prevention has become a priority. Many militaries provide MCH care to its members and people in surrounding communities.
Design a program that integrates and institutionalizes RH into existing health care and training infrastructure	Work with generals who head health and training departments. Most militaries have health department into which RH services can be integrated (e.g., condom distribution, counseling). Integrate RH into basic training as basic training includes health and hygiene.
Program goals should clearly delineate short-term and long-term goals	Examples of short-term goals: develop capacity for RH training and services in the Armed

	Forces or establish mechanisms for providing RH information to all soldiers. An example of a long-term goal: have sustainable RH training and service provision in the Armed Forces.
Determine under which department to introduce training of military trainers in RH	Train health department staff and officers who provide basic training. This may require training personnel from the health department and from the training department. Consider training teachers and health providers in military academies.
Develop IEC materials	Develop IEC materials that target different levels of military personnel and are sensitive to such issues as high levels of illiteracy among recruits and little knowledge of the official language.
Monitoring and evaluation	Provide technical assistance in developing tools to monitor RH-related activities (e.g., types of services provided, track number and gender of clients receiving RH services, record number of IEC workshops conducted and issues addressed). Provide a management system that stores the data in a central location.

To access a presentation, click on the title of the presentation.

Many countries have planned or are implementing projects targeting men in the military as a way to promote HIV prevention, engage men as partners in gender equity, reduce gender-based violence, improve their own and their partners' reproductive health status, and protect their rights.

Men in the military are a captive audience, as this is a predominantly male workplace. Furthermore, military leaders are quite interested in collaborating on reproductive health issues, particularly HIV/AIDS prevention, followed by family planning. This commitment is somewhat self-serving, as HIV has become a security issue, but also stems from the military elites' sense of social responsibility for the health of their workforce and a desire to assist civilian populations in crisis. In any case, these serve as valuable entry points for collaborating in reproductive and sexual health and for introducing gender perspectives (UNFPA, Enlisting the Armed Forces to Protect Reproductive Health and Rights: Lessons from Nine Countries, 2003).

The two military-based programs vary from each other: **Enlisting the Military to Protect Preproductive Health and Rights: Lessons from Nine Countries**, as its title suggests, looks at the challenges of working with the military; while, **Establishing Reproductive Health Counseling in Military Services: The Turkish Model** illustrates how UNFPA introduced RH counseling in the military in Turkey.

Enlisting the Military to Protect Preproductive Health and Rights: Lessons from Nine Countries, this comparative study of country experiences across regions was undertaken as part of a United Nations Populaton Fund (UNFPA) interregional project 'Improving Gender Perspective, Reproductive Health and HIV/AIDS Prevention through Stronger Partnership with the Military.'

Some of the most interesting lessons learned from the nine case studies deal with the challenge of integrating gender-sensitive RH into the health service delivery system of a hierarchical, highly structured organization whose mission is to teach young recruits, the target audience of many of these programs, to follow orders without questioning their superiors, usually older men who foster traditional models of masculinity. This, in addition to the vertical approaches to health, particularly HIV, deters interest from adopting more comprehensive and sustainable approaches to RH and gender mainstreaming.

Among the militaries studied, most of them enlisted women, yet the health service system assumed that women do not need STI testing and treatment, or other RH services. Other examples of unmet gender-equity needs in RH programs illustrated in the case studies include:

- Changing risky behaviors with "risk groups" only;
- Exploiting traditional gender roles to promote condom use;
- Explaining HIV transmission but not gender relations;
- Working with men in isolation from women's groups, on base or civilians;
- Staffing policies, including those of service providers;
- Absence of women's participation in shaping training curricula;
- Codes of conducts do not include issues of GBV;
- No easy and equal access to RH services;
- No counselling services;
- Unequal access to in-service training.

The entire study finds that gender perspectives need to be better integrated into project design and monitoring. The study concludes that in codes of conduct the defence sector offers a captive audience with cohesive codes of conduct, strong human resources and skills, training, and health and communication infrastructures. Furthermore, the armed forces have a multiplier effect of socializing young male recruits as gender-equitable sexual partners and fathers and they offer access to RSH education and services to people who live in isolated communities near military bases. Finally, the military is strongly interested in STI and HIV but has competing interests regarding RH, specifically regarding gender and rights-based perspectives.

Challenges specific to working with the Armed Forces include:

- Working in a highly structured hierarchy;
- Introducing comprehensive health care services into a health system that uses a vertical approach (in most militaries STI/HIV/AIDS prevention is disconnected from RH).
- Introducing programs with a gender perspective in an institution that exploits traditional gender roles to promote condom use, and uses a medical model to address HIV prevention and neglects to include the gender dynamic.
- Collecting data. In many countries the military is not accountable and thus is not in the habit of collecting and reporting service statistics.

The full study, *Enlisting the Armed Forces to Protect Reproductive Health and Rights: Lessons from Nine Countries*, has been compiled onto a CD-ROM, which is available from UNFPA at http://www.unfpa.org/publications.

Establishing Reproductive Health Counseling in Military Services: The Turkish Model

Implementing organization: Gulhane Military Medical Academy (GMMA) provided the military medical personnel including physicians, nurses, and non-commissioned officer.

1. Background

The modern contraceptive prevalence rate in Turkey is 37.7%, and the median age of marriage for men is 24 with 80% of the men getting married after the age of 20. Unfortunately, there is no reliable statistical data on HIV/AIDS or other STIs either for the Armed Forces or the general population. The service statistics of the RH/FP branch of the MOH indicate that few men (below 5 % of all clients) receive counseling or medical services. Currently, there are no other initiatives targeting men to increase their involvement in RH/FP.

Every Turkish male citizen between the ages of 18 and 45 is required to serve in the armed forces for an average of 15 months. Over 450,000 new conscripts are recruited annually.

2. Goal and objectives

The project aims to provide basic RH information and programs, including counseling to all members of the armed forces. The short term objectives are to:

- Develop capacity for RH training and services in the Armed Forces;
- Establish mechanism for providing RH information to all soldiers;
- Develop specific IEC materials for personnel in Armed Forces.

The long-term objective is to have a sustainable RH training and service provision system within the Turkish Armed Forces.

3. Project Design

The activities undertaken to achieve this goal are to:

- Establish a RH training center in the Gulhane Military Medical Academy (GMMA);
- Train GMMA staff as RH trainers;
- Train newly graduated military physicians, nurses, and medical non-commissioned officers;
- Train military medical staff from the field and establish RH training rooms in military installations;
- Provide RH information to all new conscripts; and
- Provide RH counseling and services in military clinics.

Training took place in dedicated RH training rooms through interactive workshops. IEC materials were developed. The clinics provided condoms for condom-use training and after counseling sessions. Female condoms are not currently available.

The medical staff provided individual counseling and services in clinics in the field. In addition, Turkish troops that join international peacekeeping forces received HIV/AIDS focused training. Plans are to emphasize gender equity/equality and gender-based violence in the next phase of the project.

Monitoring: Trainers received follow-up visits from personnel at the military medical academy. Such visits were integrated as part of the on-going supervisory scheme the military has in place. Trainees participated in pre- and post-testing. After a couple of years UNFPA will design and implement an external evaluation.

Stakeholders and their roles: The command level of the armed services, chief of staff and force commanders, fully supported the project. Currently, the command structure of the Armed Forces is supporting the project by creating a positive policy environment. The general staff of command issued general orders to initiate the training of trainers, establish training rooms, etc. Although no specific funds are allocated for the project, the travel and accommodation expenses of nearly 2,500 trainees, which came to almost USD 100,000, were covered by Armed Forces. The positive policy environment generated by top level commanders enables RH training center directors to call on their support for contacting all lower level commanders, to facilitate the establishment of centers, get commitment of others, etc. Other stakeholders are the ministry of health, MCH and FP departments which provide trainers and training materials.

Obstacles and strategies used to overcome them: The project needs support for at least three more years, whiled UNFPA's funding is decreasing. The armed forces do not have a budget for contraceptives and training materials and the education level of the soldier is low. The project addressed the last point by preparing training and IEC materials (poster, brochures, etc.) in view of the educational level of the soldiers.

The armed forces are exploring the possibility of co-financing with condom manufacturers. The European Union has recently supported RH programs in Turkey and the program with the military may be eligible to receive funds from this source.

LESSONS LEARNED:

- The armed forces are the best venue for reaching the largest male population in Turkey;
- Large-scale interventions work best, however, working with the military is challenging for NGOs;
- Donor interest is not high due to a false assumption that all militaries are well funded;
- Partnership between the armed forces and MOH has to be formed for project sustainability.

SERVICE DELIVERY-BASED APPROACHES	
KEY STEPS FOR IMPLEMENTING CLINIC-BASED RH SERVICES FOR MEN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Needs assessment	Use DHS surveys, STI/HIV/AIDS statistics, focus group discussions with men, community leaders, and service providers to assess services needed by men and those that will attract them.
Build strategic alliances	Stakeholders should include MOH, NGOs, peer educators (youth and adult), religious, traditional, and community leaders.
Develop clear goals	Develop goals based on the needs assessment (e.g., integrate men and RH programs into existing services).
Include advocacy activities in program design	Advocacy activities may include educating top mangers about male involvement and the benefits of serving men. The support of decision-makers is critical to integrate services for men.
Target outreach to men	Advertisements and promotions of services available to men at RH clinics should be carefully crafted to attract men and placed in newspapers and magazines that men read and places that they frequent (e.g., barber shops, bars, community centers, workplaces).
Train staff to work with men	All staff, from doctors to receptionists, should be trained to work with men. Training should address attitudes and behaviors so that men feel welcome when they enter a clinic. Gender dynamics should also be addressed. Technicians and medical staff should receive

SERVICE DELIVERY-BASED APPROACHES	
KEY STEPS FOR IMPLEMENTING CLINIC-BASED RH SERVICES FOR MEN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	on-going training for working with men.
Diversify service provision to include services for men	Provide services that attract men (e.g., the syndromic approach and provision of RTI/STI services, diagnosis and treatment of prostate cancer, condom distribution, male only and/or couple counseling). Develop and run IEC activities that focus on issues that concern men (e.g., sexual performance, prevention of STIs/HIV/AIDS) but also address other isses such as FP and GBV.
Monitoring	Adapt service statistics to track visits by men and services provided to them. Track IEC activities (e.g., number of workshops held, health fairs attended, number of participants, issues addressed). Supervise staff working with men, from receptionists to clinicians. Conduct regular staff meetings with staff to get feedback and make adjustments. Conduct focus group discussions with providers to assess if they judge themselves capable of serving men, need further training or other support services to provide quality care.
Measure Outcomes	Analyze service statistics to assess increase in services provided to men and those that are most sought after. Use client satisfaction surveys and focus group discussions to assess if men are satisfied with the services provided, if clinic hours meet their needs, what additional services they are interested in receiving, etc.
Evaluation	Use monitoring tools and statistics to measure outcomes to evaluate program.

SERVICE DELIVERY-BASED APPROACHES	
KEY STEPS FOR IMPLEMENTING CLINIC-BASED RH SERVICES FOR MEN	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	Conduct interviews and/or focus group discussions with clients (men and women) and stakeholders to get their assessment of the project.

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As the following programs illustrate, clinics have succeeded in integrating RH services for men. Substantive literature is available on how to convert traditional women-centered clinics into spaces where men are comfortable, feel welcome, and receive the services they need. Similarly, **Addressing Gender Issues with Men and Couples in a Reproductive Health Service in Ecuador: A Case Study in Organizational Change** informs about the challenges of integrating RH services for men.

Working with Men in the Clinic and Community: MAP Experiences from Four Countries (Bolivia, Guinea, Nepal, and Pakistan) provided an overview of its introduction of the Men's RH Curriculum in four countries. This three-part training curriculum aims to strengthen the skills and improve the comfort level of health workers who provide services to men. The curriculum is rooted in a holistic approach to RH, so provider training workshops are dynamic and interactive. Topics addressed include the importance of working with men, characteristics of male-friendly services, male sexual and reproductive health issues, service provider values, gender roles, the role of men in FP and RH, and communicating with and counseling men. The tool is available in hard copy; the PDF files are going to be put on the EngenderHealth home page by February 2004. Some of the key lesson learned from introducing men as partners (MAP) programs in several countries is that:

- Building strategic alliances are essential for program success. Stakeholders can include public (MOH) and private (NGOs) entities, peer educators (youth and adults), religious leaders, and community members.
- Men and RH programs should be integrated into existing RH services and to do this successfully support and advocacy is critical from top managers.
- Effective outreach to men requires communications and marketing strategies designed to target men.

Addressing Domestic Violence in Northern Jamaica 1999-2000, One of the objectives of the Jamaica Family Planning Association (JFPA) is to increase awareness of gender dynamics and gender-based violence, and to contribute to the reduction of violence in Jamaica. To achieve this goal, the Association builds its staff's capacity, increases awareness of RH, gender dynamics, and GBV issues among 40 perpetrators of GBV and strengthens collaboration with other agencies to address violence against women. The program had trouble attracting men, and keeping men enrolled in the

program. Lessons learned from its experience are:

- More time is needed at the start of the project for planning, preparation, and building collaboration, including judges and magistrates.
- Build a cadre of probation officers dedicated to this task, rather than have it infused in the work of several officers.
- It is essential that resources be dedicated to work with partners and families of the perpetrators.
- Men were accepting of female facilitators.
- More resources needed for monitoring and evaluation.
- Program benefits increase with greater active collaboration with partners.

Integration of Reproductive Health Services for Men: Experience from Bangladesh.

Implementing agency: National Institute for Population Research and Training (NIPORT), Directorate of Family Planning, which provides RH services through 3,700 family welfare clinics, and the Population Council.

1. Background

Bangladesh has achieved remarkable success in containing its population growth. The current annual growth rate is 1.5% and the total population size is 132 million with less than one-fourth of the total population residing in urban areas. The literacy rate is still less than 50%. However, the national FP program is a success story. Despite the lack of improvements in socio-economic conditions the program has managed to motivate more than 55% of couples to use contraceptives. Approximately 43% of contraceptive users rely on the oral pill, the most popular modern contraceptive method. Half of the acceptors stop using their chosen methods within a year. The total fertility rate has remained the same for the past 10 years. In terms of HIV/AIDS, Bangladesh is a high risk but low prevalence country. HIV prevalence is less than one percent among high risk groups except for intravenous drugs users which is at nearly four percent.

Studies indicated that men suffer from various reproductive health problems but do not use the services provided by the government service delivery system. Men mostly seek services from unqualified service providers or are self medicated. They even postpone treatment when acutely ill. In Bangladesh, the community-level service delivery points are female-focused. RTI/STIs are quite common among rural women in Bangladesh and the high incidence of STIs among women is an indirect indicator of the high prevalence of these diseases in men. Service providers lack knowledge about RTIs/STIs and their inadequate management contributes to increasing the suffering of men and women. Lack of BCC materials that target men is another major obstacle in addressing male sexual health.

2. Goals and Objectives

The overall objective of the study was to increase access to and acceptability of RH services for men at health and family welfare clinics (HFWCs). The specific objectives were:

- Increase male access to RH services;
- Modify existing BCC materials to increase male awareness about the RTI/STI issues;
- Include male RH services at HFWC and train service providers on syndromic approach and sexual health counseling;
- Assess management, technical, and financial implications of integrating male RH services into the existing service delivery.

3. Study Design and Project Duration

The study used a quasi-experimental non-equivalent control group design with eight service delivery points as intervention sites and four as control sites. The intervention activities were carried out in the experiment sites for 12 months; the duration of the project was 20 months.

Activities undertaken were:

- Theoretical and practical training of service providers on RTIs/STIs;
- Promotion of awareness about male RTIs/STIs and availability of services from HFWCs by group discussion and by developing and distributing BCC materials;
- Inclusion of syndromic approach and provision of RTI/STI services;
- Distribution of condoms;
- Mobilization of resources from the existing government allocation.

4. Results

Outcomes of the study were measured by the following indicators:

- Number of male clients motivated by the BCC activities and the number of men that received services;
- Number of males using RTI/STI services;
- Increase in provider's knowledge on STI/RTI and syndromic approach;
- Number of male clients satisfied with the services;
- Number of males who came for FP methods.

Inventory surveys informed researchers about the availability of medicine for RTIs/STIs and equipment used to prevent infections. Pre- and post-intervention interviews were conducted with 127 and 163 service providers and field workers respectively. Seven focus group discussions (FGDs) were conducted before the intervention and sixteen FGDs were conducted after the intervention. Service statistics were collected from all HFWCs before and after the intervention to estimate the total number of clients who received the services. In addition, 286 male and 300 female client exit interviews were conducted during the intervention period.

Findings indicate that the knowledge of the service providers significantly improved due to the intervention. As expected, knowledge of the service providers in the control areas did not change significantly. Like service providers, knowledge of field workers also improved in the experimental area. Before the intervention took place a test was performed to inquire whether or not a significant difference existed in the knowledge

about signs and symptoms of RTIs/STIs among service providers and field workers in the experimental and control areas. The results found no difference in the knowledge of service providers.

Service statistics were complied to calculate the numbers of clients receiving services from the selected HFWCs before and after the intervention. Findings indicate that the quarterly average number of clients in each center from January 2001 to June 2001 was almost the same in both experimental and control areas. The average number of male clients increased three-fold in the experimental area after the intervention. Also, researchers found that before the intervention these centers were treating, averaged less than one male RTIs/STI client per month and this figure increased to more than 5 after the intervention. There was no report of RTI/STI clients in the control areas before or after the intervention period although their register had provisions to record this information.

Obstacles and strategies used to overcome them: As expected, a shortage of medicines was the main obstacle encountered by the services providers. To overcome this, service providers and project staff deliberately involved district and local level program mangers from the outset of the project. They were able to redirect some of the medicines to the participating HFWCs. Similarly, involving district level managers helped reduce the transfer of staff significantly. Another obstacle was the non-availability of RTI/STI clients during the practical training of the service providers. To overcome the problems, training was conducted at the medical college hospitals.

LESSONS LEARNED

- Integrating RTI/STI services for men is possible;
- Grassroot service providers can be trained in RTI/STI management;
- Service providers need theoretical & practical hands-on training;
- Targeted BCC increases the number of male clients;
- Increase in total number of clients helps to increase utilization of services.

SPORTS-BASED AND OTHER YOUTH-BASED DELIVERY APPROACHES	
KEY STEPS FOR IMPLEMENTING YOUTH-BASED RH PROGRAMS Services in this category use a variety of approaches, from peer educators to enter-educate dramas, hotlines, and Internet sites dedicated to informing youth about RH. Youth-based approaches may be stand along projects or multi-faceted programs that have a sports-based component.	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Needs assessment	Base the project/program design on RH needs of youth. These can be obtained from national health statistics (e.g., MOH, Department of Youth Services, UNAIDS, UNICEF). Conduct focus group discussions with youth to assess their needs and concerns.

SPORTS-BASED AND OTHER YOUTH-BASED DELIVERY APPROACHES	
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IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Develop clear goals	Involve youth in developing project goals (e.g., provide young men with alternative models of masculinity and empower them to improve their health and human development; reduce the spread of AIDS among young men).
Define target audience	Projects can target one or several audiences (e.g., in-school and/or out-of-school youth, vulnerable youth, employed/unemployed youth).
Work in partnership with other organizations experienced in working with youth or knowledgeable about the topics the project/program addresses	Develop a working relationship with schools, sports clubs, and community centers to reach youth (e.g., inform school officials about project's intent; enlist support of youth advocates in community centers and sports clubs to promote and support the project). Partner with local NGOs and government departments that focus on AIDS, pregnancy, drug and alcohol prevention, career counseling, etc. Refer youth to organizations that provide services to them (e.g., clinics that offer youth-friendly services, vocational training and/or career counseling centers).
Develop or adjust existing training materials to address RH issues with boys and young men	Training sessions and materials should address issues related to the project's goal(s). Range of issues that youth-based programs can address include self identity, how to deal with feelings and relationships, and preventive health including HIV/AIDS, pregnancy, alcohol, and drugs. Training materials should be simple and focus on a few messages.
Train adults who work with youth	Train adults who work with youth, for example, coaches, teachers, counselors, and

SPORTS-BASED AND OTHER YOUTH-BASED DELIVERY APPROACHES	
KEY STEPS FOR IMPLEMENTING YOUTH-BASED RH PROGRAMS Services in this category use a variety of approaches, from peer educators to enter-educate dramas, hotlines, and Internet sites dedicated to informing youth about RH. Youth-based approaches may be stand along projects or multi-faceted programs that have a sports-based component.	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	peer leaders. Carefully select trainers by inquiring about their motivation, interest in the construct of identity, flexibility, commitment to the project/program, and teaching skills.
Use multiple approaches to inform youth about RH	Use multiple media to relay information (e.g., theatre, films, focus group discussions, inter-active participatory exercises). Offer hot lines and dedicated websites that inform youth about RH. Plan health fairs, parades, celebrations to give the project visibility and promote participants' achievements through public appraisal.
Monitoring	Conduct follow-up visits to observe the implementation of activities (training, focus group discussions, discussions that follow dramas, etc.) Develop data collection forms for supervisors to use when they make visits (e.g., number of workshops conducted and number of youth who participated, topics addressed). Schedule regular meetings with trainers and program managers to provide feedback . Track clinic referrals on intake forms.
Measuring outcomes/evaluation	Administer pre- and post-tests that ask questions about knowledge, attitudes and behaviors (e.g., How can you tell if a person is HIV positive or has AIDS? Are women equal to men? Are there situations where hitting a woman is justified? Do girls mean yes when they say no to sexual advancements?)

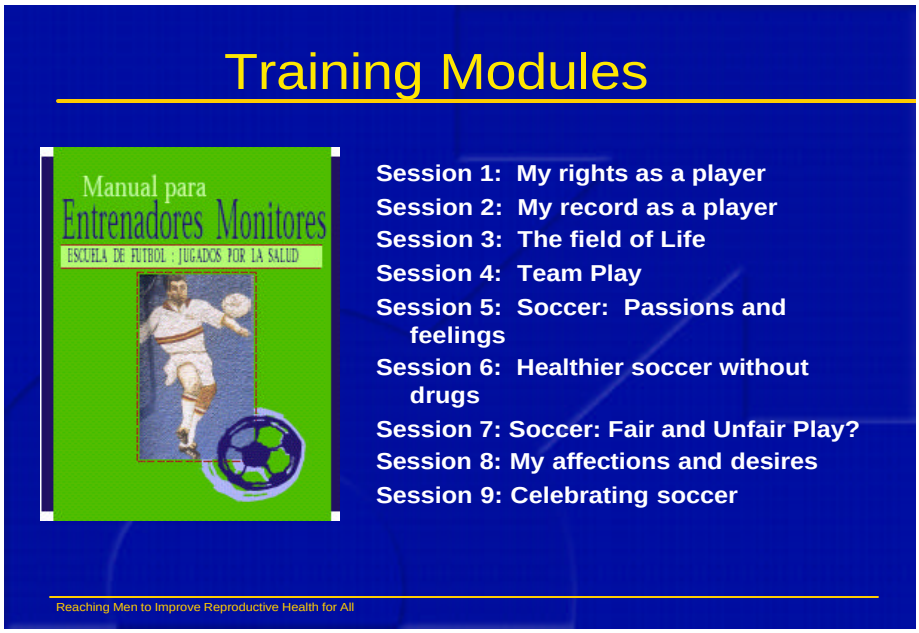
SPORTS-BASED AND OTHER YOUTH-BASED DELIVERY APPROACHES	
KEY STEPS FOR IMPLEMENTING YOUTH-BASED RH PROGRAMS Services in this category use a variety of approaches, from peer educators to enter-educate dramas, hotlines, and Internet sites dedicated to informing youth about RH. Youth-based approaches may be stand along projects or multi-faceted programs that have a sports-based component.	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	Conduct focus group discussions with trainers and with youth to assess project achievements. Analyze clinic intake forms and conduct focus group discussions with health providers and/or career counselors to whom youth have been referred.

To access a presentation, click on the title of the presentation.

The two programs that focus on reaching adolescents through youth based approaches, **Adolescents and Soccer: Promoting Health and Emerging Masculinities (Chile)** (English Spanish) **and Youth Participation in HIV/AIDS and Reproductive Health Activities (Malawi)** reach out to young men in two different settings and aim to achieve different objectives, although they target the same age group.

Adolescents and Soccer: Promoting Health and Emerging Masculinities (Chile) (English Spanish) uses soccer coaches as change agents, capitalizing on their role as mentors and on the fact that soccer teams are an accessible venue for reaching a large number of young men. The Chilean program challenges the traditional model of masculinity and aims to promote alternative models to empower young men to prevent disease and improve their health and human development. In contrast the program in Malawi, described below, is driven by the AIDS pandemic in a country where approximately 250 people a day are contracting HIV.

The soccer-based program developed a training manual for coaches that addresses identity and health issues within the context of soccer. Coaches go through a certified training process where they become familiar with the modules that they then teach to their teams in nine formal training sessions.



The **lessons learned** from this project are to keep the content simple and focus on a few messages to make sure not to overload coaches and team members. Carefully chose the coaches that will participate in such sports-based programming by inquiring about their motivation, interest in the construct of identity, flexibility, commitment, and teaching skills.

Youth Participation in HIV/AIDS and Reproductive Health Activities (Malawi)

Implementing agency: National Association for People Living with HIV/AIDS in Malawi (NAPHAM) was formed in 1993 to deal with issues concerning people living with HIV/AIDS.

1. Background

In Malawi, a country with 10 million people, over half are under the age of 15 and over 70% live in rural areas. One out of five children fails to reach their fifth birthday. Over 16% of the population between 15 and 45 years of age is HIV positive and there are over a million people living with AIDS. Stigma and discrimination surrounding HIV status discourages people from openly acknowledge their status and thus get the services they need.

Baseline survey: A baseline survey conducted prior to the project's initiation indicated that youth had misconceptions around issues related to sexuality and HIV. For instance, HIV positive school boys could see no reason of continuing their education after testing positive.

2. Project Design

To address these misconceptions, 6,200 youth were identified in 20 communities and informed about the importance of participating in activities that informed about safe sex

and how to prevent STIs/HIV/AIDS. Twenty-four youth were trained in peer education and interactive drama. The project also formed 40 soccer and 30 basketball teams while training 100 peer educators in HIV/AIDS and sexual education from among the members of these teams.

The peer educators met with youth twice a week in communities and schools to share their knowledge about HIV/AIDS and safer sex behaviors. They led focus group discussions, participated in theatre productions, shared personal testimonies, and used pictures to tell their stories. These youth-friendly tools were used to inform their peers and motivate them to change their behaviors.

Every week, before playing, team members discussed sexuality issues including issues related to HIV/AIDS and learned where they could get access to RH information. The discussions included ethical, spiritual, cultural, and moral factors such as fidelity, honesty, and communicating with partners.

Monitoring: Health educators from NAPHAM monitored peer leaders' work with follow-up visits to observe the implementation of activities. After three months, a competition was held among the different teams that included a quiz on HIV/AIDS, STIs and RH. The winning team received prizes and members who scored well on the quiz attained special recognition.

Field supervisors monitored activities on a weekly basis using data forms and questionnaires to collect data. Quarterly review meetings provided guidance and helped NAPPHAM modify activities. Data collected from monitoring activities was shared with donors, partners, and some beneficiaries.

NAPHAM held sensitization days every three months in communities that participated in the project which included car floats and marching by community members, particularly youth and their peer educators. These occasions also served to refer youth to VCT centers for testing. Clients who tested positive were encouraged to join support groups with people living with HIV/AIDS or post-test clubs. These clubs provide safe spaces for people living with AIDS to talk about their concerns.

Stakeholders and their roles: Malawi Network of People Living with HIV/AIDS (MANET) advocated for the project. Malawi Network of AIDS Service Organizations (MANASCO) helped with networking. The National AIDS commission (NAC) provided technical support, and the Malawi AIDS Counseling and Resource Organization (MACRO) provided VCT and referrals. NAPHAM works closely with District AIDS Coordinating Committees (DACC) and thus has a good partnership at the district level so that its volunteers provide counseling services in several hospitals throughout the country.

UNAIDS, working with a local partner, recruits people living with HIV/AIDS and places them in host institutions to break the silence and promote positive living. NAPHAM supplied most of the volunteers who worked with the different organizations, thus

publicizing NAPHAM's work at the national level.

3. Results
The project succeeded in reaching large numbers of youth, more than 35,000 out of school youths and over 131,000 in-school youth. It established 22 out-of-school youth clubs and 14 post-test clubs that attracted youth who were tested for HIV. Over 100 HIV positive youth joined NAPHPAM centers for counseling and supportive care services.

Challenges and strategies used to overcome them: the project addressed negative attitudes toward condoms among school youth by intensifying education on condom use and emphasizing its advantages.

It addressed youth's reluctance to disclose their status by providing supportive counseling. The counseling outlined the benefits of disclosure and discussing such confidential issues as the pros and cons of getting married while living with HIV.

Stigma and discrimination campaigns targeted schools, companies, and communities and were found to be highly effective.

LESSONS LEARNED

- One of the best strategies to involve youth in HIV/AIDS and RH activities is through sports.
- People living with HIV/AIDS are the best educators. The experiences they share with others enrich the learning experience of their students and help them accept their situation.
- NGOs should involve local people in RH and HIV activities. This will reduce preaching and get to the underlying issues that prevent people from changing their behaviors.
- When implementing VCT programs, supportive structures should be in place to care for those who test positive.

MEDIA APPROACHES	
KEY STEPS FOR IMPLEMENTING MEDIA-BASED PROGRAMS	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Needs assessment	Conduct knowledge, attitudes and practices (KAP) survey to identify issues to be addressed by the campaign. The survey should inquire about men's attitudes toward FP, men's involvement in MCH sexual behavior, their knowledge about how AIDS is spread, practices regarding communication and decision-making in their family, beliefs about gender equality, etc.
Develop campaign based on KAP results	Based on results of the needs assessment, choose themes to be addressed (e.g., use of FP

MEDIA APPROACHES	
KEY STEPS FOR IMPLEMENTING MEDIA-BASED PROGRAMS	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	is consistent with Islamic teachings).
Determine clear goals for the campaign	Based on results of the needs assessment, target audience and specify behavior change goals (e.g., enable married men to make informed FP decisions, enable men to limit their sexual partners, encourage married men to initiate discussions with their spouses on FP).
Design a campaign with multiple channels of communication	Create ads for radio, TV, and newspapers. Facilitate community mobilization sessions with religious, community leaders, and health professionals. Run national contests to test people's knowledge about an RH issues (e.g., FP, maternal care, AIDS, violence).
Monitoring and supervision	Monitor activities and their outcomes (e.g., number of radio programs, themes addressed, number of call-ins to radio station or to hot lines following a given program, number of men participating in contest, their knowledge, attitudes and practices based on answers to questions on entry forms). Supervise activities by undertaking focus group discussions with target community members and with health providers. This can provide necessary feedback on the quantity and quality of the campaign (e.g., if there enough posters visible, if the message clear and not offensive).
Evaluation	Develop and implement evaluation tools to measure program success. For example, conduct surveys of viewers and listeners that ask them about issues addressed in the campaign, what they learned from it, and the behaviors they have changed in response to the campaign. Conduct another KAP at the end of the campaign to measure changes in knowledge, attitudes and practices.
Get celebrities or popular political leaders to endorse the campaign	Enlist personalities that tend to raise the visibility of such campaigns, including

MEDIA APPROACHES	
KEY STEPS FOR IMPLEMENTING MEDIA-BASED PROGRAMS	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	musicians, actors, member of a royal family, television celebrities, etc.
Pre-test messages and materials associated with the campaign	Assure that messages are culturally appropriate and/or religiously acceptable. Test them with religious and community leaders.
Involve the private sector	Involve private companies to increase visibility and share costs. Companies are often willing to contribute prizes for contests.

To access a presentation, click on the title of the presentation.

"Enter-educate," a behavioral change communication strategy, combines entertainment and education and has been successful in raising awareness and informing men, women, and adolescents about RH. Typically, enter-educate programs use dramas and films to relay a message about a reproductive health issue. Often the performances or plots target a specific audience and address topics that people face in their daily lives. These performances demystify myths and correct fallacies but also break through the taboo of talking about sexual issues by leading discussions with the audience about topics addressed in the show. Directed discussions are integral components to media approaches that aim to change behaviors.

Two media approaches aimed at involving men in MCH: **The Suami SIAGA (Alert Husband) Campaign in Indonesia** and the **Safe Motherhood Media Campaign (Mongolia)**. These two approaches relied on television and radio to relay RH messages and supplement this with other related activities. For instance, the program in Indonesia held national public relations events including radio talks shows, roundtable discussions with health officials and political leaders, and interviews with print and broadcast news reporters that generated extensive coverage of the campaign. The program in Mongolia included short TV programs, which were supplemented with radio programs, newspaper articles, a RH newsletter, and informational pamphlets and posters that were distributed nationally.

An independent evaluation of the Suami SIAGA campaign attributed the campaign to helping men and women change their behaviors during pregnancy. The evaluation revealed that more men accompanied their wives during delivery and to prenatal check ups, an indicator of increased involvement. In the case of Mongolia, evidence that the campaign was a success was an increase of telephone calls to a hotline service and frequent requests for repeats of the television and radio programs. One of the lessons learned in Mongolia is the importance of producing films in settings that resemble those of the targeted audience. Broadcasts were in rural settings and realistically conveyed the needs and challenges faced by a rural population.

A film-based program for adolescents in South Asia is described below.

"Growing Up" Toward Gender Sensitization and RSH for Young People in South Asia.

The summary below is based on a paper submitted by Venu Arora, *Towards Gender Sensitization and RSH for Young People in South Asia*, Ideosync Meida Combine, New Delhi, India, September 2003.

Implementing organization: Ideosync Media Combine

1. Background

"Growing Up" is a film-based sex education module designed for an in-school facilitated intervention with adolescent boys and girls. Though it has been produced and designed through a participatory process with young people in India, the module is designed in a manner that is relevant to many other South Asian countries.

Country context: With a population of over a billion people, and an extremely high percentage of young people, India is a country where the reproductive and sexual health of young people continues to remain a challenge, largely because the national health policy framework has not made it a priority. This is somewhat surprising, considering that HIV/AIDS receives a fair amount of government and media attention. The media and those working in the health sector repeatedly stress that the most vulnerable segment is the sexually active young population. HIV prevalence levels are on the rise; and current estimates suggest that more than 4.5 million people in the country might be affected by the virus. The first National Behavioral Surveillance Survey conducted in 2001 shows a large number of people have heard about the virus and the fast spreading epidemic; but simultaneously reflects an extremely poor understanding of safer sexual practices and vulnerability issues.

Taboos around discussing sex and the gender bias against women compound the complexity of addressing issues of sexual health, reproductive care and HIV/AIDS prevention. This then becomes fertile ground for myths and misinformation to spread – and a happy hunting ground for quacks offering a variety of pseudo-scientific sexual therapies.

There are no safe spaces for adolescents experiencing their first sexual urges and thoughts about sexuality to discuss their fears and anxieties. Young boys, especially, are under tremendous peer pressure to prove their masculinity. Gender constructs make it difficult for young people to ask questions, especially about the opposite sex. Understanding of basic human biology, reproductive anatomy and the sexual organs are poor. A service delivery system to offer sexual health care for adolescents is completely missing. Parents and teachers, while acknowledging the HIV/AIDS epidemic and the need to disseminate more information dissemination, find it difficult to approve of interventions that directly talk about sex and explain condom use.

Some brave but isolated efforts in the face of much opposition have led to small and short-term initiatives in private schools. Unfortunately, these initiatives are limited in many cases to a single interaction with a doctor (usually with 14-15 year old girls to discuss menstruation and menstrual hygiene). Ironically, many of the girls involved are already menstruating by this time, and have already crossed the moment of fear, isolation, and guilt. Indeed, none of these interventions link the physical and psychological changes brought on by puberty to preparing young girls for sexual activity; therefore, most young girls do not know why they menstruate.

Boys, on the other hand, are not considered worthy of even this level of discussion and are often left completely out of these kinds of sessions. There is no discussion of their feelings of guilt about masturbation or nocturnal emission, or their anxieties regarding the size of their penis, for example.

The "Growing Up" project evolved in a context where fledgling efforts towards a sustained reproductive health awareness process were being made by private schools catering to the English-speaking urban Indian middle class. These schools were struggling with life-skill initiatives that started in the wake of the growing fear of the HIV epidemic; but the school-based interventions were still not meeting the challenges of answering young peoples' questions in a sustained manner, or addressing issues surrounding safer sex within the larger context of physical, psycho-social, and sexual changes during puberty and adolescence.

2. Design

The "Growing Up"module was developed as a kit to be used in schools in a sustained fashion, starting with 9-10 year olds and going up through 16-18 year olds. It has been designed as a series of video-based modules, for use in workshops headed by a facilitator or a teacher. The basic informational and empathetic content of the videos are designed to be supplemented by discussions, games and role-plays, some of which are suggested in the facilitators' handbook that accompanies each set of films.

Preliminary workshops were designed to assess the level of information and the kinds of questions asked of young people between the ages of 10 - 14. Within the first few months of conducting the workshops, designers of the tool found that teachers and parents had incorrectly assessed the students; adolescents had many questions and were very willing to talk about these issues. Through sustained interaction, the developers of the tool found that students were not only keen to talk about issues relating to their changing bodies, they were also visibly relieved to find someone with whom they could share their thoughts and ask questions without the fear of being judged from a moral standpoint. It is from such sustained interactions with groups of students that the overall design of the module was developed.

The modules are not meant to be encyclopedic; rather they have been designed to facilitate the flow of questions and answers between the facilitator and the young people. The films are meant as tools to assist facilitators to:

- Break the ice and begin discussions with young people;
- Approach the subject in a coherent and systematic manner;

- Discuss physical anatomy as a foundation towards understanding bodily changes during puberty;
- Discuss adolescence, self image, peer pressure, changing relationships with parents and other adults, and the feelings of young adolescents in the face of authority.

In addition, information regarding feelings of attraction towards the opposite sex, and conception and safe sexual practices are provided in the films through discussions between groups of young people.

An accompanying handbook follows each segment of the films closely, expanding on the issues addressed, and providing suggestions for discussion topics, interactive games, and additional information relevant to each segment. The films themselves are structured around multiple elements, including puppets, animation, songs, and dramatized sequences.

While the first "Growing Up"module set was developed in English, it has now been adapted for use by Hindi-speaking schools. The information package for the Hindi set was slightly modified to appeal to the concerns, economic, and social indicators of the Hindi-speaking youth. The films have been remade with young people from the appropriate socio-economic/cultural milieu to accurately reflect their concerns and influences. Attention to the minutiae of socio-cultural-economic context distinguishes the "Growing Up" initiative; it allows the targeted audience to strongly identify with the characters portrayed and the dilemmas they face.

The English modules in the next set targets 14 – 18 year olds and are currently under production. They will address issues around pregnancy, contraception, and sexual and reproductive care; STIs, HIV/AIDS, and safer sexual practices; and sexual choices and rights. The completion of the parallel set in Hindi will complete the "Growing Up"module package for schools.

Formative research: The "Growing Up" film-based sex education modules have been designed using results from an extensive formative research process.

The methodology for this research process was largely dependant on qualitative tools which were developed keeping in mind the sensitivity of South Asian school systems and parental resistance to discussing issues around safer sex and sexual and reproductive health with young people.

A key element of the research methodology was a three-tiered interactive workshop program with young people of two distinct age groups: 10-13 years and 14 – 17 years. These workshops were conducted with a fairly large sample of randomly selected participants from a variety of Indian schools

The first tier of workshops with both groups included:

- Rapport building between the facilitators and workshop participants;
- Delineating issues of concern to the participants, and prioritizing the issues on the basis of a majority vote;

- Creating sub-categories and topics within these issues for further exploration and comprehension.

The second tier of the workshop program included team exercises that were designed for young people to learn about sexual and reproductive health issues and understand social attitudes through group work. These team exercises included, team debates, team role plays, and team problem-solving exercises.

The third (and final) tier of workshops were designed to directly feed into the video modules in the sense that they involved the finalization and rehearsal of role plays that became part of the films; as well as group discussions and reenactments of past events from the participants' lives that were also included in the films.

An additional component of the workshop program was a basic questionnaire on puberty and sexual health issues that all participants had to answer. This questionnaire provided the project team with a quantitative baseline on information levels, knowledge, understanding and attitudes.

Development of Indicators: These three-tiered workshops elicited some of the following indicators that were used to design the films and the accompanying handbook to best respond to the needs of the adolescents:

Examples of indicators for 10 - 14 year old school going adolescents in metropolitan cities in India:

- Knowledge of at least three changes that a human body goes through as it grows;
- Understanding of (and ability to articulate) the biological differences between boys and girls;
- Understanding of menstruation, and the biological reasons for it;
- Explaining the health implications of sexual intercourse;
- Myths and misconceptions around masturbation, nocturnal emissions, menstruation, and pregnancy;
- Understanding of the terms HIV and AIDS;
- Acknowledgement of emotional confusion and awkwardness especially with regard to physical changes like the appearance of facial hair in boys, growth of breasts in girls, and the sudden increase in height or weight in both sexes;
- Understanding and ability to articulate the importance of hygiene during menstruation;
- Understanding of gender as a concept;

Examples of indicators for 15-17 year old school going adolescents in metropolitan cities in India:

All the indicators for 10-14 year olds were applicable to the older age group. Additionally, the following indicators were included:

- Adequate comprehension of the consequences of sexual intercourse;
- Knowledge regarding at least four sexually transmitted infections;
- Knowledge and understanding of HIV/AIDS and modes of transmission;
- Misconceptions around HIV and STIs and biases against HIV positive people;

- Understanding of homosexuality as a concept and biases against homosexuality and homosexuals;
- Level of approval/disapproval regarding sexual activity before marriage;
- Understanding of issues surrounding sexual abuse;
- Gender biases related to pregnancy, child-rearing and contraceptive responsibility;
- Influence of media on attitudes/role models.

The quantitative and qualitative data gathered during the workshop and questionnaire process served as direct inputs to the "Growing Up"video modules, as follows:

1. Where the original project design called for a set of modules in English and a parallel set in Hindi, research data gathered highlighted the existence of distinct sub-groups within the English medium and Hindi-medium schools which would comprise the user audience. The sub-groups were defined along economic, social and educational family backgrounds, and required sharply differing structural and thematic adjustments to the modules. Thus, while the original project design envisaged dubbing of the English version of the modules into Hindi, the emergence of these sub-groups created a need for a separate set of the modules with a similar informational content, but a markedly different treatment of the subject.
2. The research data defined the principal themes to be addressed by the modules; and more importantly, the thematic spread of issues across the three video films that comprise the set. Additionally, it defined how many of these issues would be expanded upon (a task defined in the facilitators' handbook that accompanies the films).
3. The data also suggested a structural/stylistic/thematic treatment for the films, in that factual data was eventually included in the form of animated and diagrammatic content; and attitudinal and social behavior-related information was presented through role plays, dramatized sections and puppetry. Since there was a marked acceptance for information passed on by peer role models, representative peer figures also became an important part of the films.

Pretesting: various design options for the featured muppet characters were pre-tested with a sample of the target audience, to identify preferences and character detail. The featured songs and their lyrics were also pre-tested before production, and the dramatic sequences included in the films actually evolved from the skits and role plays that emerged from the many interactive workshops conducted as part of the pre-production work on the films.

Safe spaces to address myths: **t**he experience of sustained interaction with groups of students contributes to the conclusion that it is the lack of a supportive environment that is the primary factor inhibiting young people from discussing issues around their sexual and reproductive health. Given a supportive and safe space, both boys and girls are open to understanding and learning about their bodies, and voicing their fears regarding sexual and physical interactions, and abuse. There are numerous myths regarding masturbation,

pregnancy, conception and HIV/AIDS intertwined with strong feelings of guilt and moral self castigation in both boys and girls. For instance, beliefs that:

- HIV can infect an individual only after he or she is 18years old;
- kissing or holding hands with a boy can make a girl pregnant.
- masturbation leads to infertility; that the loss of semen is like the loss of blood;

"Growing Up"is designed to provide the fostering atmosphere of respect, openness and frank discussion where these concepts can be clarified and such myths dispelled.

3. Results

Preliminary experience with young people has shown that involving boys in groups with girls, rather than separate ones, allows for a more empowering experience. It allows them to better understand each other and gives them a platform to voice their opinions. Workshops and discussions that follow the viewing of these films provide opportunities to correct such misconceptions as when a girl says no she really means yes; that the sex of the baby depends on the mother; that girls do not enjoy sex as much as boys do, or that boys are only interested in sex and that girls are very emotional.

In same sex groups, these issues did not come up as passionately. Furthermore, involving boys in mixed-gender groups has two advantages: a) it exposes them to the gender biases that girls constantly confront, such as preferential treatment of sons in families, and b) it breaks down the taboo of undertaking a group activity with women. A consistent outcome of mixed gender group workshops is that boys often concede that they should share more of the household responsibilities.

Evaluation plans: The module is currently in circulation through a three-pronged dissemination strategy. A central clearinghouse maintains complete records of all end-users acquiring the modules for future contact and feedback. Various UN agencies and government and non-government organizations have been provided with sets for use in on going interventions. A long term training-cum-discussion program with various schools across the country is also being planned to enable end-users to adopt the most appropriate strategy for introducing the module within their own spheres of activity. Ideosync Media Combine is in the process of putting together a system of feedback and monitoring that would allow them to evaluate the successes and the challenges that need to be addressed in future work on sex education in schools on a continuing and sustainable basis. They also plan to host a forum where end-users can share their experiences and strategies for using "Growing Up." The intent is for these inputs to enhance and supplement ongoing efforts towards designing innovative reproductive health communication strategies and materials for young people.

LESSONS LEARNED

Program designers found that as boys age, they become more rigid in their bias against girls, as they increasingly mimic postures espoused by the society at large. In the younger age groups, the boys were more open to gender equity in all spheres of life.

Chapter VIII
Tools and Programs for Monitoring and Evaluation

Examples of questions to include in a Knowledge, Attitudes and Practice Survey (KAPS) are included in Annex I. KAPS are useful tools for assessing program needs and evaluating program achievements.

The programs outlined is this guide show the value of program evaluation and acknowledge the complexity of measuring changes in knowledge, attitudes, and practices, i.e., factors programs aim to change. Quantifiable outcome indicators require a clear definition of desired results in terms of women's health and gender equity. Indeed, measuring outcomes goes beyond defining desired outcomes, it includes developing scales to measure results and establishing norms on timing assessments, given that change takes time. These programs recognize that quantifying outcomes plays an enormous role in persuading donors and policy makers of a program's success in accomplishing its goals and meriting longer term funding, as well as in determining which interventions are effective and should be replicated.

To inform how indicators are developed and how to use them to quantify program achievements, two presentations focus on these separate objectives. One informs about the development of indicators to measure men's gender equitability, **Measuring Gender Equitability Among Men (Brazil)**; and the other, **Preliminary Findings from the New Visions Program Pilot Evaluation in Egypt**, demonstrates the steps taken to measure the achievement of a pilot project with boys and young men in Egypt. The former suggests a scale that could be adapted to any male involvement project that mainstreams gender while the latter provides examples of quantitative indicators and how to apply them to assess improvements in RH knowledge and changes in behaviors, attitudes, and "gender awareness sensitivity."

UNFPA recently developed and published a program advisory note, *It Takes 2*, which includes a section on "outputs and output indicators for programming." These were not presented at the conference but merit mentioning as they include: a) program outputs for the different levels of society a program aims to impact; b) output indicators to measure achievement; and c) suggested activities to achieve intended outputs. This tool is available on the UNFPA website http://www.unfpa.org/upload/lib_pub_file/153_filename_ItTakes2.pdf.

Measuring Gender Equitability Among Men (Brazil)

Implementing Agency: HORIZONS program of the Population Council and Instituto PROMUNDO.

1. Background

There is an increasing awareness that gender role socialization puts men and their partners at health risk (WHO, 2000), and evidence to that effect, such as a study which indicates that young men who support 'traditional' versions of manhood are more likely to use drugs, be violent, practice unsafe sex (Courtenay, 1998). To understand risk and

prevention behaviors, we should investigate both men and women's views about gender roles, as well as evaluate the impact of programs . Unfortunately, to date there are few quantitative studies that measure "gender-equitable" norms and behaviors. Most research about men and the role that gender plays in affecting their health is qualitative, which does not easily permit comparisons across different people or groups. Of the quantitative studies, few use psychometrically evaluated and culturally-specific measures. This presentation focuses on the development and evaluation of a measure for gender-equitable norms and behaviors for men, the Gender-Equitable Men (GEM) Scale.

2. Objectives

The objectives of the study are to:

- Develop and evaluate a measure for gender-equitable norms and behaviors (GEM Scale);
- Determine the relationship between gender norms, and violence and HIV/STI risk;
- Follow with an intervention study to test the impact of a program that promotes gender-equitable norms and behaviors among young men, and investigates if violence and HIV/STI risk decreases.

3. Implementation

Stakeholders and their roles: Instituto PROMUNDO, and Instituto NOOS, both Brazilian NGOs, conducted the initial baseline, with technical assistance from the Horizons Program, a USAID-funded global HIV/AIDS Operations Research, led by Population Council and partners. The MacArthur Foundation provided financial support for the initial baseline. The follow-on intervention study is being implemented by Instituto PROMUNDO, with technical and financial assistance from the Horizons Program. Instituto PROMUNDO, PAPAI, ECOS, and Salud y Genero, designed the program under evaluation.

Cost: The intervention study cost $180,000.

Challenges and Opportunities: This was a first attempt by the research and intervention team to develop such a measure for the Brazilian context and it was unclear whether the measure would be sensitive enough or would be applicable in other cultural settings. However, there was substantial local and international interest in developing such a measure. Creating a scale was appealing because it would be a useful tool for evaluating the impact of Program H, to explore how gender dynamics are related to violence/HIV risk, etc., and if to explore if these dynamics can be influenced with interventions similar to Program H. As there were no appropriate measures available, particularly for this cultural context, HORIZONS and PROMUNDO worked together to develop a scale. An evaluation of the program, using the scale, is now ongoing

Defining "gender equitable men": The definition of whether or notmen are gender equitable is based on the results of intensive qualitative ethnographically-based research with young men in Brazil. The research involved observing and interacting with 25 young men in a *favela*, a low income neighborhood, in Rio de Janeiro. The methodology

required following these young men (ages 15-21) two days a week for one year, interviewing family members of some of the young men, conducting life history interviews, focus group discussions and key informant interviews (Barker, 2001). The study concluded that gender-equitable men have the following characteristics:

- Support relationships based on respect, equality, and intimacy rather than sexual conquest;
- Are involved fathers, both financially and in care-giving;
- Take some responsibility for reproductive health and disease prevention;
- Oppose intimate partner violence.

Based on this local research (Barker, 2001) plus various qualitative studies worldwide that discerned similar characteristics, the GEM scale was developed to include gender norms around the following domains:

- Home and child-care
- Sexual relationship
- Sexual and reproductive health
- Violence
- Homophobia and relations with other men

The scale items were administered to 749 men between the ages of 15-60, with an over sampling of young men (15-24 year olds) to allow for more analysis of the youth. The questionnaire was administered via a household survey to a random sample of men in three neighborhoods. The households were selected using census tract data, and one man was interviewed per household. The research team, which was all male, used house-hold community surveys and conducted face to face interviews in low and middle income communities in Rio de Janeiro. The surveys included 35 gender-equitable norm items and questions about key health related behaviors, such as partner violence and condom use.

Questions that are theoretically related to gender-equitable norms, such as socio-demographic status, history of physical violence, and current safer sex behaviors were used to analyze statistical associations with the gender norms.

Building a GEM scale with findings in the statistical analysis: Factor analyses and coefficient alpha tests were utilized to determine which of the gender norm items would be included in the GEM Scale. Analysis supported the hypothesis that there are multiple important domains within gender norms that should be taken into account, and the resulting scale maintains good reliability. In addition, the GEM Scale is associated with key outcome behaviors. For example, those young men who reported more equitable norms were significantly less likely to report partner violence. This supports the validity of the scale.

LESSONS LEARNED

- The GEM Scale appears to be a useful measure for gender-related norms and behaviors among both youth and adults in Brazil. (It is being tested elsewhee to see if it is universally applicaable.) It seems to be sensitive to assessing men's

attitudes about gender norms. Furthermore, the scale provides a way to measure attitudes at baseline and whether there are changes due to an intervention.

- The study provides evidence that holding inequitable gender norms is associated with reporting risk behaviors such as partner violence and lack of condom use. Support for more gender-equitable norms are associated with less partner violence among youth and more condom use among adults.

  Condom use at last sex with primary and second partner was measured. For adults, condom use with a secondary partner was significantly associated with the gender norms scale (more gender equitable, more condom use). For youth, partner violence (have you ever...hit, kicked, etc…with your current or last primary partner) was associated with the gender norms scale (more gender equitable, less violence).

- Adults are significantly more likely than youth to support gender-equitable norms. Younger men reported more inequitable norms than older men, possibly because they have less real experience in relationships and do not realize they have to negotiate or compromise.

- To develop the scale, questions were based on the qualitative research that was done with young men in the community, and a community survey was developed and tested before applying it to the young men who participated in the intervention.

  The community survey provided evidence that gender norms (as measured by this scale) are associated with HIV risk behaviors, such as reported violence and condom use.

Chapter VIII
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Chapter IX
Conclusion

Reaching Men to Improve Reproductive Health for All Conference, 2003
Meeting objectives

The conference demonstrated the impressive progress that has been made in male involvement programming since the International Conference on Population and Development (ICPD) in Cairo (1994) and even since the Symposium in Oaxaca (1998). Presentations were chosen through a call for abstracts which attracted a response that surpassed all expectations. Almost three hundred abstracts were submitted for selection and over 80 of them were approved.

Feedback from participants and donors through word of mouth and formal evaluations indicates that the conference met its objective of increasing knowledge about effective strategies to work with men on reproductive health issues with a gender-equity perspective. This response came particularly from participants from developing countries, who represented local NGOs, rarely participate in international fora, but are working with men to reduce the spread of HIV/AIDS and address the problem of violence. Participants – especially those working in isolation – were grateful to connect with colleagues worldwide working on similar programs and for the opportunity to bring home IEC materials and other useful resources that are difficult to obtain in the field. Such opportunities, together with a day of training workshops (which were well-attended despite the significant difficulties posed by Hurricane Isabel), furthered the third objective of the conference: to increase skills and access to tools for implementing program strategies.

Building consensus

> *To get rivulets to become streams to become tributaries to become great rivers will require for many if not most of us changes at the policy level to give national sanction to the work we do.*
>
> Barry Chevannes

The conference confirmed the complexity of programming for men and the increasing awareness by program managers, designers, activists and gender equitable men and women that all levels of society have to be involved in institutionalizing these changes. This is evidenced by the involvement of stakeholders in the projects presented which ranged from political to religious and military leaders, to parents and adolescents.

Furthermore, the conference solidified general agreement on key factors of programming for men. Certainly, one of its most important contributions was to move towards broader consensus. There were a number of aspects where there was common agreement which were repeatedly mentioned. These were:

- Programs can involve men in ways that support women and promote gender equity, but we are not there yet (Barker Introductory remarks, September 2003);
- Knowledge is only the first step, changing attitudes and behaviors require long-term follow-up and support (Mosena, Peer Advocates for Health, September 2003);
- Both men and women are interested in men's involvement during maternity care (Kunene, Men in Maternity Project, South Africa, September 2003);
- Forming strategic alliances is critical to program success (Shrestha, MAP in four countries, September 2003);
- The work of male involvement is personal and requires self reflection (Das, Keynote address, opening session, September 2003) at the individual and organizational level;
- Men have to be engaged by allowing them to set their own agenda. They must be allowed the space and time to shape their own discourse (Chevannes, Keynote address, closing session, September 2003);
- There is an urgent need for quantitative indicators to rigorously evaluate programs.

The conference succeeded in achieving a consensus by implementing several strategies that facilitated communication across countries, cultures and disciplines. The call for abstracts and its response served to consolidate the wealth of diverse experiences (e.g., country wide programs, pilot projects, or operation research studies). Once their abstracts were chosen, presenters worked with partners from the Task Force and Conference Advisory Group to assure high quality focused presentations. These peer to peer exchanges initiated relations between professionals working on common themes, yet strangers to each other. It helped raise the bar of expected outcomes months before the conference opened. Defining at the outset key issues that inform on program implementation facilitated disseminating information about what works, how to circumvent obstacles, who are critical stakeholders, how and when to attract them and convert them into advocates, the importance of monitoring and evaluation and what rigorous assessment and supervision entails. The "wrap-up" sessions at the end of each day, which challenged participants to apply what they learned, gave non-presenting participants an opportunity to share their knowledge and experiences. Finally, the firm belief among participants that mainstreaming gender in RH requires integrating men and that such an approach will reduce the spread of HIV/AIDS, unintended pregnancies, violence against women and improve the well being of men, women and children enabled participants to focus on lessons learned from current experiences and focus on the next steps that are critical for sustaining and institutionalizing such programs. The consensus building that permeated is reflected in the outcomes of a session held immediately after the closing ceremony where participants were charged with determining follow-up and next steps.

Future Directions for Involving Men in Reproductive Health

Before dispersing, participants met to discuss future directions for involving men in reproductive health and were divided into five groups: programming, policy and

advocacy, networking, funding, and evaluation. The recommendations presented by each group are summarized below:

A. Programming

Although interventions should target men in different age groups, a special focus should be on youth aged 10-14 since this is the group that is most open to change and can help to facilitate new gender paradigms in the long-term. Additionally, programs should target not only young boys, but other groups in the community who play influential roles in their lives, such as caregivers, siblings, families, role models/ motivators.

The following approaches/strategies were suggested by participants for programs focusing on involving men in RH:

- A focus on leadership development, specifically for men to be different kinds of men/leaders.
- Programs should be based on the needs of young men/youth themselves and should recognize the different needs of men over their lifecycle.
- Programs need to involve the community. Programmatic strategies should be "demand driven" and developed in dialog with the community, focusing on the issues that the community identifies.
- Programs should encourage behavior change, but should build on positive behaviors that already exist. Other new and positive behaviors can emerge from the community itself.
- Programs should focus on capacity building at the local level, with both with groups and individuals.
- For programming related to HIV/STIs, activities should go beyond the Abstinence, Be Faithful, Condom Use (ABC) strategy, which participants considered to be narrow and "top down". Additional activities proposed included examining gender roles, social norms, educating and informing men and women about joint decision-making and communicating about such sensitive issues as safer sex.
- Programs should encourage both same-sex as well as mixed sex groups in activities.
- There should be a strong focus on sexuality and gender in programming for men's involvement in RH.

B. Policy & Advocacy

Provide advocacy training and capacity building around advocacy for those working in the field.

Strategies

- Form a network of conference participants to develop a draft statement for the Commission on Status of Women (focus of which is men and boys and gender equality). The issue of men's roles as fathers is already being discussed. An immediate step would be to link with other advocacy groups working in this area

such as Fathers Direct from the UK, which has developed documents for the UN on positive ways of engaging men as fathers.

- Recruit legal communities, lawyers, faith-based organizations (FBOs), labor orgs, First Ladies (important in Latin America and Southeast Asia), visible leaders (e.g. Desmond Tutu).
- Work with members of the social and economic justice community in Africa and in other parts of the world.
- For policy leverage, focus on areas in which traditional versions of manhood lead to loss of human capacity, capital and lives (e.g., ask health economists to look at the costs of hegemonic masculinities such as men and substance use, accidents.) Use cost-benefit analyses as an advocacy tool.
- Create innovative policies and frameworks that inform and obligate stakeholders to advance issues of men and RH across sectors (e.g., CEDAW).

Issues to Focus On

- Advocacy around the inclusion of sexuality education in schools (focusing on gender issues/gender equity).
- Antenatal parenting classes for men and women.
- Violence prevention training for police, both preventing men's violence against women as well as effective ways of reducing violence between men.
- Research existing multilateral lending, poverty reduction structures and health and education initiative to assess their possibility of being entry points for promoting male involvement and gender equity by involving men.
- Draft a policy framework on the issues.
- Advancing men as part of agenda using existing frameworks, including Education for All, CEDAW, among others.

C. Networking

- Compendium of best practices and resources from this conference should be translated broadly and disseminated regionally (Best practices should be classified by categories).
- Follow up with regional, sub regional and national groups working on this issue. If national groups do not exist, they should be created. Information exchanges at the regional or sub regional levels should be carried out by an organization that works directly in the area of men and RH, gender issues.
- A global listserv could be created with regional subsections of this listserv; similarly, a web group could be created to focus on specific issues within male involvement.
- The Reproductive Health Outlook (RHO) website could be made more accessible, perhaps a website could be created that focuses directly on men and RH.
- Information should be shared with concerned groups, police, military, justice sectors, etc. Information packets should be developed for these groups.
- Specific events (e.g. Father's day) should be used as moments to share information and to share information between large civil society groups of men.

Rallying symbols should be found to unite such groups (e.g., White Ribbon Campaign).

D. Funding

- Donors should be actively involved in leveraging other funds. Funders can challenge other donors, particularly private sector funders, to encourage other private sector groups to do the same, and to also serve as donors.
- Donors should closely screen pilot efforts; look at how to scale up existing work by finding out what has already been done.
- Donors should fund partnerships between NGOs and the public sector. Instead of funding only one sector, donors should fund a consortium of NGOs working with the public sector to engage the public sector to scale up. Community and youth should be included in this.
- Donors should provide a long-term commitment especially to look at sustainability over a longer period of time and, in terms of research, to fund multi-year studies.
- Donors should focus on funding collaborations between countries and sharing of information.
- Donors should use various evaluation methods/multiple methods, not just narrow quantitative measures. Measures/methodologies should be developed in collaboration with grantees.
- Donors should assist grantees to look at alternative income-generation/revenue generation.
- Agencies should work with donors to inform them about this issue by finding opportunities to examine donor agendas and find ways that can match program goals and objectives.
- Donors and agencies need to examine linkages broader developmental concerns and broader social justice issues that impede local development efforts.

E. Evaluation

- Overall, there is a need for more assessment and use of biological markers as outcomes; less costly, more feasible.
- A priori research should be built into programs as part of more rigorous evaluation.
- Programs should triangulate evaluations by using both quantitative and qualitative indicators.
- Evaluations should not only focus on indicators looking at attitudes but also on behavioral changes.
- Programs should strive to identify some common indicators across projects; if possible, try to identify some measures/indicators that can be used across settings
- Evaluations examining ranges of variation within a country are more important than comparing variations across countries.

- Scales are useful to measure variability such as a range of gender norms in a given setting, but the scales must be relevant and grounded in a given cultural setting.

ANNEX

EXAMPLES OF QUESTIONS TO INCLUDE IN KAP (Knowledge, Attitudes and Practices) SURVEYS

This example is from the CEDPA presentation *Preliminary Findings from the New Visions Program Pilot Evaluation in Egypt*. (See Chapter VIII.)

How important to you think it is that boys and men should learn about reproductive health?

a. Very important
b. Somewhat important
c. Somewhat unimportant
d. Not important at all

List three modes of transmission for HIV/AIDS
What is the family planning method that protects against HIV/AIDS?
List 4 temporary family planning methods

Whose decision should it be which family planning to use?

a. Husband
b. Wife
c. Both
d. Other (specify)_____

How likely do you think you are t accompany your future wife to a family planning clinic?

a. Very likely
b. Somewhat likely
c. Somewhat unlikely
d. Not likely at all

How large a role do you think the husband should have in....(Place a check in the column with your response)

A large role A medium role A small role No role all

a. Encouraging wife to breastfeed
b. Ensuring child gets vaccinated
c. Caring for the wife while she is pregnant
d. Ensuring trained individual (midwife, nurse) attends birth of child

Is it OK if a husband hits his wife if she..... (Please indicate your response by placing a check in the appropriate column.)

Yes No It Depends

a. betrayed her husband (adultery)

b. does not fulfill her duties towards her husband
c. spends money without her husband's permission
d. goes out without her husband's permission
e. answers back

Some people argue that the benefits of female circumcision outweigh any of the damages. Do you…?

a. Strongly agree
b. Somewhat agree
c. Somewhat disagree
d. Strongly disagree

Would you prefer to marry a woman who has been …?

a. Circumcised
b. Not circumcised
c. Does not matter

How old would you like your bride to be when you get married?

Please check whether you think that each role is the responsibility for men only, women only or both. (Please indicate your response by placing a check in the appropriate column.)

	Men only	Women only	Both
a. Decision making family			
b. Pregnancy and childbirth			
c. Household duties			
d. Participation in political activities			
e. Volunteerism to serve the community			

How often have you helped out around the house in the last month?

a. Very often
b. Sometimes
c. Rarely
d. Never

Do you think that boys and girls should be treated differently in terms of….

a. Food
b. Clothing
c. Work
d. Freedom to move around outside the house
e. Marriage age