

**Involving
Men to
Address
Gender
Inequities**



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Three Case Studies:

Involving

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Gender

Inequities

Prepared under the auspices of the
Interagency Gender Working Group,
Subcommittee on Men and
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Acknowledgments

IN 1997, THE MEN and Reproductive Health Subcommittee of the USAID Interagency Gender Working Group was formed with one overarching purpose: to assess and improve the constructive engagement of men in reproductive health programs and services, particularly those funded by USAID. Four times a year, representatives from 35 agencies, funding organizations and consultants have met to assess policy, identify research, and develop useful tools for involving men in ways that promote gender equity and improve the health of women and children as well as men.

The subcommittee has focused its efforts on three primary goals: improving the gender socialization of adolescents and young men; reducing gender-based violence; and promoting safe reproductive health practices, including the use of condoms to provide dual protection against both pregnancy and sexually transmitted diseases. The case studies highlighted in this publication represent three approaches to working with men, and their content covers one or more of these three thematic areas.

In addition to the primary authors, many, many people contributed to conceptualizing, writing, editing, and producing this collection of case studies; if we overlook anyone's contribution, we ask forgiveness. First and foremost, this publication would not have been possible without the extensive editing and involvement of Margaret Greene, then of Population Action International;

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Introduction

GENDER INEQUITIES OFTEN POSE serious obstacles to good reproductive health. While the reproductive health field has increasingly recognized this fact, it has been more difficult to document how reducing those inequities can contribute to better health for men and women.

Indeed, the 1994 Cairo International Conference on Population and Development's (ICPD) Programme of Action was shaped by the recognition that enabling women and men to become more equal partners in reproduction and childrearing can improve reproductive health. This document articulates a new emphasis on women's empowerment, gender equity, and reproductive rights. Yet, the implementation of this gender-equitable approach to involving men in reproductive health programs has been limited. Many reproductive health programs sidestep men for various reasons, such as assumptions about women's responsibility for childbearing and rearing, and the acceptance of negative stereotypes about men's detachment from their families. Moreover, fear of offending men and forcing social change upon them often underlies the reluctance to promote gender equity within programs.

The Interagency Gender Working Group's (IGWG) Men and Reproductive Health Subcommittee¹ was founded in 1997, following a survey by USAID to determine the nature and

extent of male involvement activities that had been undertaken by its cooperating agencies, the agency's contractors, and grantees. The survey revealed that what was most needed were models of programs whose goals were to improve women's reproductive health and gender equity by involving men in a conscious, considered, and constructive way.

The members of the subcommittee decided to respond to that need by publishing case studies from which other organizations could learn. The subcommittee examined approaches that have been used by organizations around the world to affect change in three areas: preventing gender-based violence, improving the socialization of male adolescents and young men to increase gender equity, and promoting awareness of dual protection (preventing pregnancy and sexually transmitted infections (STIs)/HIV/AIDS).

Three innovative programs that have engaged men and youth in efforts to improve reproductive health outcomes for both men and women were identified. **Salud y Género** of Mexico has worked with men in Latin America to reduce gender-based violence and improve men's support for women's reproductive health. **The Society for the Integrated Development of the Himalayas (SIDH)** in India has focused on education as a means of achieving social justice in its work with young people of both sexes to improve gender

¹ The Men and Reproductive Health Subcommittee was transitioned in 2002 into the Men and Reproductive Health Task Force in order to focus on the September 2003 Global Conference, "Reaching Men to Improve Reproductive Health for All."

equity and reproductive health outcomes. The **Stepping Stones** program, first developed in Uganda, is a communication, relationships, and life skills training package, which has worked with men and women, including youth, to increase awareness of gender issues to prevent transmission of HIV.

Each of these programs illustrates ways in which men were not only involved but were challenged to examine their assumptions of masculinity and of their right to greater power than women, and the effect of these assumptions on their own health and that of their female partners. The approaches sometimes attempt to shed light on the fact that accepting traditional masculine roles—such as risk taking and abusing power over others—often has negative consequences for men as well as for their sexual partners, and that men who are more in tune with their feelings make better partners, resulting in happier and healthier families.

While the three case studies chosen have not been formally evaluated, these programs provide valuable models of how to constructively engage men, including innovative approaches to involving men in social change, as well as the creative methodologies and approaches each of them used. They are worthy of study, rigorous evaluation, and possible replication by other organizations.

Salud y Género, the Society for the Integrated Development of the Himalayas, and the Stepping Stones cases share several features:

- ▶ All three evolved and developed as the organizations worked on health, violence, and related issues. They did not start working with men in response to a fixed plan that was in place from the outset. In fact, they continue to evolve.
- ▶ All three rely on a sequential process for opening the hearts and minds of participants. Step by step, the activities draw participants through a logical sequence of ideas and activities.

▶ Interactive self-discovery is a cornerstone of each program. Participants—and facilitators—have to do the work for themselves and open themselves up to their own and others' experiences. Facilitators are not separate from the participants and are required to recognize how their own experiences are conditioned by gender, class, family situation, and so on. Their recognition that they must face and resolve the same challenges as other participants helps to reduce the social distance between the two groups and creates solidarity between them.

▶ The programs attempt to bring about social change by acknowledging and bringing out the linkages between individual behavior and community norms. Social change may occur at a seemingly glacial pace until a critical mass of innovators has been reached, at which time change may occur rapidly and new social norms become institutionalized. These three programs have planted the seeds for social change within the communities in which they work. These efforts need to be nurtured through continued investment in exposing more people to these new, more equitable norms and creating community consensus that these new norms will ultimately benefit both women and men.

Few innovative interventions involving men in reproductive health programs have been evaluated rigorously from the outset. Social change is admittedly very hard to document and evaluate. Practitioners often do not know how to conduct these more complicated evaluations. Some of the most interesting programmatic interventions described in these three case studies evolved out of existing work rather than being planned from the beginning with an evaluation component. The Subcommittee has challenged each of them to review their own impact, and to lay the groundwork for future rigorous studies of the ways their work influences health.

The programs described in this publication have clearly benefited participants and the communities in which they have worked by promoting gender equity and, consequently, improvements in reproductive health. Challenging gender inequities is a long-term proposition that is largely uncharted. The experiences described in this volume lay the framework for a new paradigm for the field of reproductive health—one that begins

when men and women more equitably share power, roles, and responsibilities. Organizations undertaking reproductive health research have a responsibility to evaluate and incorporate programs like these: programs that are full of promise for improving the lives and health of women and men, preventing violence, and raising a new generation of gender-equitable youth.

CHAPTER 1

Constructing New, Gender-Equitable Identities: Salud y Género's Work in Mexico*

Benno de Keijzer, Emma María Reyes, Olivia Aguilar, Gisela Sánchez, and Gerardo Ayala

This case study describes the origin, development, and methodology of the Mexico-based NGO, Salud y Género, and its work on masculinity, violence, and health, with an emphasis on its all-male and mixed-sex groups dealing with health, violence, and changing attitudes toward violent behavior.

Executive Summary

The mission of Salud y Género, founded in 1995, is to contribute to better health and quality of life through gender-related educational activities in mental, sexual, and reproductive health. Formed by a group of medical and mental health professionals to further their work on gender equality and prevention of gender-based violence, Salud y Género's work is grounded in the belief that the biological and physical manifestations of health are inextricably linked to social factors and that social inequality interferes with the attainment of good health. The organization's approaches are based on the education and communication for social change theories of Brazilian Paulo Freire, in which the process of transformation is driven by the participants. Salud y Género's main methodologies are dialogue, experience sharing, and reflection.

A unique feature of Salud y Género's work has been to sensitize men to violence as a feature of masculine socialization harmful to men as well as

women and to recognize that repression of emotion often underlies violence.

Salud y Género uses a number of approaches to lessen the negative effects of male socialization on health including:

- ▶ Advisory and consultative services to NGOs, donors, and others;
- ▶ Gender education with men, women, mixed groups, adolescent boys, and men and professionals in the public and private sectors and through workshops and consciousness-raising groups; and
- ▶ Advocacy for reproductive rights, enhanced male participation, and prevention of gender-based violence.

Salud y Género's work is often directed toward men who are facing the challenges of poverty, unemployment, and societal discrimination, and to professionals and service providers who work with the poor. The thematic areas in which Salud

*This document would not have been possible without the efforts of many people: Miguel Angel Díaz, Juan Fernando Ruiz, Pablo González, Regina Nava, Silvia López, and Carlos Selvas; Judith Helzner and the IGWG Men and Reproductive Health Subcommittee; Margaret Greene, who reviewed several drafts of the document together with Karin Ringheim and Jay Gribble; Roberto Castro (CRIM-UNAM) and the Social Aspects of Male Violence Project; Eileen Sullivan and Linda Clesceri, who translated the document into English.

y Género works include alcoholism, mental health, paternity and fatherhood, and human rights. In order to promote dialogue, men and women are often first convened separately in groups before meeting jointly. Participatory and consciousness-raising exercises help participants examine the consequences of such “masculine” attributes as:

- ▶ Inability to express emotions;
- ▶ Male “privilege” not to participate in childcare;
- ▶ Risk-taking behavior, including substance abuse, reckless driving, and male-to-male violence;
- ▶ Rejection of “weakness” within themselves and others.

Through a collective diagnosis of the issues, role play, and innovative techniques—such as body mapping and a “Time Tunnel” exercise—male participants come to understand the relationship between these attributes and men’s shorter life expectancy, failure to form intimate relationships with their sexual partners and children, and inattention to their own mental, physical, and reproductive health.

Participants in these workshops begin to open up about the problems associated with being men in a patriarchal society. They reveal the pressures of providing for families in poor economic conditions, and of continually needing to prove “manhood” to other men as well as women, especially since their self-esteem is often compromised by lack of meaningful work. Some younger men lament being thrust into the limited role of breadwinner and disciplinarian and express their longing for more intimate relationships with their children. Men also begin to understand that

women’s human rights are often contravened from birth, and that this discrimination harms their sisters and daughters as well as their intimate partners.

The relationship between alcohol abuse and violence is a commonly shared experience for men that many are unwilling to talk about. Men are often the victims of violence as children and perpetuate this behavior as adults. The use of videos and exercises, such as the “Story in Every Scar,” helps men acknowledge that they have engaged in violent behavior toward loved ones, particularly under the influence of alcohol. Salud y Género uses exercises designed to elicit the emotions that are most difficult for men to express: fear and sadness. When suppressed, these emotions can turn to anger and violence. Men can learn constructive ways of expressing these emotions.

Salud y Género is strongly committed to advocacy on behalf of new models of fatherhood and the family. It believes that, through changes in the upbringing of children and the more equitable treatment of boys and girls in families, fundamental societal change in gender norms will be created and sustained. As an organization, Salud y Género models new ways to be men and women. In Mexico, it has organized campaigns around these issues at the national level and has worked with various international organizations to reach a broader Latin American audience.

Although the work of Salud y Género has not been independently evaluated, the organization is engaged in evaluation of its own work and an examination of the long-term impact of its workshops and groups on participants.

CONTRIBUTING TO “BETTER HEALTH AND QUALITY OF LIFE through gender-related educational activities in the area of mental, sexual, and reproductive health” is the stated mission of Salud y Género (Health and Gender), a Mexico-based NGO founded in 1995. The focus of the organization, whose initial team of medical and mental health professionals actually began working together in 1986 on community mental health issues, is on education, advocacy, and research. Its objectives are lofty:

“...to promote transformation in relationships between the sexes; to contribute to the empowerment of women and men in an equitable society; to construct open spaces for reflection, analysis, dialogue, information, and planning regarding sexuality and health education; and to influence gender-related policies and health programs.”

With a mixed team of women and men from diverse backgrounds, Salud y Género acts in an advisory capacity to organizations and groups on issues related to health, education, and population programs, while maintaining its independence from religious and political organizations. The organization’s activities extend from its offices in Veracruz and Querétaro to 24 other states in Mexico, as well as throughout Central America and Peru, and to various national and international networks. The original core group of three women and two men has expanded to 13 people, including staff and volunteers.

Financial support comes from the MacArthur Foundation as well as project funds from several international organizations, such as UNICEF, the International Planned Parenthood Federation Western Hemisphere Region (IPPF-WHR), EngenderHealth, USAID’s Interagency Gender Working Group (IGWG), the Summit Foundation, and the Latin American and Caribbean Women’s Health Network, and from such Mexican institutions as the National Institute for Youth. A significant part of its budget comes from workshops it conducts for other institutions.

Salud y Género’s education and advocacy efforts are directed at increasing male involvement in the mental health and the reproductive health (RH) of both men and women as a part of the construction of equitable relationships. It chooses methodolo-

gies and new approaches that help it reach a younger population and work with men and women together. The organization addresses problems for both men and women in which gender socialization and oppression are central causes, e.g. sexist education; mental, sexual, and reproductive health concerns; domestic and social violence; alcoholism; and the role of men and the obstacles to women’s development this role creates. The organization also seeks to raise awareness within the health sector of the importance of male involvement in both the prenatal and birth processes and of modeling new roles for fatherhood.

Salud y Género’s Philosophy

Salud y Género believes that various forms of inequality based on socioeconomic class, ethnicity, age, and sexual preference shape oppressive gender relationships. The organization’s work focuses on two sets of power relationships: *inter-gender* relationships evolving from a patriarchal model that presupposes the subordination of women to men and *intragender* relationships that often promote inequality among members of the same sex. Its work has been developed at the intersection of three fields: health, gender, and culture (see Figure 1).

The gender and health connection is most central to its work; the chances of being healthy, sick or dying are different for men and women and

FIGURE 1

The Intersection of Salud y Género's Work



much determined by their differing socialization, roles, and social status. Culturally created gender roles have implications for men's and women's participation in all institutions.

Salud y Género understands health from an integrated perspective—linking biological, psychological, and social aspects of health—and believes that it is difficult for health and well-being to flourish in a society full of social inequality. For Salud y Género, reproductive health starts with a holistic approach and focuses not only on disease but also on education and prevention.

“Change must be sought out intentionally,” Salud y Género states. “By making oppressive social relationships more visible, every one of us comes to understand that we are immersed in hierarchies of power relationships that shape our behavior and reinforce the exercise of power through abuse and inequality.” Salud y Género's aim is to disarm and

deconstruct these confining myths and social patterns by promoting critical thinking about individuals' lives and society and by transforming individuals' relationships with others.

Background: The Situation in Mexico

Important changes in democratization have taken place in Mexico over the past few years, although there are still areas of repression. The themes and problems related to sexuality and human reproduction, equal rights among the sexes, and family rights all take place in a country with divergent interests. As a civil society organization, Salud y Género has established diverse alliances with like-minded groups in hopes of advancing gender equality, even as it recognizes that there is opposition on the part of some political parties to a gender equity and rights agenda. Many governmental agencies have adopted resolutions that were promoted by the international conferences of Cairo and Beijing in 1994 and 1995²; nevertheless, their practical enforcement has been inadequate.

Mexico's sexist culture is changing very slowly. Growing support for greater gender equity from state government and from the academic community has facilitated the development of work directed toward men on domestic violence, sexuality, and reproduction. As men themselves become conscious of their own discomfort with a sexist culture, they also prompt social change. Women have brought many changes to the workplace, educational system, and family planning programs, particularly in urban areas where government programs and policies are more visible.

As women have moved toward greater participation in the workplace, no comparable change has occurred in men's role in the domestic sector. Salud y Género's work encourages male participation in reproductive health and in parenting

2 The International Conference on Population and Development (ICPD), Cairo, 1994; and the United Nations Fourth World Conference on Women (FWCW), Beijing, 1995.

responsibilities, as reflected in the vision laid out in the Cairo ICPD's Programme of Action.

Development of Salud y Género's Work

In the beginning, Salud y Género focused on working with women, propelled by the powerlessness and serious health issues women faced. However, over the past ten years, the organization's work on mental health pointed to the need to work with men also. Its initial activities focused on health education and promotion with urban and rural female populations through PRO-DUSSEP (Promoción de Servicios en Salud y Educación Popular AC), a national network of health service groups. This experience with women's health and mental health services brought to light the connection between the differing gender socialization patterns for men and women and how they affect health. Understanding men's crucial role in social problems like domestic violence and alcoholism, and their absence or insufficient participation in such important issues as responsible sexuality, contraceptive use, and fathering, led the organization to a deeper appreciation of how men's and women's situations and problems intertwine.

To understand the living conditions that affect men and women, Salud y Género has constructed a methodology for working with both sexes at different levels of awareness, separately and

together, and has also created a gender-equity framework. It uses these theoretical and practical tools for constructing new individual and collective identities that promote health and equity between men and women.

Working on gender issues in a mixed team of men and women has been a learning experience for the organization but has also led to conflict and debates. Salud y Género's work with men has brought it more financial support and social recognition than its earlier work with women, causing tension in the organization. "It is one of the ways that gender issues affect us as a team," the staff admits.

Salud y Género's Activities

From 1998–2001, Salud y Género trained more than 1,000 people per year in 124 workshops (see Table 1). The majority of the 4,500 participants in these workshops were women, but about 40 percent of participants were men. This is more than would have been expected, given that the workshops address gender relations, which has, to date, often been perceived as a "women's issue." About 30 percent of participants were youth, with a slight majority of them girls. Workshops varied in length (from one- to three-day efforts to longer term) and in scale (from local to national). The great majority of the workshops were for sensitizing participants, and a much smaller proportion for training them or for providing information.

TABLE 1
Number and Types of Educational Activities, 1998-2001

Year	Number of activities by setting			Population reached		Type of institution	
	Urban	Rural	Indigenous	Women	Men	Government	NGO
1998	26	5	1	814	480	13	15
1999	19	7	5	567	606	12	13
2000	30	7	5	686	690	13	23
2001	23	4	1	601	381	17	18
Total	98	23	12	2668	2157	55	69

A wide array of government institutions, including those with health, education, and development programs, have requested Salud y Género's help. Around 50 percent of its educational activities are outside the states where Salud y Género is located (Querétaro and Veracruz).

There has been a growing acceptance of the organization's work by institutions at both the local and national levels. Many of its collaborations have been with the health sector, the Family Integration Department, the National Institute for Indigenous Populations, several universities and, recently, the National Women's Institute. Salud y Género has worked with such UN agencies as UNICEF and UNHCR, as well as with many networks of NGOs including MEXFAM, UNORCA, Casa de la Tia Juana, Medicina Social Comunitaria, EPROSCO, and SISEX, and has conducted international workshops in Guatemala and Peru.

The organization's advocacy and education programs have expanded its influence and impact immeasurably. Some of its most fruitful collaborations have included:

- ▶ The promotion of separate areas of Women and Health and Mental Health in the context of the PRODUSSEP national health network;
- ▶ The organization of two training schools together with the Equipo de Mujeres en Acción Solidaria (Team of Women in Solidarity for Action [EMAS])—which has had significant impact on the creation of Salud y Género's own Methodological School and its main activity, the Health and Gender Diploma, launched in 2001;
- ▶ The participation in the Safe Motherhood campaign in Querétaro and Veracruz and the organization of the state conferences on this issue in 1994 and 1995;
- ▶ The training of MEXFAM's community health promoters in three states and the design of the

Jalemos Parejo (Pulling Together) curriculum for rural and indigenous population;

- ▶ The collaboration with several NGOs, including Medicina Social Comunitaria in Baja California, CEMIF in Oaxaca working with health officials and local populations, AMMOR/UNORCA working with rural and indigenous population, and La Puerta Negra (The Black Door), a men's collective working with men and adolescents in Chiapas;
- ▶ The revision of educational materials and promotion of male participation among rural and indigenous populations through the ReproSalud project in Peru (1996–2001);
- ▶ Four workshops on “Masculinity, Health, and Reproduction” for health officials of different government and private institutions in Guatemala;
- ▶ Participation in several health networks and networks devoted to gender equity (Milenio Feminista, Foro de Población and a masculinity network still under formation) as well as ones devoted to sexual and reproductive rights (Demysex and SISEX);
- ▶ Project H: Working with Young Men—Production of a video and five booklets on violence, reproductive and sexual health, HIV/AIDS, fathering, and mental health (together with three Brazilian NGOs—Promundo, Ecos, and Papai). The booklets are designed for training health and education staff working with young men; and
- ▶ In the academic world, working with teachers and students in areas linking health and gender in more than 14 universities—Veracruz, Querétaro, Colima, Guanajuato, Puebla, Guerrero, Tabasco, Baja California, as well as the Colmex and the UAM (Mexico City), ITESO (Jalisco), ECOSUR, CIESAS (Veracruz) and the Cayetano Heredia University in Peru.

What Motivates Men To Get Involved?

Some of the men who take part in the Salud y Género workshops approach the organization themselves. These are usually men who are seeking a space to share with others in which they can be heard. They may be men who are in a marital or family crisis due to their attitudes or actions (violence, alcohol, etc.) or men who have been socialized in a less macho way and who are attracted by what Salud y Género offers. But most of the men who take part in the workshops are approached by Salud y Género. In these cases, it may be because a woman who has already worked on gender issues wants the organization to work with “her” men—husbands, sons, or colleagues—through the workplace, schools, or the community in general. Many of these women feel their men would be more receptive to being addressed by a male with a reflective and critical gender perspective. These men react in different ways: resistance, curiosity, and, in a growing number of cases, with interest.

Themes and Problems Approached

Salud y Género’s work in gender education and advocacy promotes equity in mental health and reproductive health through group activities that involve men, women, and mixed groups. Its actions are intended to raise awareness of and to diminish the negative effects of male socialization on the health of both men and women, and much of its focus is on preventive work with adolescents and young men. Salud y Género’s advocacy issues include fatherhood (the reproductive experience of men), reproductive rights, and health care for women. In its work, the organization must overcome the resistance of men and women to change and, perhaps even more difficult, the resistance of legislators and health care institutions.

In view of this resistance, Salud y Género’s strategies focus on education and advocacy within both private and public institutions. Over the past few

years it has formed consciousness-raising groups and has trained women and men who work in institutions where they experience problems arising from the negative effects of gender relations on mental health and reproductive health. The next step is to provide follow-up and advisory services for ongoing gender/health activities in these institutions. Current demand is greatest for work with mixed groups concentrating on shared responsibility for construction of gender norms. Another priority is the growing need for work with young men’s groups.

The organization’s main advocacy efforts focus on improving women’s and young people’s reproductive health and rights, enhancing male participation in health (including reproductive health), and preventing violence against women. These activities are linked to wider campaigns and local and international networks.

Salud y Género’s basic belief is that women have less access to and control of resources to make decisions over their sexuality, reproduction, work, and social and political participation. And, even though women often have less personal power than men, men do not really exercise control over

Themes of Salud y Género’s work

- ▶ Men and women’s health
- ▶ Mental health and emotions
- ▶ Violence
- ▶ Alcoholism
- ▶ Equality in intimate relationships
- ▶ Paternity and maternity
- ▶ Self esteem, communication, assertiveness
- ▶ Reproductive health
- ▶ Human rights of women and children
- ▶ Sexual and reproductive rights
- ▶ Quality health care
- ▶ High risk pregnancy
- ▶ Gender and public policy
- ▶ Gender and personal development

their own sexuality, their reproduction, their bodies, their health or their social participation. Data show that in some ways, men's condition of privilege has a negative effect on their health.³ Traditional male socialization does not allow individuals to express their feelings or experience more loving relationships with their children, their partners and the world around them, or to be "weak" and seek out health care.

As an outgrowth of its work with female health promoters in urban, rural, and indigenous populations, *Salud y Género* began working with male health promoters and started self-help groups for middle-class men in crisis. It has implemented educational workshops with prison inmates as well as with indigenous communities, with both adults and adolescents.

Salud y Género has concentrated on working with young people, both in and out of school settings, as well as with health professionals. By working with young people, the organization hopes to achieve a multiplier effect—by reaching them now as young men and women, and as the professionals of the future. The organization reaches health and other professionals, particularly through its diploma course in gender and health. This course consists of modules on identity, body and health, mental health, sexuality and reproduction, fatherhood, motherhood, and families.

Methodology of Educational Projects and Workshops

The educational projects created by *Salud y Género* have incorporated elements of Paulo Freire's popular education theory and are based on the dialectic relationship between theory and social participation.⁴ Thus, the populations that the organization works with are not the objects of the activities but the "directing subjects of the activi-

ties," which these populations help define. Each population is different because their socialization, gender relations, and health consequences vary by class, age, region, rural or urban residence. *Salud y Género* employs a horizontal or egalitarian methodology that utilizes dialogue among participants and facilitators as the principal instrument. Problems relating to gender roles are identified and openly discussed, and participants describe the various factors that contribute to problematic situations and come up with solutions.

Because the presence of the opposite sex often makes it difficult for participants to express themselves, men and women are separated, especially in the first workshops. In mixed group discussions, men freely state their opinions on theory, but have greater difficulty talking about their feelings and personal histories.

Workshops begin with a session in which each participant chooses a drawing or a magazine photograph and shares what it means to him or her. Next, each person is asked to imagine "the best and worst outcomes of this workshop." The technique is used mostly with men who generally can state with ease their expectations but find it difficult to express their fears. Best-case scenarios include interesting expectations of change by individuals, by their families, and in their personal relationships. These anticipated changes usually go beyond what is possible to accomplish in a workshop but show that men are willing to enter the process of change.

Commonly, the worst-case scenarios reflect resignation that "nothing will happen," "everything will remain the same," "nothing is going to change." Other fears have to do with what is known as the "gender police." The weight of criticism and fear of ridicule from other participants,

3 Benno de Keijzer, Emma Reyes, y Gerardo Ayala, "Salud mental y participación social", en Haro y de Keijzer (Edits.), *Participación social en salud: experiencias y tareas para el futuro* (OPS y Colegio de Sonora, Hermosillo, 1998).

4 Paulo Freire, *Education for Critical Consciousness* (NY: Continuum, 1973).

especially other men, promote anxiety in the workshops. This negative peer pressure—real and anticipated—is a key obstacle to profound change. Most men are afraid to be labeled “push-overs” for their spouses. The exercise closes with a question on how the workshop can accomplish the best that can happen and not the worst. Participants’ responses generally emphasize listening, participating, respecting, and communicating. These responses are then established as the golden rules for participating in and running the workshops.

Specific Workshop Exercises

The workshops employ a number of exercises that often deal with male socialization and men’s health. Some of the specific ones employed are:

▶ **“The Story of Andres”:** To help define masculinity, participants often read and comment on “The Story of Andrés,” a Spanish fairy tale in which the protagonist asks a fairy to grant him a series of dominant attributes of manliness (the power of the warrior, the king, the wise man, the father, and the conqueror) without his ever becoming what he considers a “real man.” In mixed groups, the women read a similar story entitled “Rosa Caramelo” where female socialization emphasizes being beautiful, obedient, and safe in an enclosed garden.

▶ **The Male Body:** Following careful reflection on the ways in which this process affects our lives, participants go on to an exercise on the male body that reveals how male socialization affects both health and body. In a brainstorming session, participants jot down on index cards their ideas about the physical realities of men’s lives. The results underscore the following stereotype: Men are strong, especially physically. Artifacts associated with the male body include hats, belts, pistols and—in the modernized version—a cell phone used to “shoot off” orders. Machetes and bottles of alcohol are also mentioned. Less frequent are ref-

erences to emotions, and those most often mentioned are anger and an inclination toward violence. But “loneliness” also figures high on the list. In contrast, when women do the same exercise on the body, other emotions emerge, such as love and tenderness, but also sadness and fear.

Men do heavy work, they are bosses and providers, and these roles prevail over their roles as fathers. Rarely is the word “father” included in this instant compendium of terms that cluster around the concept of masculinity produced by male workshop participants. In eight years of working with men’s groups it has come up only ten times. In women’s workshops, on the other hand, the words “mother” and “maternity” abound.

Many men, upon seeing the male image that they have created in the brainstorming activity, reject it by saying, “But that’s not us.” Ultimately, however, they recognize that they “own” parts of this stereotypical image.

▶ **“Being Male” and Health:** Participants are then asked to relate the masculine characteristics that they have identified with specific health problems. It immediately becomes clear that “being male” contributes significantly to these health problems. The reality of this connection is backed up by local and national statistics on men’s health. The exercises end with a discussion of how men care for their health—an unexplored topic for most participants.

The word “stress” comes up frequently in work with groups of men. A whole set of gendered health problems are stress-related: gastritis, headaches, high blood pressure, and heart trouble. Men often react to these problems by becoming addicted to such substances as alcohol and tobacco, which produce cirrhosis of the liver and lung cancer over the long run.

Men are also very concerned with sexuality and reproduction, prostate problems, sexually transmitted infections (STIs), and HIV/AIDS. Men sel-

MEN

How do I care for my body?

- ▶ I provide it with sexual pleasure.
- ▶ I do more every day.
- ▶ I pay attention to it.
- ▶ I attend the workshop.
- ▶ I exercise.
- ▶ I obtain intimacy, caresses, tenderness, physical contact, and relaxation.

How do I neglect my body?

- ▶ I keep my feelings to myself.
- ▶ I don't set time aside to rest and spend time with the family.
- ▶ I get angry.
- ▶ I fail to organize my work properly.
- ▶ I smoke, drink, and stay up late.

WOMEN

How do I care for my body?

- ▶ I give my stomach nourishing food.
- ▶ I go to my gynecologist for a check-up.
- ▶ I'm in therapy.
- ▶ I dance and do yoga when I can.
- ▶ I almost always take a nap.
- ▶ I stay away from people with conflictive personalities.
- ▶ I buy myself face cream.
- ▶ I stopped smoking and I feel better now.
- ▶ I refuse to feel guilty when it's not my fault.

How do I neglect my body?

- ▶ I don't take time to relax and have fun.
- ▶ I over-commit my time.
- ▶ I don't look in the mirror.
- ▶ I don't go to the dentist.
- ▶ I don't protect my body against aggression and things that might harm it.
- ▶ I use uncomfortable, constricting clothing.
- ▶ I keep things to myself that I need to express.

dom mention health problems related to violence, although the topic of injuries resulting from brawls, work-related accidents, and suicide might seem likely matters for concern. (In women's groups, however, male violence is often mentioned, presumably because women are so frequently the targets of such violence.) The health care/health neglect discussion for men is organized around a written response to questions concerning personal health and health care practices. In pairs they then analyze differences between men and women's health patterns.

The boxes on the next page show the ways men and women in the Diploma in Gender and Health course say they care for themselves or not.

▶ **“The Time Tunnel”—Human Relations and Masculine Identity:** In this exercise, participants go back in time, reviewing their lives to discover the specifics that have made them the way they

are. This “Time Tunnel” exercise is a new experience for the majority of male participants, who have never before closely and systematically examined their existence. Nor have they shared this sometimes-disquieting experience of being male with other men, in a safe setting, without relying on alcohol or resorting to competitive behaviors.

In the “Time Tunnel,” men are encouraged to describe their family, which is the crucible of relationships and masculinity. Men often describe their fathers' roles as running the gamut from absentee father to omnipresent authoritarian patriarch. Participants frequently express having had difficulties in communicating with their fathers. The mother is perceived as less distant and less evocative of ambivalence. However, her low place in the family hierarchy undeniably speaks for itself.

Friendships spring up near home and at school and these friendships are second only to family in molding masculine identities. Men tell stories about the experience of violence in these relationships, perpetrated by boys against boys, but also against girls.

A third major factor in the construction of the male personality is the workplace, because the role of breadwinner is the one that legitimates maleness. Success in the workplace is fundamental to a man's feeling of well-being and necessary to enjoying the respect of those around him.

Sexual relationships and marriage are of prime importance to a man's masculine identity. Therefore, the first sexual experience has been the focus of many of the workshops. When the stereotype of masculine sexuality prevails in a man's life—with its focus on power, immediate gratification, and control—there are grave implications regarding STIs, including HIV. Many men of the older generations have mentioned unwanted sexual initiation in brothels because of pressure from peers and family members. “Instead of this,” a 45-year-old man said, “when I turned 13, all I wanted was a bicycle!”

Over and over the participants bring up the problems that arise from being cast in the role of fathers and providers. The social importance attached to their success in these roles makes it impossible to enjoy any free time that may result from unemployment or to find different ways of relating to those around them, especially economic dependents.

Workshops often explore the fact that women's role in the region is exemplified by the Mayan myth of X'tabay. An enchantress, X'tabay is a beautiful and mysterious woman who seduces men and drives them crazy with desire. Her ultimate aim is to acquire power over men. She is

sad, however, because she is all alone in the world. She is ill, but she must suffer in silence because to speak would be shameful. In this myth, women are portrayed as silent and mysterious, voiceless regarding their own health, family problems, and other forms of physical and mental suffering. The myth also reinforces the image of women as creatures of nature, dangerous and irrational, as beings that inspire fear and are in need of domination. Thus, female feelings of shame and guilt are reinforced.

Men, in contrast, are identified with such attributes as rational thought, authority, the ability to express themselves, to earn and provide money, and to make decisions. Men themselves, however, do not hesitate to express the confusion and contradictions that they experience: How can they live up to this grandiose image when they themselves are jobless and living with their families in an impoverished environment that lacks the most basic amenities?

In Salud y Género workshops the topic of empowerment is explored, not only for women's groups, but also for mixed groups in rural areas and for Native Mexicans for whom social inequality is clear and present in all dimensions of life. Men and women have different concerns in these groups. Women express concern over lack of knowledge about their own biological functions, sexuality, and legal aid and public assistance. Men express interest in working on fatherhood, couple relations, and sexuality.

Addressing Violence and Alcohol Abuse

Though one of the most important connections established in men's shared experience is between alcoholism and violence, male participants have difficulty talking about this. Salud y Género states that it “does not deal with men as perpetrators of aggression; it simply deals with men.” Violence—

5 Salud y Género is planning to begin specific groups for men who want to stop the violence in their family and couple relationships.

while not exclusively a male problem—is a problem for most men to one degree or another. The men in Salud y Género workshops are usually persons who in certain circumstances and contexts act out different kinds of violence toward women in their lives, their families or other men.⁵

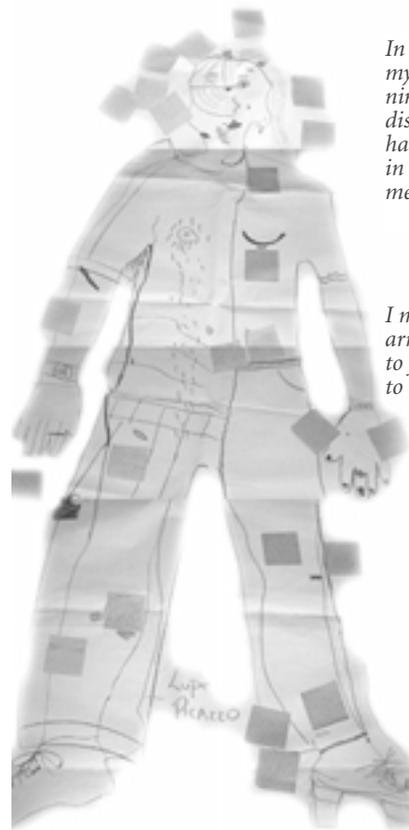
The subject of violence sometimes comes up during the opening exercises such as in “The Story of Andrés” or in “The Male Body.” In the “Time Tunnel” exercise, men tell stories of violence inflicted by parents, brothers, mothers, and friends. It is unusual, at this early point, for participants to offer stories in which they are the agents of aggression.

► **“A Story in Every Scar”:** The idea for an exercise addressing violence by reflecting on one’s scars resulted from listening to a mixed group of school children eagerly telling stories about how they got their scars. The boys in the group were particularly keen to tell their stories. This exercise is similar to “The Male Body,” and is called “A Story in Every Scar.” The scar that each participant chooses to tell about is drawn on the profile of a body. The story of the scar is written on a small sheet of paper that is then stuck on the body next to the scar. At this point, the men take turns telling about their respective scars, and this is where stories emerge about the participant as the attacker and/or the one attacked. Men tell stories of accidents that are the result of risk-taking, of transgression, and of violence. Most of the stories are somewhat amusing, although they are also accompanied by memories of physical or emotional pain. In spite of the pain, most men bear their scars as though they were badges of honor. Some of the younger men even speak of their scars as being “pretty” or “well-made.”

A typical remark might be, “In the finals, my basketball team was winning, and that was when I really got into it trying to intercept a pass, and I’ve got this scar here to show for it.” This example is in sharp contrast with women’s scars,

almost invariably the result of aggression (generally by men) and surgical procedures rather than transgression. Women do not bear their scars with pride; they associate them with stories of pain. These experiences are first shared in separate groups and only later, when the participants have become more comfortable, are they shared in a full-group mixed-sex session. In general, men are greatly moved by the stories women tell.

Another way of opening discussion on violence is by using the “Time Tunnel” exercise, but focusing on situations where the participants suffered or carried out aggression. The situations become more concrete when they are written down. Participants’ writings form the basis for further discussion and analysis. Including the experiences of participants who were on the “receiving end” of violence is important for fostering empathy.



In a basketball final, my team was winning. The ball was in dispute, I won it and have a beautiful scar in my brow as a memento.

I made the scar on my arm with a knife just to feel something and to have it there.

*“a story in each scar”
Xalapa, 2000*

MATEA

A Spanish acronym for Fear-Affection-Sadness-Anger-Joy, MATEA attempts to explore and understand the obstacles that prevent men from sharing their feelings, as well as to analyze the health costs involved in repressing them, thus providing participants with an opportunity to examine their own situations and possibilities.

The five basic emotions (MATEA) are presented, and the participants are asked *where* they feel each of the emotions in their bodies. Special emphasis is placed on distinguishing between one emotion and another. The participants then assign a number from one to five to each emotion, giving the highest number to the emotion that is most difficult to express. When they have finished, each person shares his or her conclusions with the others. The group facilitator then assists the participants in putting this information in perspective: 1 and 2 are generally emotions we have learned to exaggerate, 4 and 5 are emotions we may have learned to control, and 3 is in an intermediate space where no exaggeration and no inhibition might be necessary. Participants reflect and comment on these ideas.

► **Use of Videos:** A more indirect way of stimulating discussion on the topics of violence and alcohol abuse is the use of videos and films. Men watch these videos very intently and are eager to begin discussions after viewing them. After analyzing and even criticizing the characters in the film, someone eventually shares his personal experience and then it catches on and others follow. This is particularly true in single-sex groups where participants may feel that there is a good chance of being heard by other men with similar experiences.

Salud y Género has had good results with such commercial films as “Once We Were Warriors” and “This Boy’s Life,” and with such Mexican educational films as “Saxophone,” “What We Gained When We Changed,” and “The Friend’s Hour.” After watching a video, workshop leaders present a model developed by the Men’s Collective for Egalitarian Relationships (CORIAC) explaining how violence is triggered in men. This model questions men’s expectations regarding male authority, men’s supposed “right” to be waited on and served by women, and the way in which men perceive themselves to be at risk when these expectations are not met. Discussants then exam-

ine the different decisions that lead to aggression and strategies for perceiving danger signs in time to withdraw before violent behavior occurs. The films and subsequent discussion provide a starting point for thinking about the use and abuse of alcohol and its role in men’s daily lives.

► **“The Paths of Life”:** When working with rural or indigenous groups, Salud y Género uses material it has designed, called “The Paths of Life.”⁶ The participants are exposed to different scenes where alcohol might be consumed, and they are asked to describe the consequences of drinking alcohol in each situation. Finally, participants reflect on the possibility of going through the life cycle with less alcohol or with no alcohol at all. Alcohol almost invariably plays a vital role in participants’ stories of witnessing violence or having themselves been the objects of violence. The perpetrator of the violence is generally male; the backdrop is usually the home, the neighborhood, or the community.

► **The MATEA Exercise (See box):** After talking about alcohol and violence, the group is now ready to go into the emotional dimension. The instrument used for this purpose is called MATEA, and it raises the participants’ awareness of the gamut of

6 Developed through an educational project funded by UNICEF.

emotions and their legitimate right to express their emotions in a non-violent way.

The two most difficult emotions for workshop participants to express are fear and sadness, although even tenderness is a problem for some men. Upon reflecting, participants begin to understand how gender socialization influences men and women in different ways. In childhood, boys are pressured to control their fear and girls to control their anger. It is news to many men that fear and sadness are not essentially feminine, but are simply human.

The emotional health of both men and women suffers when they avoid expressing their emotions. Groups discuss how an emotion is repressed and turned into another. Men often transform sadness or fear into anger—frequently in a violent way. Women tend to suppress anger and turn it into sadness and even depression. For emotions to work as proper barometers, both men and women must learn to give themselves permission to express a broad range of feelings. Thus, men must learn to express and understand their anger in a non-violent way. A participant once insisted on including “indifference” as a feeling, but on closer examination he discovered that indifference only masked the fear and sadness that he had not learned to express. Salud y Género facilitators present both feeling and expressing feelings as signs of good mental health.

Themes That Arise in Workshops

Many of the workshops conducted by Salud y Género reveal common themes, often concerning violence and communication.

Discussions have often centered on why men hurt each other. Is it to avoid emotions? Do women bear any responsibility for propagating violence over the centuries or is it due to the weight of tradition? Some of the quotes that have been heard at workshops illustrate the depth of emotion:

“When I get angry I would like to be Van Damme or Seagal and enjoy the pleasure that men get out of harming others.”

—Young woman at a Querétaro workshop

“We hit as a way of not caressing. How should we get close to each other?”

—Young man in Querétaro workshop

“We know boys want to get near to us, but why should they do it by kicking?”

—Young girls in a Xalapa high school workshop

Women frequently complain that their men refuse to listen to them, while men often say they have their own reasons for not engaging in dialogue.

Equity is an underlying issue in communication. When a man regards “his” women—wife, mother, sisters—as female and, therefore, inferior, it is easy for him to shout them down and shut them up. Few men have ever had the opportunity to walk in a woman’s shoes or to appreciate the double and triple workday; as a result, they lack the empathy that would facilitate communication.

What Must Change?

In order to put an end to violence, Salud y Género believes that men and women must learn to identify their emotions. Too often strength has been equated with emotional unresponsiveness. Men have thus been emotionally wounded by cultural tradition, restrained from expressing fear, sadness, and tenderness. Women, on the other hand, generally learn to avoid accessing their anger, their joy, and their sexual pleasure. Both men and women suffer, but from differing types of physical and emotional distress.

The workshops deal with emotions using the MATEA exercise, and then go on to explore the possibility of constructing new kinds of relation-

ships. The keystone of change is improved communication and the improved self-esteem it implies. Workshop participants learn to substitute passive and aggressive communication with assertive communication.

In men's workshops, the focus is on self-esteem. Low male self-esteem is sometimes overlooked owing to the influence of the myth that men already think more than enough of themselves. Frequently, however, this male attitude of bravado and confidence is no more than a mask, though one that men are extremely reluctant to remove. In the ten years that Salud y Género has worked with men, only once did a participant voice the desire to work on self-esteem.



"What I like and dislike of being a father"
Peru, 1998.

Moving Toward Advocacy

Although much of its work has occurred at the individual and community level, in recent years Salud y Género has begun to move toward emphasizing advocacy and has committed itself to influencing public policy and programs through transformation of the institutions that work on health.

In keeping with the international agreements made at Cairo in 1994 and Beijing in 1995, the organization's priorities cover four general areas:

- ▶ Women, health, and quality of care;
- ▶ Men, health, and fatherhood;
- ▶ Young people, health, and human rights; and
- ▶ Reproductive rights.

The Campaign on Fathering

One of the main advocacy themes that Salud y Género has adopted is fatherhood.



Discussing fatherhood has turned out to be a good entree with men who might feel threatened by topics such as violence, alcohol or sexuality. Fatherhood is a socially respectable part of manhood and central to male self-esteem. It is also a point of intervention for strengthening equitable relationships through sharing in childcare. A starting point for such male participation is a father's presence at the birth of his children. For this reason, Salud y Género is committed to consciousness-raising in the health sector with the

goal of defending men's reproductive rights—including their right to be present during labor and birth. In Mexican reality, this is a long-term advocacy process.

The organization's campaigns to promote responsible fatherhood have been conducted in collaboration with CORIAC, and have often been linked with broader information campaigns. The "How My Daddy Looks to Me" campaign focuses on fostering fuller paternal responsibility and emotional commitment toward both male and female children. The first "How My Daddy Looks to Me" campaign was launched in 1998. A request for drawings went out to specific primary and pre-schools in three different cities and yielded 500 drawings. The same campaign was conducted in 2000 at the national level with full government support and produced nearly a quarter of a million pictures. The drawings from around the country were displayed widely with the help of local, state, and national governments. Products—posters, calendars, and a book published by the National Institute for Women and UNICEF—have been designed around these pictures.

A review of the main themes children emphasized in their drawings shows that they prioritize what fathers do in their work followed closely by what fathers do with children in free time. Many drawings are about love and a striking number revealed authoritarian attitudes and even violence. Significantly, few of the drawings were about fathers' presence in domestic life, except for their help with homework.

The Salud y Género team has consulted on the production of five Mexican videos on the role of men in reproductive health. In 2000 an additional video called "¿Padrísimo?"⁷ was produced on the organization's work with adults ("Looking at Fatherhood and Motherhood" workshop) and

adolescents ("Taking Care of Your Egg-Baby" workshop).

Evaluating Change

Change is the result of long-term processes—processes that must be monitored and evaluated. Until recently, Salud y Género had not been able to do this kind of painstaking follow-up and evaluation of its action-oriented activities. The organization evaluated its work every six months and asked for feedback from workshop participants, but the assessments were not systematic.

However, the organization is now developing baseline data that reflect the areas in which it expects change, and has gone on to define variables, indicators, and some of the necessary evaluation instruments. This evaluation system has already been applied to the first generation of the Diploma course, and should provide a better understanding of the changes the organization is trying to bring about.

Change is a complex multifactorial process; still, Salud y Género seeks to understand certain patterns. What motivates the desire for change? Is change measured by discourse or by practice?

The Levels of Change

Change occurs not only across different dimensions, but also at multiple levels. A closer look at the Diploma course and at Salud y Género's work with men in Tijuana, in collaboration with Medicina Social Comunitaria, shows a continuum of levels that start from the personal and extend to the institutional.

Change can go from the personal health level (eating habits, exercise, excessive work, alcohol, and tobacco use) to how emotions are expressed to self-esteem. As a male participant in the Diploma course described the process of change:

7 Produced and directed by Alberto Becerril as part of the series, "Reproductive Health: A Joint Task."

“I feel a personal empowerment that mobilizes my capacities.”

As a result of change, men may become more sensitive to how they are present (or not) in their family relationships. Their awareness of the nature of their contact with children increases. Dealing with couple relationships can be more challenging and workshops frequently uncover problems that already existed. To identify these problems and start working on them is generally easier for women than men.

Salud y Género also hopes and expects to see change at the level of programs and, eventually, public policy. The process of change at this level starts with initiatives taken by participants in their personal spheres of power and eventually leads to the slower process of institutional change. Personal and institutional change can be seen in Lillith, an NGO in Tecate, Baja California, that works with female victims of domestic violence. The organization discovered the profound need and the potential for working with men and subsequently changed its statutes. Said its director, a woman lawyer, “We never imagined how our vision would change toward working with women and men.”

Lessons Learned and Conclusions

The need to involve men and to work with them regarding reproductive health, violence, addictions, self care, or other aspects of well-being is clear. That men, as perceived beneficiaries of patriarchy, would respond to this initiative has not been so clear. Salud y Género’s experience has shown that many men do respond, at least partially overcoming all kinds of resistance.

Moreover, their experience has shown that much of the methodology developed by the women’s health movement can be adapted for work with men and mixed groups, and that it is applicable also to different age groups, settings, classes, and even countries. It is based on three elementary

educational tools: dialogue, experience sharing, and reflection.

New Models for the Family

While men may dispute the validity of the traditional father figure—repressive, violent, drunken and womanizing—they also point to the fact that this was the model handed down to them. They know no other way. Salud y Género emphasizes the need to find new ways to be men (and women), but warns that “we can’t model these new behaviors until some shift has occurred inside us to catalyze change.” Salud y Género outlines some of the challenges and risks of change:

▶ **Untying the Knots in Gender Relations**—The “knots and holes in the fabric of human rights” begin with unequal upbringing in the home, Salud y Género believes. Male and female children enjoy different privileges, live by different values, have different kinds of relationships with their parents, and learn different ways of communicating. A cycle is established that is difficult to change.

Mixed workshops provide an opportunity to break this cycle. They provide an atmosphere in which everyone can speak and be heard, to start with, and perhaps later engage in heated discussions where competition plays a role—and anger, too, especially that expressed by women.

Achieving this requires careful planning. The ground must be painstakingly prepared so that participants feel safe, confident, and respected. They must commit to transmitting these same feelings to one another. Once this environment has been developed, other things can be expressed: feelings, divergent viewpoints, discomfort, needs, and desires. This is the basis for increasing intimacy and opening up new hope for communication between men and women.

▶ **Addressing Male “Subjectivity”**—There is a poorly understood gap between the social construction of male identities and the consequences

for violence and problems related to reproductive health. Salud y Género believes it is crucial to address what it calls mental health or male subjectivity to obtain better results in addressing the consequences.⁸

This means that efforts to reach men must include:

- ▶ Focusing on the emotions and pain involved in understanding and changing. Understanding these emotions can enhance the development of what recently has been conceived as “emotional intelligence” as opposed to what is typically thought of as male rational intelligence;
- ▶ Questioning the ways men establish different types of power relations with women and other men;
- ▶ Assessing the costs of masculinity on the health and lives of others, and the possible rewards of changing, not only for women and children, but also for men.

This approach is by necessity slow and complicated. “In our contact with people in various programs we have sensed a mixture of need, curiosity, fear, and resistance among men invited to such a process, combined with a considerable pressure from women,” according to Salud y Género. “We must find more creative ways to invite men, since announcing workshops on ‘masculinity’ or ‘for men’ sends out unimaginable messages and drives many men away.”

Going the Next Step

According to Salud y Género, another important lesson is that “to be meaningful, the gender perspective has to affect our lives deeply, whether participants or trainers. Otherwise, the experience will be nothing more than political correctness.”

Over the years, Salud y Género has gone from responding to demand to actively offering its

educational and advocacy services for different social processes, and sums up what it has learned in the following way:

“We have won clarity on the need to pursue and construct spaces where men and women can share experience and negotiate alternative ways of relating. An initial period where men and women work apart is necessary. Our methodology carefully seeks ways of bringing them together, fostering communication rather than conflict. As a prison inmate and promoter in Tijuana has said so beautifully,

‘We win life. Because we’re tied to our mask, we feel incapable of expressing our emotions. When I changed I started experiencing life—to enjoy my family, to begin with. I can hug them, feed them, change their clothes, bathe them. Not to be so lonely in my fatherhood... to have my wife to share living. I think we win life. We win freedom.’

“That this prisoner has found freedom from gender constraints is an ironic metaphor for the emancipation of men: this emancipation involves a struggle for empowerment not in the public arena, but in the private space of self-knowledge and emotional expression.”

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CHAPTER 2

Gender and Social Justice: Society for Integrated Development of Himalayas (SIDH) Nurtures Young Men's Partnerships With Women*

*Pawan K. Gupta, Anuradha Joshi, Barbara Crook***

This case study describes the work of the Society for Integrated Development of Himalayas (SIDH), a nonprofit organization founded in 1989 that focuses on education as a means of achieving social justice in the villages of the Central Himalayas of northern India.

Executive Summary

The Society for Integrated Development of Himalayas (SIDH), founded in 1989, is a nonprofit organization working with villages in Uttaranchal in the Central Himalayas of India. SIDH's primary focus is education, holistically defined. Its Gandhian-influenced philosophy emphasizes the integration of equity, gender, and social justice for long-lasting attitudinal and behavior change.

At the heart of SIDH's work is a comprehensive, gender-sensitive, non-formal educational curriculum providing primary education to adolescents and young adults in 20 villages. This curriculum provides the context for the key component described in this case study: a four-day training module entitled, *Men's Partnership in Women's Reproductive Health*.

SIDH's strategies are founded in the belief that people are motivated to change only if they see a personal gain in their effort. Even values such as justice and equity need to be explained through self-interest. Gender equity must be beneficial to both men and women. Gender equity is important, not only because it can reduce the injustices meted out to women, but because it can also liberate men. SIDH emphasizes that enabling women must not mean the "disempowerment" of men.

To understand and address the gender issues deeply rooted in the cultural and traditional values of these villages, SIDH staff conducted qualitative research and engaged village youth in a participatory process to develop project activities. As a first step, SIDH staff conducted a comprehensive needs assessment in four Jaunpur Block villages, SIDH's primary target community. Staff members

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interviewed men, women, and young people about their beliefs and values related to gender relations, social and economic aspirations, and women's health-seeking behaviors. The staff then analyzed the data, and applied the findings to the design of the training module, Men's Partnership in Women's Reproductive Health. After the training module (in Hindi and English) was thoroughly pre-tested and then modified accordingly, it was incorporated into a comprehensive educational curriculum to be used in SIDH's non-formal village schools and ongoing courses for young men and women, Sanjeevani and Sanmati.

Key to the project's success was the use of qualitative research in the design of the module. Even though the master trainers were from villages that spoke the same language and had the same cultural traditions as the project's target villages, the research gave them new insight into the gender differences within their village culture. They became aware of practices and values—and injustices—that they had taken for granted in their own communities. And they experienced firsthand how closely linked values and practices are and the tremendous effort necessary to change them.

The four-day training module begins with an introduction to the concepts of "gender" and "sex" and provides statistics on discrimination at the societal level. The second day attempts to reach participants at a deeper cultural and emotional level, using popular idioms, traditional songs, films, exercises, and discussion. Day three of the module focuses on reproductive health, providing basic information about anatomy, reproductive cycles, and STIs/HIV. The male and female participants discuss this information in separate groups, then reconvene to discuss the socio-cultural aspects of reproductive health through activities such as role-plays. Practices and misinformation in the local culture perceived as harmful are discussed and corrected. On the fourth and last day, all of these issues are linked firmly to personal

responsibility, leadership, and justice. At this point, master trainers ask each youth participant to make a personal work plan detailing how they will apply their newly learned attitudes toward men's involvement and gender justice to behavior change in their own villages and homes.

Staff members' lives were changed, sometimes significantly, by their participation. Challenged to question their own underlying values and social beliefs, male staff members often responded by resolving to make changes at home. Female staff members expressed themselves more in staff meetings as well as at home. Both male and female staff emerged with a wealth of knowledge on reproductive health issues and with a reinforced commitment to helping youth question underlying values and develop new paradigms for gender relationships.

As for the effects on young people generally, SIDH purposely designed the training module to create dissonance in young people's values and social beliefs, by linking gender to universal justice, leadership, and responsibility in the home and village. SIDH's hope was that this process would ensure long-term behavior change. Knowing how difficult it would be to make personal changes without ongoing support, SIDH's youth supervisors visited the villages two, six, and twelve months after the training to meet with the young participants. They also provided a refresher course three months after the initial training so that young people could review what they had learned earlier and share their experiences and difficulties.

While the four-day training module was written as a stand-alone module, it is also a major component of a comprehensive non-formal educational curriculum. This curriculum is used as the basis for continuing courses, Sanjeevani, a one-year residential course, and Sanmati, short seven-day courses offered four times a year. Both Sanjeevani and Sanmati are attended by adolescents and young men and women from villages.

THE SOCIETY FOR INTEGRATED DEVELOPMENT OF HIMALAYAS (SIDH) is a nonprofit organization working with villages in Uttarakhand in the Central Himalayas of India. Its 50 staff members—28 men and 22 women—work primarily in holistic education, which SIDH defines as “education that integrates issues of equity and gender in order to achieve long-lasting attitude and behavior change that results in social justice.” At the same time, the organization feels that striving for social justice as a universal, fundamental value can lead to long-lasting attitudinal and behavior change.

SIDH’s Philosophy

The philosophy of SIDH is that gender equity and women’s reproductive health must be addressed within the broader context of social justice.

Equitable gender relations may lead to everyday happiness within families. While happiness or a sense of well-being may seem a simple, obvious value, its importance to stimulating social change is often overlooked. This social change is a fundamental goal in SIDH’s work on men’s partnership in women’s reproductive health.

Mahatma Gandhi said, “We need not wait until women become literate to improve their status.” The organization’s philosophy is based on the belief that women’s emancipation and social change is possible if men change their attitudes toward women, and on Gandhi’s belief in the inherent integrity of humanity and his appeal to the highest ideals dormant within individuals. SIDH believes that this appeal succeeded in converting many oppressors, whether they represented more powerful race, class, caste, or sex, and that “changes in the oppressor reinstate social justice in a nonviolent manner.”

It is SIDH’s philosophy that gender equity and reproductive rights are deeply rooted in a community’s values, and that achieving gender equity involves challenging existing attitudes and cultural beliefs, and raising awareness of gender discrimination in such a way as to create discomfort in both trainers and participants. What makes SIDH’s Men’s Partnership in Women’s Reproductive Health training module especially

noteworthy is that the trainers must struggle with a broad range of issues related to gender and reproductive health. The injustice of these issues must disturb them. They must reflect upon and constantly question their own attitudes and behavior and be prepared to work constructively with the discord that emerges during the training.

SIDH’s strategies are founded in the belief that people are motivated to change only if they see a personal gain in their effort. Gender equity must be beneficial to both men and women; it must not only reduce the injustices meted out to women, but also “liberate” men. SIDH emphasizes that empowering women must not mean the “disempowerment” of men. Furthermore, it believes that if men understand that their involvement in women’s health issues is an essential part of their traditional responsibility to the family and reflects positively on their leadership, they may be more motivated to change. Thus, SIDH uses a positive focus on leadership in the training module.

Training that attempts to change attitudes and behavior as well as to impart knowledge and skills is extremely challenging, SIDH warns. It is slow, even painful, and results are difficult to measure. This case study documents the project’s process, the lessons learned during the design and implementation of the training module and the comprehensive educational curriculum, as well as the emerging impact of the project on village youth and SIDH’s staff and organizational strategy.

Background

Since 1989, SIDH has worked in Jaunpur Block of Tehri Garhwal District in the Central Himalayas, a largely tribal area. The district includes 2,020 villages that are small, averaging 15 families each, and scattered—the average distance between villages is 1 to 1.5 kilometers. Travel among villages is difficult since there are few passable roads. Agriculture and animal husbandry are the main occupations, supplemented by milk sales and seasonal wage labor.

In 1991 in the Tehri District, the literacy rate was 72 percent for men and 26 percent for women. To improve the education of children and youth, SIDH began with primary education, then expanded its efforts to include pre-primary schools, non-formal schools (not state-funded), and the production of books. SIDH has developed non-formal educational curricula and materials for its target village schools and has shared these materials with NGO and government schools in nearby areas. These schools are the nucleus of SIDH's integrated community development program.

To implement its program, SIDH trained a team of village youth (17–24 years old) to work as teachers in the non-formal schools and as youth leaders involved in a range of social issues, including women's health, agriculture, energy, and village economy. It also formed education committees at the village level, set up literacy classes for women, and established libraries and youth groups. Related activities included forming women's groups and training women to participate in the political process by taking advantage of provisions for women in the amendment of the Panchayati Raj Act of 1993, which legitimizes village government and expands the role of women, lower castes, and tribal members.

The area has not faced some of the problems commonly found in more urbanized parts of the

region. For instance, the practice of dowry did not exist until recently and the community has traditionally sanctioned the right of women, even after marriage, to leave their husbands and find another partner. Women have had the right to keep the money they earn from selling goats and wine and to lend it out, earning interest on it. However, many such traditional practices are dying under modern influences. Male migration out of the area is on the rise. Aspirations are becoming more Western, universalized, and similar to those of the upwardly mobile urban middle class. These trends are reflected in the alienation of young women and men from their roots, beginning at about 14 to 16 years of age. Unfortunately, educated youth are caught between traditional and modern values.

Strengthening Men's and Women's Status

This background led SIDH to explore what educational approaches could strengthen and expand both men's and women's status. What group would be most receptive, who would be the best teachers, and what methods would be most effective?

Based on its own experiences and beliefs, SIDH drew on the following concepts as the basis for its educational approaches:

- ▶ Among the young, learning occurs faster and more easily, and its impact on attitudes and behavior change is longer lasting, thus youth were chosen as the target group for male involvement activities;
- ▶ Young people must be encouraged to examine their own assumptions, attitudes, and behavior in order to keep them from blindly accepting *any* idea or value. Young people's listening and communication skills must be strengthened so that they may act in an independent, thoughtful, and responsible manner. At the same time, SIDH avoids imposing its own worldview, preferring to lead young people into questioning the attitudes behind their actions

or behavior, to improve their self-esteem, and to invoke their sense of social justice;

▶ Because gender and reproductive health issues are deeply rooted in cultural, social, and traditional Jaunpur values, these issues should be analyzed and challenged within the community context rather than approached in isolation. In the Jaunpur region, men would often become defensive when women “demanded gender justice”; therefore, SIDH felt that the most effective way to reach young men was through male leaders who adopted a non-threatening and empathetic approach; and

▶ The curriculum must meet the diverse needs of the students. Prior to 1995, SIDH had tried reaching youth groups in the villages through non-formal classes offered in the evening. But the group attending the non-formal classes was very diverse, ranging in age from 12 to 20 years and in educational experience from no education to early dropouts to attendance in senior classes (high school classes 8 through 10).

Thus, in 1995, SIDH began to hold sessions for two hours a day: one hour for mathematics and reading skills, and one hour to address issues of social injustice and responsibility. Of particular relevance to the region were caste, class, and gender injustice. Two of the major topics included were gender equity and reproductive health. For example, reading exercises were designed to incorporate information about the importance of prenatal nutrition. In mathematics, the rates of maternal and infant mortality and morbidity in the area were discussed.

This was the precursor to the training module, Men’s Partnership in Women’s Reproductive Health, and a comprehensive, integrated curriculum for non-formal schools in the region. Supported by the Program for Appropriate Technology in Health (PATH), with funding from the John D. and Catherine T. MacArthur Foundation,

the project has important lessons for involving men in women’s reproductive health. The project began in 1996 and today there is a comprehensive, one-year residential course for young men and women called Sanjeevani in which extensive discussions of gender equity and reproductive health issues take place.

Project Objectives and Activities

The project’s key objective was to motivate young men to become partners in improving women’s reproductive health, whereby men and women are equally involved in information gathering and joint communication and decisionmaking regarding family planning and child spacing; in seeking reproductive health care and pregnancy and delivery care and support; and in preventing and treating sexually transmitted infections (STIs). Unmarried youths 14 to 22 years of age were the main focus, and SIDH staff was a secondary focus.

Indicators of project impact on both young people and SIDH staff included:

- ▶ Increased awareness of gender inequity, reproductive health, and decisionmaking issues related to health;
- ▶ Increased feelings of motivation to change beliefs, attitudes, and behavior to improve women’s status; and
- ▶ Behavior change related to improving women’s reproductive health.

The project was not intended to involve formal quantitative research with rigorous sampling and data collection. These indicators were measured informally through discussions at staff meetings, evaluation and feedback during the trainings, responses of youth participants to SIDH field supervisors during visits to the villages, and recounting of young people’s actual experiences during the refresher trainings. The qualitative research conducted as part of the needs assess-

ment was used to design the four-day training module and project activities. PATH provided technical assistance to SIDH, including assistance in project design and training module development, and training in qualitative research skills and reproductive health issues.

Project Activities

SIDH undertook to:

- ▶ Train SIDH project staff in qualitative research skills and gender issues so they could conduct a needs assessment of reproductive health and gender issues in the villages;
- ▶ Develop, pretest, and implement the four-day training module, Men's Partnership in Women's Reproductive Health, with youths;
- ▶ Develop a holistic, integrated, non-formal educational curriculum for 14 to 22 year olds in the villages, that includes basic modules in reading, mathematics, and history;
- ▶ Develop and pretest a five-day training-of-trainers module and use it to train local NGO staff in the use of this curriculum;
- ▶ Hold dialogues with village youth involved in SIDH-sponsored youth groups regarding gender inequities and other forms of social injustice; and
- ▶ Encourage SIDH staff to discuss and analyze gender issues in a social justice framework.

SIDH felt strongly that the reproductive health training module should be one component of a larger, comprehensive educational curriculum that would be used over the ensuing years as the basis for non-formal educational courses. This would reinforce the long-term impact of the project on attitudinal and behavior change, both with SIDH staff and village youth.

The issue was how to begin. SIDH had many years of experience establishing non-formal schools, implementing environmental projects, and conducting workshops on women's rights, but limited experience in reproductive health.

SIDH decided to start with a needs assessment of reproductive health and gender issues in the villages. This called for training SIDH project staff in qualitative research skills and gender issues. Because the project required expertise that the SIDH staff did not have, the organization hired a local research consultant to assist with qualitative research planning and data analysis, a curriculum writer to write the non-formal educational curriculum, and a project coordinator to oversee the whole project.

Program Development Phases

The program had seven basic stages, from training of the master trainers to monitoring and evaluation.

I. SIDH Staff Training

Two men and two women in their mid-20s were chosen as the core master trainers. All had bachelor's degrees in English or sociology from Garhwal University. Their responsibilities were to:

- ▶ Conduct the initial needs assessment;
- ▶ Develop the four-day Men's Partnership in Women's Reproductive Health training module;
- ▶ Collaborate to develop the comprehensive non-formal educational curriculum;
- ▶ Develop the five-day Training-of-Trainers module;
- ▶ Conduct training workshops with target youth;
- ▶ Conduct training-of-trainers TOT workshops with staff from other NGOs; and
- ▶ Monitor and evaluate project progress.

A PATH staff member collaborated in the initial training workshop on qualitative research skills. The seven-day training, in April 1996, provided the SIDH project staff with both qualitative research theory and practical skills in conducting field research. These skills, in combination with participatory rural assessment skills with which they were already familiar, were critical for completing the needs assessment. Immediately after

the workshop on qualitative research, the master trainers participated in a gender-sensitivity training conducted by a local consultant. This process provided SIDH staff with a new perspective on traditional attitudes and behaviors related to gender inequity.

Next, the project coordinator and master trainers clarified project activities and determined how the overall project would progress over the next two years. Project objectives were developed as part of a general discussion regarding monitoring and evaluation.

II. Needs Assessment and Qualitative Research

Over the years, SIDH had conducted several surveys and held informal meetings, workshops, and training programs with women and young girls and boys. All of this provided a rich source of data, which were used alongside the needs assessment data to design the Men's Partnership in Women's Reproductive Health training module.

After discussing the project plan and objectives with heads of several villages and receiving their support and approval, SIDH project staff conducted qualitative research in four project villages. Focus groups, in-depth interviews, and participatory rural assessments identified priority health problems and determined health awareness, health-seeking behaviors, gender labor divisions, core values related to gender beliefs, caste discrimination, and gender-related economic issues for youth, such as migration for non-traditional labor. This data was supplemented with informal discussions, conversations, and case studies.

The field workers encountered many difficulties during the research phase. To begin with, both the research team and the community were inhibited when discussing issues related to reproductive health. In focus group discussions (FGDs), youth were more inhibited than elders in speaking about reproductive health issues. Elders dominat-

ed the FGDs and when they were asked to allow other people to speak, they would then harangue the shyer participants. Some FGD participants were reluctant to give information to the research team members who were not married because they were seen as having "no status."

Some villagers were suspicious of the recording of information, and considered open-ended questions such as "What do you think?" artificial. Because the SIDH research team members were from the local villages, the community was curious about their need to inquire about things they already knew. The villagers would often ask "Don't you know the answer to your question?" Eventually, the researchers replaced standard focus groups with informal "in-depth" conversations in small groups that took place during routine chores, such as collecting water or cleaning grain, or while drinking tea. These efforts proved more productive in gathering data.

During the needs assessment, SIDH tried to explore with adults the issue of gender discrimination at home. Generally, people denied such discrimination, saying, "This happens in other parts, but not our area." Mothers and grandmothers did not acknowledge injustice toward female children, and most men seemed completely unaware of discrimination at home.

To supplement data from adults, the research team used the SIDH-sponsored school magazine, *Apni Baat* (Our Talk), which provided anecdotal data on gender issues through children's writing of their home experiences. A group discussion was held with all older elementary school children (9 to 14 years of age). An example of discrimination was that all the girls said that they were kept from eating "good" food like fruits, sweets, butter, and milk. Most boys, like their fathers and uncles, did not consciously consider this discrimination.

III. Analysis and Major Research Findings

Some of the major findings that resulted from the research were:

▶ **Identifying health issues.** Young men and women (12–20 years old) identify their health issues differently. Women depend on their personal experience for understanding the cause of diseases, while young men depend on outside information. Young men know names of diseases, while women refer to symptoms. Indeed, the women in this case study expressed their problems by identifying symptoms like pain in the body, back, eyes, etc., while most men identified the problems by naming the diseases, e.g., TB, jaundice, diarrhea. Women knew very little about their own health problems or men's health problems, while men knew much more about their own and women's health problems.

▶ **Endangering mothers' health.** A number of local beliefs endanger the reproductive health of mothers. For example, a popular belief is that eating less and working hard help mothers have an easy delivery. Because of this, pregnant women are rarely given supplemental foods or discouraged from lifting heavy loads of grass or wood during pregnancy. Women are expected to continue with all their normal duties until the ninth month, during which they are allowed to rest between basic duties.

▶ **Assisting in childbirth.** Some men assist in pregnancy and childbirth. Men are considered sensitive if they stay in the house at night during the ninth month of their wife's pregnancy, in case the wife needs help. During childbirth, it is common practice for the husband to hold the wife while she is squatting, placing himself behind her with his knee in her back and holding her across her abdomen very tightly. While some women felt they needed help during pregnancy and childbirth, most said they needed help even more *after* childbirth. Unfortunately, this is the time men

would stay away, feeling they had already fulfilled their duty.

▶ **Limiting family size.** Many men and women support limiting family size, although men are motivated by the extra expense, while women are concerned with the extra work. Both adolescent men and women prefer smaller families than did their parents. Spacing of births by two or three years is considered important for women's health by both men and women. Older women prefer sons because daughters go to another household (when married) while the sons stay home and look after them in old age. Although men are usually the decisionmakers regarding childbearing, younger women are slowly asserting themselves more.

Most people had little or no information on family planning methods with the exception of the "operation" (sterilization) and the copper-T IUD. Some older, more traditional, women felt that young women should not learn about family planning because it is not appropriate for women and harms health. Female sterilization is seen as the only safe family planning method. Although the majority of women believe the "operation" ruins women's health, all women said they are in favor of family planning, because children mean much work and pain. Both men and women expressed the fear that if men are sterilized they will lose their strength, which they need for hard labor to earn income for the family. This cultural belief even extends to the use of condoms. One woman said,

"Men get their strength from their 'virya' (sperm). We must take our share of their strength. Condoms will prevent that."

▶ **Accessing health care.** Men, who are more mobile than women, can go to the marketplace or nearby town to visit the doctor. If a woman is seriously ill, she must seek permission from her husband who then decides if she is to get medical

care. Traditionally, it is believed that women are able to bear more pain, and as a result, are not taken for medical care until the illness reaches the stage where they are unable to walk.

► **Women's savings.** Savings are seen as more important to women's well-being than earnings or income. In Jaunpur, the custom called *juar* allows a woman complete control over money earned from the sale of goats, poultry, and wine. Goats are traditionally given to the daughter as part of her dowry. A woman keeps *juar* money a secret from her family, ensuring some economic power. She sometimes uses it to make high-interest loans to village men and will use this money for the family only in dire circumstances. Women were not supportive of outside income-generating programs because they felt that their husbands or neighbors would be jealous or resentful, or they would be forced to give the income to the husbands. One woman said:

“We don't need extra income because it goes into the hands of men and children who spend it on all the wrong things. The men very often spend all the money from cash income in buying liquor or unnecessary items. Extra income does not necessarily improve our lives or bring happiness.”

► **Fighting within families.** Conflicts among women within joint families are common. Daughters-in-law are expected to work hard, sparing more powerful mothers-in-law and sisters-in-law additional work. Daughters-in-law often want to show they are as strong and capable as other women in the house and won't admit they cannot do everything expected of them. This often extends into the concept of women bearing pain. Mothers-in-law often said about pregnancy,

“I suffered, so she has to suffer too. Is she the first person to have a child? I had many children, but I did not complain.”

► **Valuing work.** Women's work in the home is invisible with little tangible result and is treated as having no value. But fetching a load of fodder or fuel, which is visible, is treated with respect. One young woman said,

“The wood and fodder a woman gathers has more value than cleaning, tending children, or cooking, as it can be seen and measured. When I come home with a big bundle of grass on my back, it can be seen, and I am treated with respect, and my mother-in-law rushes to me with a glass of water or tea. That is why I prefer working outside the home where my work is seen.”

The gendered division of labor is rigid and value-laden. When a man does “women's work,” he is considered odd, and other men feel that he is inferior in some way. A man who helps his wife with chores other than animal husbandry and harvesting is called *juro ka gulam* (slave of the wife).

► **Decision-making powers.** Most village women feel that they have limited decision-making power regarding issues such as marriage, number of children, and education. Their decision-making power is limited to leaving bad marriages, spending *juar* money, and attending women's gatherings. In some families women are allowed to make decisions if they are considered “wise”, meaning that they have previously made decisions that supported the decisions of their husband or family elders. The local word for husband is *malik* (owner).

At the completion of the needs assessment, during ensuing meetings in the four villages, SIDH discussed the findings and how they would be applied in the project design and implementation. Project staff incorporated the research findings into the four-day Men's Partnership in Women's Reproductive Health training module.

IV. Group Design of the Training Module

After the needs assessment, SIDH developed the four-day training module through a challenging 10-day group process that involved the project coordinator, the PATH consultant, and the four master trainers. This design process served as a miniature training-of-trainers for the SIDH master trainers, who had had limited exposure to reproductive health information. The team realized that they had to become very familiar with and comfortable presenting illustrations of reproductive anatomy, using anatomical terms, describing functions of men's and women's reproductive systems, and discussing menstrual cycles, fertility, sexually transmitted infections, and pregnancy.

The group process began with extended discussions of reproductive anatomy, dispelling misconceptions and checking the accuracy of information with the project coordinator and the PATH consultant. At the beginning, the trainers were shy and embarrassed. The youngest trainer, for example, giggled and hid her face when asked to make a practice presentation to her peers of women's reproductive anatomy using a simple line drawing. The trainers were encouraged to learn the correct anatomical terms and to feel comfortable discussing such material with their colleagues first if they were to work successfully on these issues with youth.

The male master trainers were genuinely interested to learn about women's menstrual and pregnancy cycles and were surprised and intrigued by the function of various components of women's anatomy, including the uterus, ovaries, and clitoris. As the process progressed, it became clear that the male trainers wanted to be knowledgeable lovers for their future wives. This is an example of the type of self-interest that can motivate new learning and, in turn, attitudinal and behavior change. By the end of 10 days of discussing, designing exercises, and practicing role-plays, the

master trainers felt comfortable talking about reproductive health issues.

Two male master trainers conducted most of the training in large group sessions that combined both female and male youth participants. SIDH felt that, based on previous experience, the two women master trainers would not be as effective, because the young men might become defensive. However, the women trainers played a critical role; for example, they led reproductive health exercises in separate sessions with the female youth, participated in the general discussions, assisted with exercises, and provided constructive feedback to the male trainers.

SIDH designed the four-day training module to start with general topics and progress to more sensitive issues:

► **Day one.** The focus is on issues of gender, e.g. the difference between the terms “gender” and “sex,” statistics regarding gender injustice, and case studies illustrating gender discrimination. This information raises awareness of gender issues and starts to create discomfort but is not personally embarrassing.

► **Day two.** The participants are reached at a deeper cultural/emotional level, using popular idioms, traditional songs, films, activities, and discussion. SIDH has adapted an awareness-raising exercise from *The Oxfam Gender Training Manual* by incorporating a traditional village song about women's workload during pregnancy. A classic training exercise on perceptions is also used that involves showing a line drawing of a woman who could be perceived as either old or young. This exercise illustrates how, regardless of the similarities in our cultural values, perceptions and/or attitudes are affected by unconscious influences.

► **Day three.** The focus is on reproductive health issues. Basic information about anatomy, reproductive cycles, and STIs/HIV/AIDS is presented

to young men and women in separate groups. The male and female groups then come together to consider the socio-cultural aspects of reproductive health through activities such as role-plays. For example, one role-play focuses on a man discussing his STI infection with his wife and the need to visit the doctor jointly. Issues such as the importance of antenatal care, good nutrition, reasonable workloads during pregnancy, and men's responsibility for diagnosis and treatment of STIs are emphasized. Key areas of misinformation in the local culture are also addressed. The groups learn that the hymen can break during physical stress and, therefore, should not be a factor signifying virginity; that men as well as women can be infertile, and that men, not women, determine a baby's sex.

Gender disparities in health are also covered during sessions on reproductive anatomy, health, and disease in the four-day training. Young women and young men learn accurate anatomical terms and are provided information on reproductive health, diseases, and infections. Different types of contraceptives are reviewed, including their correct names, how they function, and how different contraceptives may be appropriate for different couples depending on their family planning needs. Trainers emphasize informed choice regarding contraceptive decisions, discuss and correct myths regarding contraceptives, and reinforce the participants' practice of honest communication between partners through role-plays. Pregnancy issues, including the importance of nutrition and the effect of harmful practices such as carrying heavy loads, are discussed to dispel local beliefs that might endanger the health of mothers. Women's access to timely medical care is reinforced.

► **Day four.** On this last day, the trainers review and link all reproductive health issues to responsibility, leadership, and gender justice. For example, trainers might begin by reinforcing the point that communicating about STIs and seeking treatment

is a man's responsibility to his wife and children. Or they might point out the benefit of fathers supporting the education of their young daughters or of a young man helping his mother and sisters with daily household chores, thereby actively promoting gender justice. This forms the basis of the participants' future leadership role as it establishes their integrity and reduces the gap between gender justice rhetoric and actual practice.

At this point, master trainers ask each youth participant to make a personal work plan detailing how they will apply their newly learned attitudes toward men's involvement and gender justice to behavior change in their own villages and homes.

SIDH adapted the four-day youth training module to create a five-day Training-of-Trainers (TOT) for senior staff from local NGOs and government programs. A training-of-trainers workshop involved both NGOs and government-organized NGOs, eventually training 60 staff from more than 13 organizations. To assure adaptation to other cultural contexts, SIDH's TOT module emphasizes the importance of conducting a needs assessment using qualitative research to gain insight into local traditional beliefs and practices.

V. Implementation

To prepare for the workshops, SIDH project staff pre-tested the four-day Men's Partnership in Women's Reproductive Health module with SIDH field staff and one youth group. After the pre-test, extensive feedback sessions were held with the master trainers, initial workshop participants, the project coordinator, and SIDH executive director. These sessions proved to be crucial for revising and polishing the module.

SIDH developed specific recruitment strategies to ensure young people's participation in the training. The title of the workshop was changed to Leadership and Gender Sensitization to invoke a more enthusiastic response from the youth groups.

As an additional incentive, a certificate—essential for job interviews—was issued to each participant who completed the training. In order to attract young people, SIDH announced the titles of the popular films that would be shown during the training, and imposed a small registration fee (Rs.5) to enhance the value of the training.

The SIDH field supervisors recruited youth in their villages, emphasizing that the training was meant only for the brightest potential youth leaders. For subsequent workshops, participants were asked to recruit their peers. Ultimately, SIDH ensured the popularity of the training by providing a rare opportunity in village settings: a supportive environment in which female and male youth could jointly discuss their problems. A total of 261 village youth leaders in 42 villages were engaged in the training.

VI. Monitoring and Modifications

SIDH constantly reviews and evaluates its program activities and has done so with the four-day Men's Partnership in Women's Reproductive Health training to make it as effective as possible.

▶ **Participant observation, feedback, and daily diaries.** During the first 10 Men's Partnership in Women's Reproductive Health trainings, a SIDH staff person was assigned to observe each day of training and record participants' comments and feedback. At the end of each day, all participants and trainers also reflected on and wrote down their thoughts and feelings about the training. Participants and trainers then discussed these reflections before the training day closed. The first session each morning was devoted to reviewing the previous session. The youth rated each session according to whether it was useful, boring, or interesting.

On the last workshop day, participants reviewed the entire four days of training. Master trainers again requested feedback on how to make exercis-

es more effective. After the participants left, each trainer sat alone and reflected, updated his or her daily diary, and wrote lessons learned. The trainers' notes, including feelings about the training and insights gained, were then discussed within the SIDH project team and used to revise the training module before the next training.

After each training, master trainers modified the module slightly to include anecdotal information from youth. In fact, each training experience led to new techniques that were incorporated into subsequent trainings. This process of constant learning and evaluation of the training maintained the enthusiasm of the master trainers and, in turn, contributed to the quality of the training.

▶ **Supporting youth after the initial training workshops.** On the last day of the workshop, participants made a Personal Work Plan to help them actualize what they had learned during the training. They were also asked to list what types of problems they expected from friends and family when introducing these new attitudes and behavior, and to whom they would turn for help.

Excerpts from Personal Work Plans show how some of the young people planned to change their own behavior:

Question: What will you do if your friends make a nasty comment about a girl or woman?

Answers:

(Young man) "If I am sitting with my friends, then I will certainly protest. We have to look into how society functions. Why does it pick on the girls so easily, and why does it keep quiet when a boy does the same thing? Don't boys also have bad habits?"

(Young man) "We all have sisters and we feel protective towards them—so the girl we joke about is someone else's sister. How can we look at our sisters in one way and other girls in a different way? If we have a problem

about the behavior of a certain girl, then we should go and speak directly to her and not crack dirty jokes behind her back.”

Question: After going home, what changes will you work on?

Answer:

(Young woman) “I used to do all the housework, but now I will persuade my brother to help me. I never did the bank work, but now I will go and do it myself. I will read more to understand gender and share these ideas with my girlfriends.”

Two, six, and 12 months after the initial training, the SIDH youth supervisors went to the villages and reviewed the Personal Work Plans with each participant and their families to problem-solve and to support behavior-change efforts. Work plans were then modified and adapted to their changing home situations.

The SIDH program also provided a one-day refresher course three months after the initial Men’s Partnership in Women’s Reproductive Health training. The day before the refresher training, the master trainers met with the SIDH youth supervisors to discuss their experiences visiting participants in their villages after the initial training. They gathered information and chose issues that required further discussion and support during the refresher course. Two refresher courses were held, with a total of 270 participants. During these refresher courses, youth seemed genuinely interested in each other’s experiences, and what had worked and what had not.

During the refresher course, master trainers reviewed key points from the original training and young participants from specific clusters of villages sat in small groups to discuss their experiences and problems in implementing the changes. Experiences were listed on charts and were later discussed within the entire group. Participants

also noted which information from the original training had been most significant to their own behavior change. Most mentioned that they needed support from close friends to maintain attitude and behavior change.

Participants reported at the refresher course that the training had affected their home and village life. Some young women now felt more comfortable discussing questions about reproductive health with their mothers and sisters-in-law. The majority of participants helped their mothers more at home with household chores such as gathering wood and water and washing clothes. Both young women and men reported that they had become more sensitive to the problems their women relatives experienced when pregnant. And both young men and women felt their clearer understanding of gender helped them behave more responsibly, which, in turn, earned them increased respect from their family.

Some of the young women and men said that their peers were often interested in the reproductive health issues, and closer friendships sometimes resulted from being able to discuss deeply personal issues. Many participants wanted more reproductive health information because their friends now considered them “experts”. This increased their self-esteem and they were eager to learn more.

VII. Impact

SIDH clearly accomplished quite a lot programatically over two and a half years (1996–1998), but did the organization have the intended impact on young people, trainers, and NGO staff?

► **Impact on NGO staff trained by SIDH.** In July 2000, SIDH conducted a group discussion with senior NGO staff, followed by a survey to evaluate the long-term impact of the Men’s Partnership in Women’s Reproductive Health training. Thirty-

five staff from three NGOs trained as trainers participated in the survey.

The majority of the NGO staff participants felt the training had changed staff attitudes on a long-term basis. For many, the training resulted in greater understanding of and appreciation for the complexities of gender issues, decision-making power within traditional families, and the benefit of men and women working together to improve both gender relations and women's reproductive health.

Several areas of the training had a profound effect on trainees. One was the introduction of the concept that different people can perceive the same issue in different ways, and that people's perceptions are not inherently right or wrong. One song from the training, *ek nazaria tunhara aur ek hai hamara*—"I have a perspective and you have a perspective, there is no right or wrong"—reminds people to be patient with others and to respect the viewpoint of others, whether male or female.

Another area of significant impact was the practical information on reproductive cycles, specific health issues of women (importance during pregnancy of good nutrition and less manual labor), and the importance of men being diagnosed and treated for STIs as a way of protecting both women and children.

Learning how to communicate about reproductive health and STIs was also important to the participants. Before the training, men were reluctant to talk to a doctor about these issues, and women were afraid to talk with their husbands. Most had never discussed these issues; because of cultural taboos, women and men did not communicate about such things. During the training, these issues were addressed through role-plays—one in which the husband talked to a doctor about his STI symptoms, and a second one in which the husband and wife together visited the doctor.

Beyond clarifying gender issues, the long-term impact of the training has changed NGO staff

attitudes toward reproductive health problems, especially those of women. This has increased participants' ability to apply practical reproductive health information (such as visiting the doctor for STI treatment or supporting prenatal care) and has motivated male staff members to help their mothers, sisters, and wives in household chores. The most important change for young male NGO staff has been in their attitudes toward girls and women, particularly regarding women's rights to education and decisionmaking (including marriage). The male staff understands that respecting these rights is essential not only to their personal relationships but to community leadership as well.

► **Impact on SIDH staff.** The skills acquired during the various Men's Partnership project phases provided core project staff with increased confidence and the ability to train and work with youth on sensitive issues such as gender relations and reproductive health.

The core project staff's sense of confidence resulted in part from their new knowledge of reproductive anatomy and understanding of the impact of gender inequity on reproductive health. Their new qualitative research skills provided them with the means to explore these issues within their own cultural context—their villages. Analyzing and applying the village data to the development of the training module challenged staff personally and professionally. The intense 10-day process of working collectively as men and women required the master trainers' personal exploration of complex gender and reproductive health issues, while at the same time preparing them to share that information with others.

The master trainers' commitment to the project was based on timely personal circumstances as well as ideological interest. At the time of the project, the four master trainers, ages 25–26, were unmarried and were being pressured by their

families. The mysteries of gender and reproductive health were naturally in their thoughts. They eagerly integrated this new knowledge into their lives and, being from the villages, felt a responsibility and an urgent need to share the information with other village youth.

The Men's Partnership project sensitized the entire SIDH staff to gender and reproductive health issues that were previously acknowledged but not dealt with in depth. As a result of the new awareness, SIDH staff has begun to understand better the complexity of women's roles, power, and status in local rural society and has been careful to incorporate this understanding into staff activities. Gender issues, such as the challenges young women face in continuing their education, are currently discussed during the men's and women's daily interactions and in the general staff support meetings (*sammelams*) that occur every six months. This reinforces and supports new attitudes and behaviors, blending gender and reproductive health issues into the work and culture of SIDH.

The impact on the SIDH male staff was clear, as they began to help wives, mothers, and sisters with household chores. (See also box on next page.) Male staff members also have begun to actively listen to and acknowledge and value the contribution of women staff, as they had not done previously. During the course of project work, they engage in deep discussions with women colleagues regarding gender issues and work jointly to incorporate these issues into their projects. Occasionally, these interactions are painful and confusing, requiring counsel from other staff. These daily male-female interactions subtly work to modify attitudes and behavior that could result in long-term change.

Moreover, by continuing to work with youth on issues of responsibility in reproductive health and community leadership, the male master trainers

serve as role models for positive behavior. This reinforces changes in the traditional attitudes and behavior of young male students involved in the non-formal schools.

► **Impact on female staff.** The environment at SIDH for female staff and the young women who attend SIDH non-formal education courses improved as a result of the Men's Partnership project. The female staff of SIDH, adolescent girls, and the young women who participate in the shorter Sanmati courses all revealed at an evaluation meeting that the most important reason they participate in SIDH programs and courses was because they trust and respect the staff's attitude toward women.

Indeed, immediately after the training of SIDH staff, the majority of young women expressed themselves more in staff meetings than they had done previously. Somewhat predictably, some were angry and aggressive with male staff. This initial anger gave some the confidence to speak out for the first time without hiding their faces or giggling. Over time, the initial anger has evolved into confident, assertive communication that has led to supportive rather than defensive responses on the part of male staff members. The resulting mutual effort by both male and female staff to work on gender inequities has led to better communication and problem solving.

SIDH female staff members' newly attained knowledge about reproductive and sexual health issues has reinforced their self-confidence in communicating with other women and adolescents. This increased self-confidence has, in turn, enhanced their leadership skills, and some of the women are now field supervisors in each village cluster.

While newly attained knowledge on reproductive health has helped to allay some women's fears about marriage and their sexual duties, very few SIDH female staff marry. Most of the senior female staff are not married, and many are almost

PERSONAL STORIES OF MALE TRAINERS

The personal decisions regarding marriage of the two male master trainers, Shoven and Jagmohan, demonstrate the project's immediate and long-term effects. Changes in their values toward traditional marriage led them to marry women who were middle-class, educated, and with whom they hoped jointly to make family decisions. Both men paid a price for their non-traditional behavior.

After enduring much parental pressure to participate in a traditional arranged marriage, Shoven agreed to marry at the age of 27 on two conditions: he would not participate in the ritual of approving or disapproving of the girl after meeting her, and that he would take no dowry. No one in Shoven's family supported him, but he remained firm in his decision to resist material (dowry) and social pressure. With emotional and some financial support from SIDH team members, he had a simple wedding that set an example in his village. He says, "I have a continuous dialogue with my wife (sometimes confusing and frustrating for us both) about complementary gender roles. I help in many household chores."

He and his family later reconciled.

Jagmohan explained to his family that he wanted a wife who would be employed and not stay in the family house as a traditional daughter-in-law. The family rejected this, concerned about ridicule from the village. Although this was a very difficult experience emotionally and financially, Jagmohan, like Shovan, remained committed to his newly developed values and married a woman of his choice at age 28. SIDH staff supported him throughout the difficult process, and in so doing, saw him as a role model for their own complex struggles with tradition in their homes and villages. Since the marriage, Jagmohan has further shown his commitment to his new values by involving himself in his wife's pregnancy. Remarkably, he studied and prepared for his wife's delivery to the point that had his wife gone into labor unattended, he was prepared to deliver the child himself.

In spite of Shoven and Jagmohan's enthusiasm, their marriages have been a tremendous challenge. Both men feel that their wives have not always appreciated their efforts at increasing gender equity. For example, Shoven's wife comes from a middle class family with traditional expectations regarding the role of family members and feels she must serve him. Shoven states,

"I sometimes discontinue my support in the house because...she resents this.... She believes it reflects badly on her duties as a capable wife. However, on the other side, when I do not extend any help at all, she complains a lot. We have not succeeded in keeping an optimum balance."

Both Shoven's and Jagmohan's wives often have interpreted their husbands' gentleness as weakness. As a result, the men have been confused and hurt, and, occasionally, have criticized their wives—and women, generally. Shoven states,

"There are moments when I do not feel that our attempts to resolve gender differences will succeed; our solutions must be more integrated, holistic. While I sometimes am frustrated, I am not without hope; I understand that the roots and the complexity of gender relations go really deep, and I am still grappling to understand these issues.

"Today, I can say that I generally have a positive perspective toward women. I try to be constantly aware of the old bias within me, especially when I occasionally feel that I am reacting to some old prejudice or sanskar. Today, I see the men and women as complementary to one another."

30 years old. Their completion of high school, as well as their leadership qualities and increased expectations regarding their partners' educational attainment, may make it more difficult for them to marry.

Female staff members all said what a difference it had made to them to learn about their bodies and to feel comfortable talking about reproductive health issues. They noted how little they and the women in their communities really knew about reproductive physiology, and how much more sensitive they now were to women's health needs, particularly those of pregnant women.

Feeling bolder to speak not only about health matters but in general has also had a positive effect on these young women's lives, as their suggestions regarding family decisions are taken seriously.

One female staff member stated:

“Learning about gender was the most important issue for me. I had accepted a lot of things because I only knew about sex [differences]. We have different bodies and there is nothing one can do about it. But gender difference is created by society. I saw a possibility of change at last. It made me feel hopeful and I saw a way out of the limitations of our body—I felt good.”

► **Impact on youth leaders.** Most youth leaders who participated in the four-day workshop, male and female, were 17 to 24 years old and had completed class 10 at the age of 16. In order to determine the impact of the four-day training on them, youth supervisors went to the villages and met with workshop participants and their families every three months for 15 months after the initial training. They further discussed the impact during the refresher courses.

What they found was that by the last day of the training, young women and men were interacting more spontaneously than at the beginning. Young

women spoke more assertively and were more animated, and young men appeared to have genuinely gained insight into the difficulties women face with reproductive health.

Two areas of the training immediately affected youth leaders' attitudes and behavior. The first was the issue of seeing men and women and their roles as simply different and complementary rather than superior and inferior. They began to understand that men and women do not have to play the same roles to be equal. The second area of significance was learning about reproductive health (male and female anatomy, women's menstrual cycles and pregnancy, and STIs) and the responsibility of men toward women in reproductive health. These topics traditionally are shrouded in mystery and shame. However, youth leaders became extremely motivated to learn as much as they could about these issues. Of particular importance was that young women learned that STIs could be transmitted from men to women. Disease transmission during sex was a new concept and was key to their understanding of one aspect of men's responsibility for their reproductive health. As a result of this understanding, the young women became more assertive in their decisionmaking regarding relationships and reproductive health.

Because of the training, many youth leaders are now seen by their peers as advisors or “experts” in reproductive health. This new role has served to reinforce their self-esteem and led them to learn and share more about such topics.

Not all the effects have been positive. Participants (particularly male youth) said that because they discuss issues with their friends and family, they are sometimes teased or ridiculed by older members of the family or younger friends who say they have “dirty minds.” As a result, they reported feeling isolated. Not surprisingly, youth leaders requested more support from the SIDH youth

supervisors, whose presence, they felt, was essential to supporting attitudinal and behavioral changes. Youth leaders also suggested that they should keep diaries of their experiences at home and write personal letters to the SIDH training team describing their problems.

For their part, SIDH and other NGO staff trained as trainers in the project felt that the impact of the training on youth was mixed. NGO staff felt that while the young women's increased assertiveness might lead to long-term change, it would require on-going support. While the training led to drastic change in young men's behavior that lasted for about one year (helping female relatives with chores, etc.), the lack of ongoing support and the resistance of older women in their homes dampened their enthusiasm. While their intellectual understanding toward gender relations had changed, many of them had slipped back into traditional behavior.

Ensuring Long-Term Impact

To ensure the long-term impact of its effort to involve men as partners in women's reproductive health, SIDH has integrated the lessons into both non-formal education courses and ongoing women's groups.

Non-Formal Education Courses

One of the original objectives of the Men's Partnership in Women's Reproductive Health project was to develop a comprehensive gender-sensitization curriculum for non-formal educational courses that would enhance the long-term impact of the project. As a result, SIDH has redesigned its non-formal education programs for village youth. Activities have been modified to respond to the needs-assessment phase of the Men's Partnership project and to the discussions that occurred during the trainings. This has led to the development of two major non-formal education programs for village youth: Sanjeevani and

Sanmati. The target groups are working youth between 17 and 24 years old. Both courses focus on youth as "change agents" and have furthered the long-term impact of the men's involvement project on youth.

Sanjeevani: A one-year residential course. The primary aim of Sanjeevani is to support the efforts of village youth toward self-reliance. The Sanjeevani course initially started as a one-year residential course for 17- to 24-year-old men because there was no separate dormitory for women. However, since 2001, young women have been enrolled. Interestingly, the inclusion of young women has led to a healthy confrontation on gender issues and has resulted in further modifications to the curriculum; now young women and men jointly examine such things as family relationships, cooking, and home budgets.

A basic approach of the Sanjeevani course is to expose youth to opposing points of view so that they develop the ability to challenge dominant cultural paradigms and develop alternative values. The emphasis is on knowledge rather than information—on *how* to think rather than *what* to think.

Sanjeevani aims to:

- ▶ Build young people's sense of self-confidence and self-esteem;
- ▶ Increase awareness of the benefits, limitations, and contradictions of both the traditional and the modern value systems;
- ▶ Encourage and support realistic choices for change;
- ▶ Challenge youth's existing thought patterns and beliefs, develop their analytical skills, and thus, increase their openness to new ideas;
- ▶ Improve analytical and decision-making skills;
- ▶ Improve self-motivation;
- ▶ Encourage youth to take leadership roles in personal and public life;

- ▶ Provide skills in the basic principles of business and management; and
- ▶ Impart vocational skills/livelihoods.

Ultimately, the course encourages long-term behavior change.

In the 2002 review of the Sanjeevani program, SIDH was satisfied with the impact on individual students. However, it felt that the impression on society was limited because students came from scattered areas within Uttaranchal. As a result, SIDH has decided to recruit most new students primarily from one local area in order to develop a “critical mass” that will both create a support group for individual students and further social change within mainstream society. SIDH continues to experiment.

Sanmati: seven-day short courses. A substantial number of interested and eligible youth are not able to take the Sanjeevani course because of their work responsibilities, family protection of adolescent girls, and other situations. As an alternative to the one-year Sanjeevani course, SIDH has established some short, seven-day courses with similar broad objectives. They include courses on language and communication, problem solving, culture and history, and socio-political analysis. These courses challenge youth’s modern and traditional beliefs, and encourage creative, original thinking as part of the process necessary for introducing new mores and values. External resource persons are invited for these courses. Approximately 60–70 women and men, 17 to 30 years old, attend each of these courses, which are held four times a year.

Women’s Groups

The Sanmati course has led to the development of a forum for adolescent girls called *Jyoti Manch*, a series of sessions based on self-respect for all adolescent girls working at SIDH. In late 2001, SIDH began a one-year course for adolescent girls that

will probe reproductive health, gender equity, education, and related issues more deeply to enhance long-term behavior change.

Indeed, while recruiting women field supervisors, SIDH found that women were significantly less confident than men in decisionmaking. As a result, SIDH formed an all-women’s group called *Jyoti Sangha* within SIDH, implementing intra-gender sensitization modules with *Mahila Dals* (women’s group) and self-esteem exercises with *Yuvati Dals* (groups of young girls) in the villages.

Lessons Learned

The issues examined and discussed within this project are extremely complex. Because there are many causes and contexts for these issues, a range of approaches from both youth and gender perspectives must be used to understand and resolve them. Key to the success of the project were the following elements:

- ▶ **Involvement of both women and men in efforts to overcome gender inequities.** The inclusion of women in this “male involvement” project led to a more stimulating training that prevented the young men from becoming isolated and defensive, provided them the opportunity to communicate directly with women on difficult reproductive health issues, and allowed them to be more open to change.

- ▶ **A comprehensive needs assessment of the community.** Program staff must be skilled or trained in conducting qualitative research to conduct these assessments. Most NGOs will need to hire a consultant who specializes in qualitative research and has experience in conducting needs assessments.

- ▶ **Sufficient time to analyze and discuss the results of the needs assessment.** This is time well spent, as staff gains cultural insight and anecdotal information that will enhance the appropriate cultural design and implementation of the proj-

ect. The master trainers should be involved in both the initial needs assessment and the process of developing the training module. Planners should allow at least two to three months for the needs assessment and two weeks for developing the training module.

▶ **Informal, in-depth interviews with several representatives of the village.** For example, during women's work groups (shelling corn) and at night when sitting around and drinking tea, researchers would listen quietly to the discussion, interjecting a few questions when appropriate. SIDH master trainers found that conducting qualitative research was more difficult than originally expected. However, this informal method was more effective than classic focus-group discussions.

▶ **Inclusion of the master trainers in the development of the Men's Partnership in Women's Reproductive Health training module.** This provided master trainers a comfortable venue for in-depth discussion and learning about reproductive health issues. The information was relevant to trainers' own lives, which motivated them to integrate it, enabling them to become effective role models for youth. Participating in developing the module created a bond between male and female master trainers. The process increased their confidence in discussing and sharing reproductive health information with others.

▶ **Understanding the nature of the community before planning or implementing any intervention.** If social issues such as gender inequity are challenged in isolation separate from a community context, the effort will fail. Social change in villages stems from perceiving people not as individuals, per se, but as community members whose responsibility for the well-being of the whole community is emphasized.

▶ **Incorporating role-plays into the workshops.** Switching gender roles was especially effective in

demonstrating unequal status and power. This was utilized in role-plays where men played the role of women and vice versa in a traditional family where the young daughter-in-law is pregnant, and in another situation where the husband and wife visit the doctor together.

Some of the lessons learned from the project identify areas that might need to be addressed in future projects:

▶ **Realistic expectations for change must be established among young leaders.** The master trainers worried early on that SIDH staff might not be able to provide the consistent follow-up and support required to sustain the major personal changes expected from participants. Fear of alienation, isolation, and ridicule from family and peers were the biggest obstacles to maintaining new attitudes and behavior change.

Even though SIDH youth supervisors made regular visits to the villages, youth leaders felt they needed more support from both youth supervisors and their own peers. The lack of support from family members inhibited the progress of the newly trained youth; their enthusiasm began to wane about a month after the training. It was agreed that, to avoid teasing and criticism, youth should first talk with and get support from fellow trainees, sympathetic peers, and SIDH youth supervisors. They should not try to convince older family members or younger children who initially would find the new concepts a basis for ridicule. They also suggested conducting refresher courses every three months, providing skills on how to cope with teasing, and training more extensively to create a "critical mass" of peers and family members who could share in this new awareness and be mutually supportive.

▶ **Realistic expectations of change must be established regarding women's roles in the family.** Gender inequities are extremely complex in a joint-family system, and the problems of daugh-

ters-in-law are especially challenging. Daughters-in-law felt they must work hard and, when ill, bear pain to maintain their good image within the family and to maintain the family's image within the village. Men as well as other women in the family, especially sisters-in-law or mothers-in-law, benefit from their labor and reinforce their subservient role. This has led to in-depth discussions of relationships among women and the need to focus more attention on the power of the mother-in-law to implement and support changes in gender roles and improve the reproductive health of their daughters-in-law.

▶ **Training in counseling skills needed for youth supervisors.** Based on their experiences supporting youth who had attended the training, SIDH youth supervisors identified a need for training in counseling skills. They requested training in concepts of counseling, informed reproductive-choice issues, active listening, reflection of feelings, and summarizing. They felt this would strengthen their ability to provide support to youth leaders who were attempting to implement behavior change within their family and village environments.

For More information

SIDH's documents are available to NGOs in Hindi and in English from SIDH and include:

- ▶ The four-day module, Men's Partnership in Women's Reproductive Health;
- ▶ The comprehensive, non-formal curriculum used as the basis of the Sanjeevani and Sanmati courses;
- ▶ The five-day training-of-trainers manual, Men's Partnership in Women's Reproductive Health.

(Note from the authors: These materials should be pre-tested in local communities and modified accordingly to ensure their cultural appropriateness.)

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Stepping Stones: Highlighting Male Involvement in a Gender and HIV/AIDS Training Package*

*Gill Gordon with Alice Welbourn***

This report summarizes the findings of a desk-based review of Stepping Stones, a communication, relationships, and life skills training package with a focus on reproductive health and HIV prevention that has been used throughout Africa and Asia. The role of men and the successes and challenges of actively involving men are highlighted in this review.

Executive Summary

Until recently, men have been neglected in reproductive health (RH) and HIV/STI prevention programs worldwide. Despite recognition that the involvement of men is critical (not only because men have unmet reproductive health needs but also because little will change for women unless men change also), involving men remains a major challenge.

Stepping Stones is a communication, relationships, and life skills training package, which also covers HIV prevention and reproductive health. Designed originally for use in non-literate rural communities in sub-Saharan Africa, Stepping Stones has been widely adapted and used throughout Africa and Asia. This report summarizes the findings of a desk-based review of the program commissioned by the Interagency Gender Working Group (IGWG) of USAID. It highlights the role of men in the program, and the successes and challenges of actively involving

men. Experience indicates that Stepping Stones is an effective community-based approach to HIV prevention that can improve relationships between men and women, promote gender equality, and create an enabling environment for reproductive health.

Purpose and Methodology

The purpose of the review was to gather available evidence for the effectiveness of the Stepping Stones approach, including highlighting strategies that change RH attitudes and behaviors of men. This report draws on experience in Cambodia, the Philippines, The Gambia, Ghana, Kenya, South Africa, Tanzania, Uganda, and Zambia. The methodologies used included analysis of reports and publications, focus group discussions and interviews, workshop discussions with facilitators and participants, and review of research carried out in The Gambia.

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** Gill Gordon is one of the initial advisors to Stepping Stones and has experience in Stepping Stones trainings in Gambia, Uganda, Ghana, Zambia, India, and Cambodia. Alice Welbourn is the author of the original Stepping Stones training package.

Positive Outcomes

In all the country settings reviewed, Stepping Stones has resulted in:

- ▶ Increased knowledge of reproductive health issues;
- ▶ Enhanced decision-making and communication skills and ability to discuss sexual issues;
- ▶ Improved gender, inter-generational and peer relationships.

These changes have in turn contributed to changes in behavior, including reduction in conflict, gender violence, and alcohol consumption; increased practice of safer sex; and redistribution of household resources and increased income-generating activities. Knowledge has been shared with others in the community and has resulted in less stigmatizing and discriminatory attitudes and behavior toward people living with HIV/AIDS.

Factors Contributing to Success

The effectiveness of Stepping Stones is based on the process, approach, and activities employed. The Stepping Stones process involves working with peer groups divided by age and sex, bringing the groups together to discuss their varied perspectives, and presenting requests for change from each peer group to the whole community. Working with individuals and peers helps to create the knowledge and skills that are prerequisites for behavior change, and presenting requests to the community creates the supportive environment that is necessary to effect and sustain behavior change.

The comprehensive approach of Stepping Stones to reproductive health is key to its success, as it gives men and women the opportunity to explore issues that affect their reproductive well-being. Moreover, it facilitates the development of knowledge and skills that enable people to take control of varied aspects of their lives.

This review looks at the factors that appear to be of particular importance in changing the reproductive and sexual attitudes and behaviors of men. These factors include:

- ▶ Providing men with opportunities to improve their knowledge and skills and to address their concerns;
- ▶ Working separately with older and younger men, who often have different needs and concerns, especially in contexts where younger men do not have a public voice;
- ▶ Building trust within peer groups and helping older and younger men to comfortably explore their own attitudes, behavior and vulnerability;
- ▶ Enabling men to hear the perceptions of women and to consider the impact of their attitudes and behaviors on the situation of women;
- ▶ Recruiting and training skilled male facilitators; and
- ▶ Creating positive peer and community pressure for behavior change.

Challenges to Effective Implementation

The review also identifies a number of challenges to the implementation of Stepping Stones, as well as strategies for overcoming the challenges and sustaining the changes. Some examples of challenges include motivating men to attend, especially men who most need to change their attitudes and behavior, and overcoming male resistance to the participation of women. Suggested strategies for involving men include using male community leaders and mobilizers to promote Stepping Stones to men.

Sustaining change is critical, but the extent to which different communities have been able to do this has varied. Some strategies for sustaining change focus on the role of facilitators, including follow-up visits, and responding to ongoing needs by introducing new activities and topics to maintain interest.

CREATED IN 1995, STEPPING STONES IS A communication, relationships, and life skills training package, with a particular focus on HIV prevention and reproductive well-being. Its overall goal is to help men and women express their hopes and fears to one another, explore factors that determine their well-being, and develop individual and group strategies to improve the quality of their lives.

Designed originally for use in non-literate rural communities in sub-Saharan Africa, Stepping Stones has been widely adapted and used throughout Africa and Asia. Experience indicates that Stepping Stones is an effective community-based approach to HIV prevention that can improve relationships between men and women, promote gender equality, and create an enabling environment for reproductive health and well-being. Since little documentation exists on how Stepping Stones works, or the specific impact of involving men actively in the program, much of this review relies on examination of that experience.

Methodology of Stepping Stones

Since Stepping Stones is a community-based program, the first step in using Stepping Stones is to organize a meeting with community leaders to explain the purpose and process and to obtain their support. Next, community leaders call a meeting of the community so that they may learn about Stepping Stones and be invited to participate. This is followed by a series of workshops for peer groups divided by age and sex—older men, older women, younger men, younger women. At fixed intervals, the peer groups meet together to share ideas in a structured way. Finally, the whole community meets to watch a drama created by peer groups and to hear the “requests for change” in the community from each of the peer groups.

The original training package includes a manual and a video. The manual covers 18 workshop sessions, grouped around four themes (see box on following page), to be held over three to four months and designed so that participants progress from easier to more challenging ses-

sions. The video, made in Uganda, is intended to attract participation in Stepping Stones, prompt discussion in the sessions, and reflect the reality of AIDS. The package differs from other HIV prevention approaches in its emphasis on aspects of life other than HIV and sex.

Each session takes approximately three hours and is comprised of: 1) a review of what was explored at the previous session; 2) a warm-up game associated in a fun way with the particular session and leading into the main topic; 3) exercises lasting up to 40 minutes each; and 4) a wind-down game.

Adaptations to the Original

Stepping Stones was designed originally for use in heterosexual relationships in sub-Saharan Africa, but has been adapted by organizations in many countries, such as the Philippines and Cambodia. Sensitive adaptations have been critical to the widespread success of the package. Some organizations have broadened the focus of the original manual to include reproductive health issues that reflect the concerns and priorities of their communities. For example, some organizations have added modules on reproductive rights, gender violence, teenage pregnancy, contraception, infertility, abortion, puberty, menopause, and sexual problems. Other organizations have left out some sessions in order to shorten the process or reach more people. It is important to note, however, that the package was designed to be used in its entirety.

Methodology Used for This Review

This review draws on experiences in Cambodia, the Philippines, The Gambia, Ghana, Kenya,

Theme 1: Group Cooperation

- ▶ Positive and negative feelings about sex
- ▶ What love means
- ▶ Taking risks
- ▶ Blaming others

Theme 2: HIV and Safer Sex

- ▶ Facts and feelings about HIV and people with HIV
- ▶ Hands-on learning about condoms

Theme 3: Why We Behave in the Ways We Do

- ▶ Hopes and fears for the future
- ▶ Exploring why we behave in the ways we do in sexual situations
- ▶ Pros and cons of alcohol use
- ▶ Pros and cons of traditional practices
- ▶ Issues around household income and expenditure
- ▶ Accepting and taking responsibility for our actions

Theme 4: Ways in Which We Can Change

- ▶ Learning about assertiveness and rehearsing for reality
- ▶ “I” statements
- ▶ Trust
- ▶ Preparing for death
- ▶ Asking the community for support to change the future

South Africa, Tanzania, Uganda, and Zambia. The methodology used for this review included:

- ▶ Review of reports and publications;
- ▶ Focus group discussions and semi-structured interviews with participants, facilitators, and trainers in Ghana, and e-mail feedback from facilitators and trainers in The Gambia, Kenya, South Africa, and Uganda;
- ▶ Workshop discussions with facilitators and participants in Cambodia;
- ▶ Analysis of participant perceptions in urban Tanzania and rural Uganda; and

- ▶ Review of research conducted in The Gambia, including an evaluation carried out by the U.K. Medical Research Council, and work carried out by The Gambia Department of State for Health, ActionAid, Family Planning Association, and the World Wide Evangelization for Christ Mission.

Positive Effects of Stepping Stones

Participants, trainers, and facilitators have reported many positive changes in the lives of individuals, peer groups, families, and communities, including effects on knowledge and skills, relationships, and behavior.

Knowledge and Skills

In many countries, people are aware of HIV and other STIs, but they lack the knowledge and skills that are a pre-requisite for behavior change.

Participants in all countries reported that Stepping Stones had increased their knowledge of how HIV is transmitted, the consequences of infection, their own risk, and how to protect themselves. Many realized for the first time that someone can have HIV without visible symptoms. The increase in knowledge was highest in countries with low HIV prevalence and among women, who generally have less access to information. In The Gambia, the workshops increased knowledge about STI transmission and the link between STIs and infertility, a major concern.

Male and female participants reported improvements in decision-making skills, particularly in their ability to think critically about their lives and the advantages and disadvantages of different courses of action.

Men and women appreciated learning how to be assertive rather than aggressive or passive by using “I” statements. Older men reported that wives and young people have become “more polite.” Men use the “I” statement to ask wives more politely to perform tasks for them. In Uganda, young men now

use this approach instead of demanding sex, and they report that girls have a greater sense of ownership of themselves. Women said practicing these skills helped them to say “no” to unwanted sex and oppressive male behavior, as well as to ask their partners for money or permission to travel. The “I” statement appears to help both men and women say how they feel and request changes in behavior in a way that improves their relationships rather than causes conflict.

In all the countries, participants reported that the workshops had enhanced their communication skills, enabling them to communicate their own needs and listen to the needs of others, and to consider how they relate to others in their everyday lives. Women were better able to express themselves in public. Men reported being able to speak the truth more openly and to resist peer pressure. Young men spoke of learning cooperation through discussion with others. More specifically, the workshops enabled people to talk openly about sexual issues for the first time, as partners, parents, peers, and communities. More open discussion has enhanced relationships in general and made it easier for people to discuss safer sex.

Relationships

The ability of individuals to change their sexual behavior is determined by gender relations, peer influence, and the family and community environment, as well as by knowledge and skills. Stepping Stones aims to promote relationships based on openness, understanding, and respect between men and women and parents and children, and to develop positive peer pressure for safer behavior.

Participants reported better gender relations—greater equality, mutual respect and empathy, increased respect for women’s rights, sharing of household work, and improved sexual relations—as a result of improved life and communication skills and the ability to talk about sexuality. After

Stepping Stones, Cambodian women were able to attend meetings and Gambian women were allowed to travel freely. Women also reported that they were able to participate in discussions in the home and men took account of their contributions. In The Gambia, increased dialogue and mutual respect within marriage were noted.

“People used to be very shy to discuss with their husbands... but now things have changed. After taking food, you can sit beside him and chat.”

—Older woman, The Gambia

In all countries reviewed, Stepping Stones had changed men’s perceptions about their wives and the contribution of women. In the Philippines, a facilitator noted that men who attended began to see the importance of changing their sexual behavior and their attitudes to women, and empathized more with the situation of women. In Uganda, younger and older men felt that they would be more likely to achieve their aspirations for their families and communities if they worked together with their wives. Respondents in all countries said that men were sharing domestic work more often.

“Before there was not much helping here... now many men are on their feet to help their wives... Men go to the bush with horse carts to bring the firewood home. Previously women would carry the firewood themselves and bring it home.”

—Imam from The Gambia

Similar changes in attitudes toward women’s empowerment were reported among young men in Kenya, some of whom had argued that a self-sufficient woman would be threatening because she might take a “boyfriend outside.” After discussion, they concluded that poor women are more vulnerable to manipulation by other men and that a woman should have the freedom to make a living in an acceptable manner so that, if she loses

her husband, money is not the main reason for finding another man.

Better Relationships Between Generations

Stepping Stones facilitates the sharing of concerns between generations. In all countries, older and younger participants reported better communication, more respect, and improved relationships between parents and children. In Uganda, bringing peer groups together has also helped to challenge older people's ideas about young people.

After participating in Stepping Stones, some parents in Uganda talked more openly with their children about sex, and the numbers of mothers in The Gambia who discussed sexual issues with their children increased substantially. Respondents also reported that parents are taking greater responsibility for the welfare of their children. In the Philippines, one facilitator noted that men now consider the welfare of their family before their personal self-interest while, in Ghana, parents pay more attention to meeting their children's material needs so they are less likely to engage in transactional sex with "sugar daddies." Children are also taking greater responsibility for the welfare of their parents. Participants in Uganda said that young men have become more active and industrious, and that young people stay at home and help their parents more.

Positive Peer Group Relations

Participants felt that working together in a group over a period of time, sharing their thoughts and feelings, had helped to strengthen their relationships with their peers. As one young man stated:

"Without someone guiding you, you may not know you went wrong. A friend can tell you that this is the right path. Before we despised each other, now we listen."

Members of an older women's group in Uganda said they had benefited from friendship, openness, and sharing. Young men in Uganda felt that the sessions had increased their respect for each other and created "oneness" among those who had attended. Facilitators in Cambodia and Uganda noted that articulating common problems and aspirations had created a sense of togetherness and a special bond between men who participated in the workshops. This was seen as important, they said, because men are less likely than women to have close friends with whom they can discuss personal issues.

Changes in Behavior

The Stepping Stones training package resulted in changes in the actual behavior of the participants, including a reduction in alcohol consumption and in violence, and an increase in safer sex practices. The video, which was part of the package and which was made in Uganda, had some positive impact on behavior—encouraging men to discuss the behavior of husbands, influencing men to drink less alcohol, raising the issue of rape—but there were also considerable logistical problems with transporting video equipment to rural villages.⁹

Reduced Alcohol Consumption and Conflict

The session on alcohol is an important part of Stepping Stones, since alcohol abuse often plays a role in quarrels between couples, unsafe sex, and gender-based violence. Reduced alcohol consumption was reported in Ghana, Tanzania, and Uganda. Bar owners in Uganda reported less serious drunkenness, fewer fights, and less sexual activity in bars. Also, school children had stopped going to bars.

In all countries, people reported less conflict and violence in general and within relationships.

⁹ Some organizations opted to replace the video with other activities. This often worked better, because people discussed their own situation rather than being distracted by the situation portrayed in the video.

Young men in Tanzania had become more tolerant and less angry. Women in Uganda said they were now able to defuse potentially violent situations by using assertive behavior. In The Gambia, men and women reported that they had learned how to reduce conflict within relationships.

Increase in Safer Sex

According to the feedback received, Stepping Stones has increased abstinence and condom use and resulted in a reduction in the number of partners and in extra-marital sex.

Participants reported more positive attitudes toward condoms, new skills in negotiating condom use and in using condoms, and a better understanding of situations where condom use is appropriate. Young men in Tanzania appreciated the dual protection condoms provide against HIV and unwanted pregnancy. Young men in Uganda gave high priority to condom use and had shown their friends how to use them; some said they were now able to persuade girls to agree to use condoms. Men and women in The Gambia were clear about the importance of condom use in preventing STIs.

In The Gambia and Ghana it was reported that condom use had reduced extra-marital sex. Couples no longer had to abstain from sex for birth spacing purposes if condoms were used and, therefore, wives were more sexually available.

Participants also noted that condoms reduced the risks associated with extra-marital sex. Some women encouraged their husbands to use condoms because they do not expect them to be able to stay faithful and the women want to protect their own health. Men in Ghana reported that they had stopped having unprotected sex, while men in The Gambia noted that women were no longer willing to have sex without a condom.

“She does tell me that if you cannot stick to me alone then you should use condoms

because if you use them we cannot infect each other with disease.”

—Male participant, The Gambia

In The Gambia, several groups welcomed the opportunity to practice condom use.

“We had seen condoms before but never used one, so actually knowing how to use it was important.”

—Male participant, The Gambia

Economic Changes

Evidence suggests that Stepping Stones has resulted in a more equitable sharing of resources in the household between men and women. Men in Ghana, Uganda, and Tanzania reported giving more money to their wives once they stopped spending it on extra-marital sexual relationships. As a young man in Tanzania stated:

“I was giving half my salary to girls, but since I have put a limitation on girls, all my salary goes to my wife.”

Men and women now discuss household expenses and budget together. Men in Uganda help women with income-generating work as well as with domestic tasks. Young men and women in Ghana started engaging in income-generating activities, and all peer groups in Uganda planned to start income-generating activities.

In Uganda, husbands are now writing wills and buying land for their wives, and women are establishing independent sources of income. Male participants in Stepping Stones in Cambodia said they now plan for the future and for family life, saving money they would have spent in the brothel to build a house for their future marriage and thinking about protecting their future wife from HIV.

Care and Support for People Living With HIV/AIDS

Participation in Stepping Stones has decreased fear of HIV/AIDS, a first step toward reducing stigma and discrimination, and has increased people's capacity and willingness to provide care and support. In Uganda, young women said that Stepping Stones had given them the strength to care for sick husbands or for their children after they had been widowed. Young men reported that they had previously shunned people with HIV/AIDS but had now decided to help them and their families.

Widening the Circle of Influence

Curiosity about Stepping Stones activities has been used as an opportunity for peer education. By facilitating open discussion, Stepping Stones aims to promote wider sharing of new knowledge and skills and to create a supportive environment in the community that enables all individuals to change their behavior. In The Gambia, Stepping Stones participants have been encouraged to act as "peer educators," sharing what they learned through informal conversations and by acting as role models. Some, for example, have told their neighbors and people in nearby villages about how to avoid the spread of STIs. Participants in the Philippines have also shared what they have learned with others in the community or encouraged others to attend. In Uganda, participants felt responsible for teaching those who did not attend, and some older women in Tanzania have become educators, taking drama to primary schools and teaching the pupils life skills.

"The community is proud to say that they went to sensitize a village and showed dramas which emulated the Stepping Stones program so that the people there would also be interested to carry out a program."

—Young woman, The Gambia

Factors Contributing to Success

The feedback from trainers and participants revealed that there are key components in the Stepping Stones methodology that contribute to positive outcomes.

Working in Separate Peer Groups

Participants reported that working in peer groups separated by sex and age enabled them to identify their needs, analyze causes of problems, look for solutions, and decide what issues to share with other groups. In a mapping exercise in Tanzania, men and women drew different maps showing locations where they were at risk of unsafe sex, identified different reasons for unsafe sex, and suggested different action points. When the groups came together, the men were sobered by the women's perceptions. Such insights might not have occurred if the groups had worked together from the start.

Working in peer groups also enables men and women, young and old to freely discuss sensitive sexual issues without domination, accusation or derision. Experience shows that older men need protection from the ridicule of young men, and that young men need to be able to express themselves without moralizing from older men.

Groups that mix men and women have met with varying success. In Tanzania, one facilitator noted that men visibly changed their attitude when they listened to women talking about their experiences and feelings related to gender and sexuality, but that women were less able to speak up in mixed groups because of the way they had been socialized. In Tanzania and the Philippines, young people found it easier to share experiences in a mixed sex group, but older men and women worked better in separate groups, as they grew up during a time when it was taboo to discuss sex.

Valuing Different Perspectives—the “Fission And Fusion” Process

Peer groups meet together three times for structured dramatic presentations to each other and discussion. During this process, facilitators, who ideally are the same sex and age as their groups, openly acknowledge and value different perspectives rather than downplaying differences to reach an artificial consensus. The review showed that the “fission and fusion” approach, in which peer groups share perceptions and learn to communicate better across sex and age lines, is critical to attitude and behavior change.

Researchers in The Gambia found that this arrangement encourages assertiveness between peer groups. Members have sensitive conversations within their group, but can select what messages they give to others.

Participation of Partners and Family Members

Communication between couples is most likely to improve if both partners attend Stepping Stones. This was reported in Cambodia, Uganda, Ghana, and The Gambia. Maximum effect is also achieved when younger and older members of the same family attend. Working with different age groups and then bringing them together can affect a wide range of problems; for example, monetary support by parents so young family members don’t have to trade sex for money.

The “Special Request” Strategy

The Stepping Stones process culminates in a final meeting where each peer group makes a “special request” for change to the whole community. The community then has to accept or reject the request. The special requests are an effective tool because the community is an important social structure and acceptance makes the requests binding. In Uganda, older men, who had previously waited outside schools to pick up girls and take them to bars, stopped doing this as a result of

a dramatization and the “special request” at one such meeting.

Positive Peer Pressure

Working in peer groups, bringing the peer groups together, the community drama, and requests and agreement on acceptable behavior—these things together establish positive peer pressure. Peer pressure created by participating in Stepping Stones motivates people to behave well and was a force for change in The Gambia and Ghana, reducing domestic violence and male drinking. As one elderly man in Gambia stated:

“From the final request, we have assigned ourselves as watchmen to one another so that we know who will violate the promise on domestic violence, especially wife beating.”

One cautionary note, however. If Stepping Stones is not well facilitated, there is a danger that it can be used to reinforce more authoritarian or judgmental views held by some members of the community, and these views can be imposed on others. For example, peer group pressure exerts considerable influence in Tanzania, where it was reported that the group “helps” young people to get back to the “right path” if they have “fallen off the straight and narrow.” It is important, therefore, for facilitators to explore with all participants the balance between safer behavior and respect for the perspectives of all groups.

Comprehensive and Participatory Approach

In order for trainings to be successful, the full Stepping Stones methodology should be followed and in the order in which it is intended. The participatory approach of Stepping Stones is also critical.

A facilitator in the Philippines noted that it is essential to start with activities that build trust before addressing more sensitive issues. Using the whole package rather than individual components has the greatest influence on attitudes and

behaviors. In Tanzania, when exercises on relationships, communication, and assertiveness skills were left out, local laws that focused on controlling women's behavior and punishing transgressors were introduced.

The participatory approach of Stepping Stones is key in making participants feel valued and respected. Participants particularly mentioned the right to decide whether or not to participate in the workshops and whether or not to be involved in monitoring and evaluation. Stepping Stones participants give feedback after each session on the facilitation, process, and content of the session, and discuss their own progress and efforts to share new ideas and try out new skills. This allows participants to share ideas about successful approaches. In one community in Uganda, women shared their experience of asking their husbands to use condoms, which encouraged others in the group to do the same.

During the last session, participants evaluate the whole Stepping Stones program against the hopes and fears they identified in the first session. Often people do not have a clear idea about what to expect when they begin the process, so the achievements are more far-reaching than they had hoped for originally. At the end of the program, participants in each peer group also identify the changes they hope to see in six months time and ways to measure these changes. Participatory monitoring and evaluation helps to reinforce learning and to create a sense of ownership and achievement.

Experiential, Enjoyable, and Interesting Learning Activities

Sessions use active, participatory adult learning methods to enable people to explore, experience, and discover answers for themselves. As one facilitator in Cambodia stated:

“Stepping Stones and other participatory activities use a different approach to the methods used by many organizations. Before

we started using participatory approaches, we used to transfer knowledge to our groups. Now they use their own knowledge and we learn from them. We used to give lectures, now we facilitate people to learn by doing themselves. When people do the role-play on sexual encounters, each peer role-play shows actual behavior. Men and women of all ages now analyze their own situation, behavior, and its causes.”

In all countries, participants most frequently mentioned role-plays, drama, songs, and drawing as activities bringing about change. Performing arts are not only entertaining and educational, they allow people to express themselves and to practice what they have learned. Role-plays can demonstrate good and bad sexual relationships or can show circumstances leading to sexual encounters. Participants can then analyze factors that influence the situation, consider how they would like things to be, and discuss ways to change the situation. Role-plays help participants to practice communication in difficult situations and can be replayed using new skills to result in a different outcome. In Cambodia, facilitators reported that young men with a reputation for violence had changed as a result of using role-play to explore behavior and practice skills.

All Peer Groups Do the Same Activities

Another important factor is that all peer groups do basically the same activities. In Ghana, participants thought that this helped men and women and older and younger people to learn from and about each other. Gaining an understanding of the perception of the other sex on issues such as rape increased empathy. In The Gambia, facilitators felt that it was important for men and women to know that they participate in the same activities, even if they do not talk much about the sessions at home.

Workshop Contents

The workshop contents and activities themselves were mentioned by participants as factors contributing to success. They said that the sessions are enjoyable, informative, and respond to their needs. All peer groups in Uganda and The Gambia appreciated the factual sessions on HIV and STIs, including information about modes of transmission and prevention. Participants said that holding sessions in the community with local facilitators helped to make the information more acceptable and provided a more thorough understanding of messages heard elsewhere. Face to face discussions also gave participants an opportunity to explore myths and perceptions about HIV/AIDS.

Challenges to Implementation of Stepping Stones and Strategies to Overcome Them

This section highlights some of the main challenges to implementation of Stepping Stones, from issues of attendance and participation to open discussions of condom use, and identifies strategies to overcome these challenges and to optimize the use of Stepping Stones for each community.

Persuading Men to Attend

Attracting men is a particular challenge, either because they do not perceive any benefits in participation, cannot afford time away from work, or view health and social issues as “women’s business.” In South Africa, it was found that getting men to participate was very difficult because men believed they were not vulnerable and that they already knew more than their female partners. Most preferred to spend their time on other activities, such as sports, and were only interested in participating if it would help them to get a job.

Another related challenge is that the men who do not participate are likely to be those who most need to change their attitudes and behavior. Female participants indicated that husbands who did attend were already more sharing and con-

cerned about marital relations than those who did not.

Strategies to Encourage Men to Attend

- ▶ Using male community leaders and mobilizers to promote Stepping Stones to men;
- ▶ Encouraging men who have benefited from Stepping Stones to promote it to their peers;
- ▶ Planning with men how best to facilitate their participation, through convenient timings and venues;
- ▶ Shortening the Stepping Stones process by selecting priority activities for men based on an initial needs assessment by men and women;
- ▶ Promoting the aspects of Stepping Stones that will particularly interest men;
- ▶ Holding pre-Stepping Stones meetings with women to rehearse how they can persuade their husbands of the benefits of attending Stepping Stones;
- ▶ Finding out from male participants what factors encouraged and helped them to attend;
- ▶ Recruiting and training appropriate facilitators; and
- ▶ Encouraging employers to promote Stepping Stones workshops during paid work time and convincing them of the long-term economic benefits to their businesses in doing so.

Men’s Resistance to Women’s Participation

In some countries, men were opposed to women participating. In most cases these were men who were not themselves participating. All peer groups in Uganda mentioned husbands who refused to allow wives to attend. Despite this, some women were determined to attend. One woman, whose husband described the training as “stupid, only for AIDS patients,” attended when he was away.

Getting Both Partners and Younger and Older People to Attend

Getting both partners to attend is also a challenge. Often a significant barrier is lack of childcare. In Ghana, less than half of participants attended with their partners because of concerns about leaving children at home alone. In South Africa and Cambodia, the partners of many younger men do not live in the same area. However, unless men also attend, it can be difficult for women to share what they have learned or to achieve any change. Getting different generations to attend can also be difficult. Again, in South Africa, very few young people participated with their parents in combined peer group sessions.

Strategies to Increase Attendance by Both Partners

- ▶ Organizing childcare for participants;
- ▶ Structuring childcare sharing with partners or family members as part of the process; and
- ▶ Asking participating men and women what persuaded men to allow their partners to attend.

Attracting the Poorest and Most Marginalized Groups

In Tanzania, better-off literate young men participated. Some people felt the workshops were meant for them rather than the poorest. In Uganda, poorer men could not afford the time away from work; some stopped coming when they realized Stepping Stones did not provide resources or AIDS treatment.

Women who work as sex workers may also feel excluded from Stepping Stones, despite the fact that money or material reward for sex is an issue commonly discussed in workshops. Facilitators need to ensure that sex workers are not stigmatized by the process, and that their perspectives are included in the workshops.

People having sex with others of the same sex may also feel excluded from the workshops or

from participation in the peer groups because of the stigma and hostility surrounding this practice. The Manual does not currently explore different sexualities and other issues of diversity; sensitive training and approaches would be needed to enable facilitators to raise and explore these issues safely.

As more programs address stigma and as access to high quality Voluntary Counseling and Testing increases, people living with HIV will gain the ability to talk openly and safely in the workshops. If people living with HIV become involved in the peer groups, they stand to gain increased support, other participants will benefit from their experience, and stigma will be reduced.

Strategies to Increase Participation of the Poorest and Most Marginalized Groups

- ▶ Communication that the program is for everyone and does not require reading and writing skills, and enlisting the help of local service providers, NGOs, and community organizations;
- ▶ Explaining the purpose and process of Stepping Stones clearly to all sections of the community, including poorest people who have not been to school;
- ▶ Exploring the use of peer educators to make Stepping Stones accessible to poorest people;
- ▶ Discussing economic barriers to attending with the poorest people and identifying ways to reduce these barriers, perhaps by including economic activities and micro-enterprise as a component of the program;
- ▶ Exploring how women who work as sex workers can be included in the process, if they want to be;
- ▶ Including exercises on sexualities and other issues of diversity in the workshops; and
- ▶ Emphasizing that Stepping Stones can reduce medical expenses and loss of wages by helping people to avoid serious illness and death.

Overcoming Gender and Age Group Dynamics

In some countries men and women have a difficult time openly expressing vulnerability and discussing sexual attitude and practices. In South Africa, while both men and women were able to express their vulnerability and were very open about their attitudes and behaviors, men spoke more freely about relationships and women spoke more freely about violence against women. In contrast, participants in Ghana said that men were more willing to share their experiences and show their vulnerability to risky sex than women. This was because women feared that others in their group would spread their stories around town, whereas men are “more trustworthy and seldom gossip.”

Facilitating groups of men was often challenging. In South Africa, men reportedly often listened badly, argued, and verbally attacked one another. Older men in Ghana sometimes paid scant attention to their own discussion, because they were curious to know what the women meeting nearby were saying and doing. Some men dominated the discussions, despite ground rules, and facilitators needed considerable skill and experience to get groups to work together well.

Bringing peer groups together sometimes caused embarrassment and conflict between male and female and older and younger peer groups. Discomfort between older and younger peer groups was most common. Young people in Uganda and Zambia felt nervous about doing role-plays in front of their in-laws. Older people in Uganda and Ghana worried that the young were being exposed to sexually explicit information that would make them promiscuous.

Women worried that men would be angry if their role-plays were critical of male behavior and men were concerned that women would understand male behavior too clearly. In Cambodia, some women experienced harassment from men in the

audience after the role-plays because of their openness about sexuality. In some settings, men wanted to make unchallenged decisions and women would say little in the presence of men. Participants in Ghana felt that women were better than men at listening to the views of other groups. In South Africa, young men listened better to women than to older men, because they welcomed the chance to hear the opposite sex’s perspective. In Uganda, young men felt that peer groups took a competitive approach to the dramas, instead of trying to understand each other.

Strategies to Reduce Peer Group Conflict

- ▶ Making sure the program follows the Stepping Stones sequence before bringing peer groups together, so that they are well prepared and have developed some understanding and empathy;
- ▶ Helping peer groups to prepare for performing their role-plays in a way that maximizes their positive influence across all groups, including planning their language and actions carefully and holding a session on listening, questioning, and empathizing;
- ▶ Increasing joint peer group meetings so that more dialogue and learning take place; and
- ▶ Turning the role-plays into a performance for a wider audience.

Ineffective Community Meetings

Making sure that the final community meetings are effective can also be a challenge. Older men tend to speak most, which is frustrating for other groups. Sometimes, so much time is spent on speeches or celebrations that there is insufficient time for proper community discussion. The dramas created for the final meeting can cause conflict because of the nature of the special requests and the fact that many in the audience have not participated in Stepping Stones. Although the requests are supposed to be assertive “we” statements that show peer groups taking personal

responsibility for problems and change, they can end up being accusatory. In one community in Ghana, the young women's group blamed older men for impregnating adolescent girls. While the men accepted this, they also requested that young women dress decently, and this resulted in conflict. The facilitator managed this interchange by returning to the health consequences of early sexual activity for young women and the need to find ways to address this.

Strategies to Maximize the Opportunities Presented by Community Meetings

- ▶ Assisting peer groups to create effective dramas that show the consequences or causes of a problem or a new way of behaving, and that encourage accepting responsibility for actions;
- ▶ Emphasizing the presentation and discussion of the special requests and agreement on next steps at the community meeting;
- ▶ Including a values clarification activity related to the request to keep discussion constructive; and
- ▶ Allowing adequate time for presentations, questions, discussion, and action planning.

Concerns About Open Discussion of Condom Use

Stepping Stones participants are often concerned that open discussion of sexuality and condom promotion will increase promiscuity, and these concerns need to be addressed. In the countries reviewed, some believed condoms would encourage husbands to have extra-marital relationships and young people to start sex early or have many partners. An older woman from Uganda stated:

“Husbands chase any skirt they see because condoms make it safe.”

An older man stated:

“Underage children are starting to have sex because of condoms. This damages their

reproductive organs, distracts them from their studies, and gives them a bad reputation.”

Ugandan participants also thought condom use could increase STIs and pregnancies, because condoms sometimes break.

Strategies to Overcome Concerns About Condoms

- ▶ Giving equal prominence to all choices for safer sex practices, including abstinence, fidelity, and condoms;
- ▶ Discussing the limitations of condoms and constraints to their effective use in all age groups, including the role of cultural and religious values in making decisions about sexual behavior; and
- ▶ Exploring the reality of current sexual behavior in all age groups.

Difficulty Sharing Knowledge Within the Community

Some participants were hesitant to share their new knowledge with others, because they lacked credibility as educators. In South Africa, some people feared that they had not grasped the new knowledge sufficiently to discuss with others. Older men in Uganda were concerned that people might not take them seriously and did not find it easy to recall information.

Others felt that Stepping Stones might exacerbate existing differences between different groups in the community, such as those who are better off and more educated over those who are poorer and do not have the resources or confidence to attend.

Still others experienced negative reactions from community members who did not attend. In Uganda, older women who attempted to share information received hostile responses; people accused them of having nothing else to do or said that they were going to die soon because they used condoms. Young women were told that they are idlers who are looking for men. In Tanzania,

one young woman participant reported that her friends ran away from her and insulted her, accusing her of pretending to be educated and knowing everything. The facilitator in Tanzania noted that non-participants mocked and jeered those who took part. In The Gambia, men and women reported that they were criticized because of their involvement, and that suspicions were raised because of the involvement of the Family Planning Association.

The perception of non-participants was that the participants had “superior attitudes” and were unwilling to share information. In some cases, people who asked for information were told to attend the training if they wanted to find out. As one older woman participant admitted, “We kept information close to our chests.” This may be a negative effect of the solidarity that develops within peer groups. For example, older women in Uganda were reluctant to admit other women who would not know how to communicate in the new way, and outsiders felt that the group had a new language.

Strategies for Sharing Learning with the Wider Community and Influential Individuals

- ▶ Meeting with all stakeholders before Stepping Stones begins to plan strategies to diffuse learning;
- ▶ Explaining that the program aims to benefit everyone in the community whether or not they attend;
- ▶ Informing the community that they should ask participants about what they have done in the sessions and to discuss their new ideas;
- ▶ Helping participants to understand that they are fortunate to have the opportunity to attend and can help their community by sharing what they learn with those who cannot attend;
- ▶ Continuing to promote strategies for sharing learning throughout the process;

- ▶ Asking participants what help they need to facilitate sharing; for example, simple visual and local language material to remind them of their learning;
- ▶ Asking people what they would like to share and with whom after each session, allowing time for practice and discussion of possible barriers and ways to overcome them, and asking for feedback at subsequent sessions;
- ▶ Explaining that participants can also share by being good role models, and that their own behavior may be more effective than talking;
- ▶ Identifying participants who would make good facilitators, if resources are available to expand the program;
- ▶ Performing some of the peer groups’ role-plays as dramas for the whole community;
- ▶ Encouraging peer groups to include in their action plans at the end of the program how they will diffuse their learning to others;
- ▶ Encouraging peer groups to invite people who did not attend to join the established peer groups; and
- ▶ Using the final community meeting as an opportunity for advocacy related to services and policy, for example, by making a video of the event to show to planners and policymakers.

Sustaining Change

Sustaining change is critical, but the extent to which different communities have been able to do this has varied. Further activities, facilitator and peer support, and continuing reflection and action are crucial if the changes brought about by Stepping Stones are to be sustained.

In Uganda, although behavior had lapsed somewhat after six months, things were still better than they had been before. None of the peer groups continued to meet in Uganda, although they had planned to do so, mainly because of the lack of peer group leaders. Younger men had returned to work or schooling and thought that further

action was not expected. In The Gambia, participants gave an optimistic picture of increasing and sustained positive changes a year after the workshop. In The Gambia, young men had maintained their peer groups one year after the workshop but the older men were less successful, and the women met once a month in the dry season.

Peer groups who plan to continue meeting but do not through lack of support represent a missed opportunity. Experience suggests that it is not enough to just discuss the group's plan to continue in the Stepping Stones session allocated for this, as witnessed in Uganda and Gambia. In The Gambia all groups were disappointed that the facilitators had not continued to come to the village as proposed in their action plans.

Strategies to Sustain Peer Group Meetings and Behavior Change

- ▶ Giving sufficient time and emphasis to action planning and continuation at the end of the program;
- ▶ Ensuring that facilitators spend enough time with peer groups to help them make an action plan, select leaders and identify local resource people, and develop skills for managing activities;
- ▶ Agreeing on the future role of facilitators, including when they will make follow-up visits and ensuring that time is allocated in facilitators' work plans;
- ▶ Responding to ongoing needs by introducing other activities and topics to sustain interest;
- ▶ Maintaining the motivation and commitment of facilitators through refresher training, exchange visits with other programs, and monthly review meetings; and
- ▶ Working with the community to ensure that reliable supplies of affordable condoms are available to support consistent use by all groups.

Additional Lessons Learned About Working With Men

The Stepping Stones methodology includes facilitating separate groups of men and women, as well as combining them into mixed-sex groups. This section highlights some of the lessons learned during the Stepping Stones process about working with men.

▶ **Men Need Knowledge and Skills.** Men often lack accurate knowledge and information about RH issues, and few programs attempt to respond to their needs. Men need opportunities to discuss and learn about issues that concern them, such as sexual virility and STIs. Men can also benefit from improved assertiveness, decisionmaking, and communication skills. Opportunities to practice condom use are critical.

▶ **Focus on Gender Relations Is Crucial.** Positive change in male sexual behavior depends on changes in gender relations and in male attitudes toward women. A critical component of changing attitudes involves enabling men to hear the perspectives of women and to consider how their behavior affects women. For this reason, it is essential that both partners participate in the process.

▶ **Different Age Groups Have Different Needs.** Men of different ages have different needs and concerns. It is also often difficult for younger men to express their views in the presence of older men and vice-versa. Programs need to work separately with male and female peer groups of different ages before bringing them together.

▶ **Activities Should Be Suited to Men.** Some men feel uncomfortable with activities such as games and role-plays, and, in particular, with acting out the roles of women. Programs need to identify and use types of activities that men find interesting and enjoyable.

▶ **Positive Relations Among Men Should Be Promoted.** Men often find it difficult to discuss personal issues, including with their peers. Promoting trust and positive relationships within

peer groups is critical, both to enable men to explore their attitudes and behavior and to create mutual support and positive peer pressure for behavior change. As one male facilitator in Uganda stated:

“What helped me to change was the realization that my fears and hopes are the same as those of my peer group.”

► **Effective Male Facilitators Are Critical.** Skilled male facilitators are critical to the successful involvement of men, both in motivating them to attend and sustaining their participation. Facilitators need to be gender sensitive, friendly, empathetic, and egalitarian. The most effective are those who allow men to be in control of their learning, since experience suggests that men do not appreciate being directed or having agendas and knowledge imposed on them. Male facilitators who are similar in age and share the same language are most effective in helping men overcome their reluctance to talk about their concerns and feelings. Effective facilitators can act as role models, showing men that they can interact by listening, showing empathy, and managing conflict constructively rather than by dominating and arguing. They can challenge men to think about things differently and help them understand their vulnerabilities.

► **Facilitators Need Appropriate Training.** Male facilitators need training that helps them to explore their own attitudes and behavior and that improves their understanding of their own sexuality and values and of gender inequalities, culture, and power. As one trainer stated:

“It is a challenge to train sexist men. Training that addresses cultural norms and relationship issues helps them to confront and work toward changing their own beliefs and behaviors.”

Training is often also needed to help facilitators change their approach from a didactic to a participatory one. Facilitators must also experience

Stepping Stones first themselves as participants and be convinced of its benefit before they facilitate it. It is important to allow facilitators sufficient time to develop their skills and change their attitudes. This needs reinforcement through refresher activities and ongoing support from more experienced facilitators.

A Supportive Environment

Finally, no single intervention package can work effectively to change any community, despite many attempts to find the “magic” package. If Stepping Stones is to achieve maximum impact, it needs to be complemented by a concerted and well-coordinated approach which includes: support for a community’s other complementary and on-going development initiatives, such as women’s literacy; wider efforts to create a supportive environment for reproductive well-being, such as well-developed broadcast and print media, and improvements in health services; and, last but by no means least, changes in legal and policy frameworks.

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For More Information

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Stepping Stones Program: Chart of Review Sources

Country	Implementation	Context	Review methodology
The Gambia	MRC, ActionAid, GFPA et al. adapted the original manual for The Gambia. Implemented the complete process with older and younger male and female peer groups.	Rural; agricultural economy; low cash income; Muslim; some polygyny; adult HIV prevalence 1.95%.	Preliminary evaluation in two villages where Stepping Stones was carried out compared to two control villages. Methods included participatory evaluation, 84 in-depth interviews, 7 focus group discussions, KAP questionnaire administered to random sample of 25% of the adult population at 3 time points, monitoring condom supply.
Uganda	First Stepping Stones workshop in Buwenda. Stepping Stones implemented fully by ActionAid et al. in two communities of Kabanga and Nabirumba, with sessions held daily for two weeks.	Rural; agricultural economy; low cash income; majority Christian; adult HIV prevalence 8.3%.	Focus Group Discussion (FGD) using diagrams with peer groups who attended Stepping Stones 16 months after workshop explored changes since workshop. FGD with peer groups who attended and did not attend Stepping Stones one year after workshop using diagrams and role-play, key informant interviews, interviews with facilitators, review of facilitator records and evidence of condom use, explored positive and negative impacts, perceptions of Stepping Stones process, continuing activity, problems remaining and action plans to address them. In-depth interview with male facilitator from Uganda and Stepping Stones trainer.
Ghana	Stepping Stones program implemented by PLAN International/Ghana and PRO-LINK in two areas; focusing on young people but adult peer groups were also facilitated.	Rural; fishing and agricultural areas; low cash income; majority Christian; adult HIV prevalence 4.6%.	Separate FGD with participants and facilitators carried out by PLAN and PROLINK, and written interview with staff and facilitators, explored process and impact of Stepping Stones. Quantitative KAP survey with young people but impact survey not yet completed.
Zambia	PPAZ and MoH trained community reproductive health workers to facilitate Stepping Stones activities in their communities. Implemented with older and younger male and female groups, but did not bring peer groups together.	Rural; agricultural economy; low cash income; majority Christian; adult HIV prevalence 19.95%.	Quantitative survey on knowledge, service use, positive and negative impacts of program. FGD using diagrams with peer groups exploring positive and negative impacts, perceptions of Stepping Stones process, problems remaining, and sustainability.

Stepping Stones program: Chart of Review Sources

Country	Implementation	Context	Review methodology
Cambodia	Khana trained partner NGOs in participatory activities, some adapted from Stepping Stones. Training in Stepping Stones carried out November 2000. NGOs implemented activities adapted to their context with peer groups established since 1997.	Urban and rural; variety of peer groups from male police only to older and younger men and women; adult HIV prevalence 3.5%.	Interviews with staff and facilitators of MODE and RACHANA in two rural areas. Observation of peer group meeting with MODE. Workshop to review progress since the Stepping Stones training and adapt manual for Cambodia. It was not possible to separate the effect of previous training in participatory activities, which included Stepping Stones, and the most recent training on the whole process, although some key principles were common to both and role-play activities were used more after the Stepping Stones training.
South Africa	MRCfunded program trained facilitators in Stepping Stones, now being implemented.	Urban; adult HIV prevalence 19.94%	Written interview with staff member of MRC responsible for implementing Stepping Stones on training and facilitation process. No information yet on impact.
Philippines	PHANSUP trained partner NGOs in Stepping Stones. Activities and process adapted and implemented by NGOs in different areas.	Urban and rural; adult HIV prevalence 1.0%	E-mail interview with PHANSUP, Alliance link organization. PHANSUP and the Alliance carried out evaluation and interviews with people who had participated in Stepping Stones training, as well as other participatory approaches.

The Interagency Gender Working Group (IGWG), established in 1997, is a network comprising non-governmental organizations, the United States Agency for International Development (USAID), cooperating agencies, and the Bureau for Global Health of USAID. The IGWG promotes gender equity within population, health, and nutrition programs with the goal of improving reproductive health/HIV/AIDS outcomes and fostering sustainable development. For more information, go to www.igwg.org.

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