

YOUNG MEN AND HIV PREVENTION

A TOOLKIT
FOR ACTION



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Founded in 1997, Promundo is a non-profit Brazilian organization focused on promoting gender equity and preventing violence against children and youth. Our projects have an international reach and have been implemented in several countries.

Based in Rio de Janeiro, Brazil, Promundo carries out research, implements community interventions and participates in networks and strategic alliances in Brazil and around the world. Promundo also provides technical assistance to other civil society organizations, foundations, governments and multilateral organizations, including UN agencies.

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PRESENTATION

Why is a toolkit on young men and HIV and AIDS necessary?

In much of the world, including Latin America and the Caribbean, young men are generally raised to be self-reliant and not to worry about their health. Often, they see sexual and reproductive health as an issue that only concerns women and girls. Moreover, for many young men, sexual experience is often associated with initiation into manhood and multiple partners with sexual prowess. These and other rigid attitudes and ideals related to masculinity, including those which espouse male dominance over women (physical and sexual), have implications for the vulnerability of both young men and women to HIV and AIDS.

However, while there has been increased recognition of the role that non-equitable gender norms and behaviours play in the spread of HIV and AIDS young men are still rarely explicitly addressed in HIV prevention policies and programmes. In many cases, this is due to a lack of knowledge on how to appropriately and effectively integrate them into prevention work as well as lingering doubts and scepticism regarding the possibility of young men changing their behaviours. **This toolkit serves to reinforce the benefits of working with young men and provide practical strategies and examples on how to do so in ways that apply a gender perspective.**

What does it contain?

The toolkit presents conceptual and practical information on how to design, implement

and evaluate HIV prevention activities which incorporate a gender perspective and engage young men and relevant stakeholders. Specific topics include how to:

- Carry out a needs assessment to understand the influences on young men's attitudes and behaviours and possible entry-points for engaging them in HIV prevention.
- Facilitate group educational activities to promote critical reflections about gender norms and skill-building related to HIV prevention.
- Design and implement campaigns to create a favourable environment for young men to assume more gender-equitable behaviours.
- Organize health services to be more attractive to young men and more sensitive and responsive to their needs
- Carry out advocacy to influence support and decision-making on work with young men.
- Monitor and evaluate activities to assess and improve impact.

How was it developed?

The toolkit was developed by Promundo and UNFPA with input by several leading organizations working in the fields of gender, sexuality and HIV prevention, including ECOS in Brazil and Salud y Género in Mexico. It included a review of strategies and practical lessons from programmes throughout the region as well as a field-testing with UNFPA offices and partner organizations in Guatemala (in collaboration with the Armed Forces), Belize (in collaboration with Belize Family Life Association and Youth for the Future) and Brazil, in collaboration with SESI (Serviço Social de Industria – Industrial Social Services).

Who is it for?

This tool kit is designed for programme planners, health providers, peer educators, advocates and others who work with and/or for young people on issues related to gender-equity, health and HIV and AIDS. While the research and programme examples draw primarily from experiences in Latin America and the Caribbean, many of the strategies and lessons learned are also relevant for other regions.

How should it be used?

The toolkit is organized into different modules which can be read and used together or separately. All of the different modules, with the exception of the introduction, have accompanying “tools” for further guidance and hands-on application of concepts and strategies. It is important to keep in mind, however, that there is no single set of strategies and tools for working with young men; those presented here are intended to serve mainly as inspiration and examples and should always be adapted according to local needs and experiences. Moreover, although the programme planner, advocate or other user of the toolkit may have a specific programming focus it is worthwhile to peruse the toolkit in its entirety to gain an understanding of how programmes and advocates can support integrated efforts which work at different programme and policy levels and address the multiple health and development needs of young men.

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- Checklist for young man-friendly services
- Survey for Health Services Staff
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- Informational handout on preventative exam for testicular cancer
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PROGRAMMING: CAMPAIGNS

- Creating Campaigns: Step by Step
- Mapping Young Men's Media and Social Networks

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- Sample Logical framework
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INTRODUCTION



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Gender, youth, and HIV and AIDS

According to the most recent reports, there are 38.6 million people living with HIV around the world (UNAIDS 2006). The epidemic continues to magnify societal, gender, and economic inequities as the burden of the disease and its related costs have fallen disproportionately upon the most vulnerable populations and individuals. Among the most vulnerable are young people 15-24 years old, who represent more than half of all new infections worldwide. Of these new infections, approximately 60% are among young women, a stark indication of the feminization of the epidemic (UNAIDS 2004).

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Gender norms – the socially constructed ideals of appropriate behaviours, beliefs and attitudes for women and men – are among the key factors which underlie young people's vulnerability to HIV and AIDS. For example, in many parts of the world, young men are expected to be sexually knowledgeable and active and young women, in turn, are expected to be sexually coy and passive. It has been widely recognized how these types of gender norms put women at risk however, there has been less attention to how these gender norms also put men at risk, although disproportionately less so than women. Therefore, to truly address the HIV and AIDS epidemic, it is necessary to understand how social constructions of gender, particularly masculinity, fuel

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the epidemic and put both women and men at risk and most importantly, how they can be transformed for the health and well-being of both.

HIV AND AIDS AMONG YOUTH GLOBALLY AND IN LATIN AMERICA AND THE CARIBBEAN

Of the over 1 billion young people worldwide, 10 million are currently living with HIV (UNAIDS 2004). Every day, 6,000 young people ages 15 to 24 become HIV positive – more than five new cases every minute (UNAIDS 2005). As a result, almost 12 million young people are now living with HIV or AIDS. In Latin America and the Caribbean, an estimated 560,000 young people are living with HIV - nearly 40% of all individuals living with HIV in the region. As in most other regions, the HIV and AIDS epidemic among youth in Latin America and the Caribbean is driven primarily by heterosexual intercourse (UNAIDS 2005). Underlying the specific vulnerability of youth are various factors, including continued misconceptions about HIV and AIDS and transmission, the lack of consistent and correct use of condoms, higher rates of STIs and unequal power in gender relations. Moreover, in much of the region, youth's rights are not respected, particularly their right to information and services related to sexual and reproductive health. Some governments in the region have passed laws requiring secondary and in some cases primary schools to provide sex education, however even in these countries many youth do not receive sex education as schools are not prepared and do not yet have sufficient support to implement such programmes.

FEMINIZATION OF THE HIV AND AIDS EPIDEMIC

The feminization of the HIV and AIDS epidemic has brought international attention to the importance of gender in influencing an individual's vulnerability to HIV infection. In the 1980's, the HIV and AIDS epidemic was mostly concentrated among male homosexuals and injecting drug users, however, that pattern has changed significantly over the last two decades. Worldwide, nearly half of all people currently living with HIV are female and approximately 62 percent of youth living with HIV are female, reflecting an alarming gender imbalance in vulnerability to HIV and AIDS (UNAIDS 2006).

Although the rates of girls and women ages 15-24 living with HIV are highest in sub-Saharan countries, the rates of infection among girls and women have also begun to increase in Latin American and Caribbean countries with far lower prevalence rates. For example, 4.2 percent of women ages 15-24 are living with HIV in four of the most populous municipalities in Haiti, compared to only two percent of males in the same age range (UNAIDS 2006). In Trinidad and Tobago, the rate of HIV among young women ages 15-19 is six times greater than that for young men of the same age (UNAIDS 2005). In Argentina, females represented only one of every 16 infections in 1988, but in 2004 they represented one out of every four infections. (UNAIDS 2005) As these statistics illustrate, though the degree of feminization varies from country to country, the Latin American and Caribbean region is experiencing a general trend of feminization similar to other regions of the world.

Both biological and social factors play a role in the feminization of the HIV and AIDS epidemic. The risk of women contracting the HIV virus during unprotected vaginal intercourse is two to four times

greater than for men (NS Padian 1991). This physiological vulnerability is heightened by inequitable social norms in which women may have limited decision-making and negotiation power regarding if and how sexual relations happen. An extreme form of power imbalance, sexual coercion and violence is associated with decreased condom use and in the case of forced sex, increased likelihood of HIV transmission due to possible injury to the genital tract and anus. Furthermore, violence can interfere with a woman's ability to access services, including testing and treatment, maintain adherence to ARV treatment, or carry out her infant feeding choices. Evidence also exists that living with HIV can constitute a risk factor for violence, with many people reporting experiences of violence following disclosure of HIV status, or even following admission that HIV testing has been sought. Thus a vicious cycle of increasing vulnerabilities to both gender-based violence and HIV can be established (Harvard School of Public Health 2006)

In many countries in Latin America and the Caribbean, sexual relations between older men and younger women are relatively common (Bastos 1989; UNAIDS 2006b). This has contributed to increasingly higher rates of women becoming HIV positive, since older men, as a result of having had more sexual partners, are more likely to have acquired HIV, and are therefore more likely to transmit the disease to their partners. Furthermore, young married women are generally 5 to 10 years younger than their husbands. These young women, who represent between one quarter and two thirds of young women in the region, are among the most vulnerable groups to HIV and AIDS due to the combined facts that marriage itself often results in an increase of unprotected sex, partially from pressure for child-bearing, and that the significant age differences between young married women and their husbands lends to unequal decision-making power (Clark et al 2006).

SEX, SEXUALITY AND GENDER

Sex refers to whether we are born male or female. It is a biological classification and, for the most part, is fixed throughout our lives¹.

Sexuality is the expression of who we are as human beings. Sexuality includes all the feelings, thoughts, and behaviours of being male or female, being attractive and being in love, as well as being in relationships that include intimacy and physical sexual activity.

Gender refers to how we are socialized. It includes the attitudes, behaviours and expectations that society associates with being male or female. Masculinities (and femininities) are shaped by social and historical circumstances, as well as factors such as age, race, sexual orientation and cultural context. In this sense or in reality, there is no single or universal experience of what it means to be a man or a woman. Moreover, it

is not gender in and of itself that is negative – but rigid differences and the power imbalances these differences can bestow.

It is also important to distinguish between sex, gender and sexual orientation. Sexual orientation is the feeling of being able to relate romantically or sexually with or toward someone of the opposite sex (heterosexual), the same sex (homosexual), or with or toward persons of both sexes (bisexual). Sexual orientation is defined by identity and lifestyle, not sexual behaviour on its own. Many men who have sex with men do not identify as gay. For this reason, HIV prevention projects directed at gay men may not reach men who do not identify as gay. The term “men who have sex with men” (often abbreviated to MSM) is recommended to differentiate between sexual identity and behaviour (NSWP 2004).

Young men and HIV and AIDS

Around the world, many young men feel a pressure to live up to rigid ideals about how they should act and feel as men. In Latin America and the Caribbean, this set of ideals of masculinity is called machismo and affirms that men need sex more than women do and should always be strong and dominant. Women, on the other hand are often expected to remain faithful, virginal and defer to men in sexual matters. This contrast in gender norms, or ideals for how men and women should behave, establishes unequal power dynamics which often frame sexual and intimate relationships in the region. The dichotomy or polarization of men as “active” or “in-charge” and women as “passive” is an underlying construct of masculinities and femininities in the region and also characterizes many same-sex relationships among men in the region (Parker 1999).

1. There are individuals who do not self-identify within rigid categories of male or female. For example, transgender people do not identify with the gender to which they were assigned at birth, such as an individual who was born female but identifies as male, and transsexual people are those who choose to medically transition to the gender that feels right for them.

Throughout Latin America and the Caribbean, medium age at first sex for young men is 15.8 to - 17.5 (Guttmacher 2003). For many young men, sexual experience is frequently associated with initiation into a socially recognized manhood, or proof that they are “real men” – that is, conquest and achievement, rather than intimacy (Marsiglio, 1988; Barker & Loewenstein, 1997). Young men are often socialized to believe that men have a greater need for sex – indeed, research from Mexico and Brazil found that some men believe they cannot turn down any opportunity to have sex, even if they do not have a condom with them (Aramburu & Rodriguez, 1995; Barker & Loewenstein, 1997). In Nicaragua, having multiple sexual partners is often taken as a sign of virility and the pressure to be sexually active and have multiple partners may be so intense that young men who do not fulfil this expectation are open to ridicule by their peers for not being a real man (Berglund et al 1997; Zelaya et al 1997). In fact, research has found that between 28% and 59% of unmarried sexually experienced young men have had two or more sexual partners in the last year and, of these, 39-68% did not use a condom at last intercourse (Guttmacher 2003).

A common belief among many young men across the region is that they should “know it all” about sexuality and sex, when in fact they are frequently uninformed or misinformed on these matters. Indeed, various studies in Latin America and elsewhere suggest that young men have misconceptions about their own bodies, about HIV/STI transmission and about the female sexual anatomy and functioning (Singh 1997; Morris 1993). Due to cultural norms of masculine strength and self-reliance, however, young men

"Due to cultural norms of masculine strength and self-reliance young men may feel inhibited from seeking information."

may feel inhibited from seeking information or admitting their lack of knowledge about sexual matters and may consequently engage in unsafe behaviours that put both them and their partners at risk (Paiva 1996; Weis, Whelan and Gupta 1996).

Just as gender norms influence young men's motivations and decisions around sex – they also influence decisions and behaviours related to prevention. Although condom use has increased

"Violence is also closely linked to sexual behaviours and HIV and AIDS vulnerability."

among young men in much of Latin America – it is still inconsistent (UNAIDS 1999). This is mainly due to a lack of information and skills regarding the correct use of condoms; low risk perception; dislike of condoms; and rigid gender norms regarding communication between partners; and about whose responsibility it is to propose condom use and which associate condom use with lack of manliness (Barker 2005). Moreover, many young men may believe that sexual and reproductive health is a “female” concern. At the same time, however, prevailing norms frequently hold that it is the male’s responsibility to acquire condoms, since for a young woman to carry condoms would suggest that she is promiscuous or ‘easy’.

The idea of manhood as defined by conquest and number of female partners – reinforces an exclusively heterosexual definition of masculinity. Consequently, homophobia is a common aspect of young men’s socialization throughout Latin

America and the Caribbean. Boys and young men may be socialized to believe that being a “real man” means being not only “not a woman” but also “not a homosexual”. Young men who diverge from these norms in their mannerisms, attitudes or behaviours are likely to be ridiculed or criticized. For young men who are gay, or who have sex with men, this stigmatization can lead them to practice their sexuality clandestinely and inhibit them from seeking out sexual health information and services, thus creating situations of extreme vulnerability to HIV and AIDS.

Often considered one of the most extreme manifestations of unequal power dynamics, violence is also closely linked to sexual behaviours and HIV and AIDS vulnerability. In many settings, boys and young men may grow up learning violence as an acceptable means for resolving conflicts – or asserting authority and strength. In fact, studies have found an association between young men’s adherence to rigid gender attitudes and their use of violence against women (Barker et al 2004). Other studies have also shown that men who use violence have a higher probability of having STIs, pointing to a greater propensity to engage in riskier sexual behaviours, including having multiple partners (WHO nd; Barker et al 2004). In relationships where violence is present, the risks for HIV transmission are increased, mainly due to the reduced possibility of negotiating condom usage and in the cases of sexual violence, genital trauma. Moreover, women who suffer violence (physical or psychological) are less likely to come forward about their HIV status and to seek HIV related diagnostic, secondary prevention and treatment services (WHO nd; Barker et al 2004).

Substance use, often seen as part of the masculine ideal of risk-taking, is also associated with HIV and AIDS vulnerability, including an increased number of partners and decreased use of condoms. Moreover, the sharing of needles or syringes is

a direct means of HIV infection and a significant contributor to the HIV and AIDS epidemic in certain settings in Latin America and the Caribbean, as well as the primary source of infection in other regions such as Eastern Europe and Asia

YOUNG MEN WHO HAVE SEX WITH MEN

Research from around the world has found that between 1-16% of young men report having had some sexual contact with a male partner (Panos Institute 1998). Within the region, 36% of all HIV and AIDS cases are among men who have sex with men (MSM); in the Andean region and Mexico levels are close to 50% (Caceres et al 2002). Unprotected sex between men is also a driving factor in the HIV epidemics in Belize, El Salvador, Nicaragua and Panama (Caceres et al 2002). However, due to widespread stigma and the fact that sex between men is criminalized in several countries in the region, it is likely that the prevalence of HIV and AIDS among MSM is severely underreported and not accurately reflected in epidemiological data.

Physiologically, unprotected anal sex carries high risk of transmission for HIV and AIDS. This risk is heightened by rigid norms of masculinity – often reflected in the use of homophobic language to criticize boys who act in alternative or non-traditional ways – stigmatizes MSM and may lead them to have clandestine, and often unsafe, sexual encounters. The vulnerability of MSM also leads to increased vulnerability for the wider population, as many MSM also

have sex with women, acting as a 'bridge' into heterosexual populations.

Health programmes and services often have limited knowledge about and contact with MSM. Likewise, programmes which target gay men seldom meet the needs of MSM. This is because some MSM do not self-identify as gay and do not therefore relate to gay-specific messages. This may also be because these young men may fear the social stigma and violence—sometimes intensified by culture and religion—directed at those identified as homosexual or because they are unsure of their sexual orientation and may view same-sex sexual behaviour as experimental and temporary. Since these young men seldom identify as gay, they may not recognize unsafe behaviours that put them at risk for HIV/STI (Roseman and Klindera 1999). Moreover, for some young men, trading or selling sex to other men may offer a means of survival in otherwise difficult circumstances and while they may be aware of risks, they may have limited negotiation power. These young men who engage in sex work, particularly transgender or transsexual sex workers, may also be vulnerable to violence by clients, other men and law enforcers (UNFPA nd).

MEN AS PARTNERS IN ACHIEVING THE MDGS

In September 2000, at the United Nations Millennium Summit, leaders of 189 countries pledged to eliminate poverty and create a climate for sustainable development. This pledge was outlined in the Millennium Declaration in the form of eight Millennium Development Goals (MDGs). The MDGs are a set of time-bound and interrelated targets for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women.

The third millennium development goal, or MDG 3, specifically addresses gender – calling for an end to disparities between boys and girls at all levels of education. It reflects the recognition that “the equal rights and opportunities of women and men must be assured” in order to achieve sustainable

development. Although MDG 3 is the only one which explicitly addresses gender, the promotion of gender-equity is of critical importance to all of the MDGs – including the sixth millennium goal (MDG 6) of halting and reversing the spread of HIV and AIDS (as well as Malaria and other major diseases) by 2015. To achieve MDG 6 and reverse the spread of HIV and AIDS will require promoting both the empowerment of women and more gender-equitable attitudes and behaviours among men, including increasing their acceptance of prevention methods and their participation in the prevention of mother to childhood transmission (PMTCT) services.

For more information visit the United Nations Millennium Goals website at:
www.un.org/millenniumgoals

(UNAIDS 2006)². The link between substance use and unsafe sex, coupled with unequal power norms, means that young men's substance use also leads to women's increased vulnerability to HIV and AIDS.

Boys and young men are also frequently socialized into non-equitable ideas about care-giving, household roles and childrearing. Various studies in Latin America and elsewhere confirm that men's participation in domestic chores in general is far less than that

of women's. For example, one study in Nicaragua found that women devote 85 percent of the time required for domestic chores, while men provide the remaining 15 percent (Alatorre 2002). These norms about gender roles and care-giving often place a disproportionate burden of HIV and AIDS-related care on women. Studies in Latin America and elsewhere show that it is mainly women who provide care for people living with HIV, in essence extending and reinforcing the burden of the epidemic on women (Rivers and Aggleton 1998).

2. There is also an overlap between drug use and sex work - injecting drug users may engage in sex work to sustain their habit and likewise, individuals involved in the sex work environment may develop a drug habit as a coping mechanism (Deany 2000; NSWP 2004). The overlap between sex work and injecting drug use is linked to growing HIV epidemics in a number of countries, such as China, Indonesia, Kazakhstan, Ukraine, Uzbekistan and Vietnam (UNAIDS 2006).

The diversity of masculinities

It is necessary that HIV prevention strategies take into account the complexity and diversity of constructions of masculinity and femininity (Mane and Aggleton 2001). The process of socialization is different for every individual and the degree to which a young man internalizes the attitudes and behaviours of rigid masculinity is a factor of his family and social context and individual life experiences (Barker 2005; Ricardo et al 2006; Welsh 2001). Social class, for example, has been shown to be influential in the construction of gender identities. In Colombia and Argentina, studies have found that rigid gender norms are more prominent among lower socio-economic classes than higher socio-economic classes (TGI 1999 and 1999b). The hypothesis is that individuals of higher socio-economic classes have greater access to education, and therefore to ideologies about equality and rights. As a result, women are more likely to participate in formal economic activities, rendering positive changes not only in the perceptions around male and female roles but also in the actual relationships and dynamics between men and women. Conversely, other studies suggest that in some situations, the demands of poverty can lead to greater flexibility in gender roles; unemployed low income men, for example, may take on domestic tasks, including child care, so that their partners can work (Barker 2000). These contrasting studies call attention to the fact that there is no formulaic way in which class or other factors influence gender – rather, it is a confluence of various factors that vary from individual to individual.

It is also important to recognize that, just as there are diverse constructions of masculinity and what it means to be a man, there are myriad levels of power among and between men. For example, young men of higher socio-economic classes often hold more power and access to goods and opportunities than young men of lower socio-economic classes. This disparity in power and access, in turn, has implications for young men's behaviours and HIV and AIDS vulnerability. In this way, certain groups of young men are often more vulnerable than others – including young men in prisons and detention centres, migrants, refugees or mobile populations, including street children and young men who engage in sex work. For this reason, it is important not to generalize when discussing how to engage young men in HIV prevention

As the world's nations affirm their commitment to the Millennium Development Goals – as new technologies such as microbicides become available, and as anti-retroviral treatment therapy becomes more widespread – it is important to recognize that these initiatives will only succeed if men and boys are adequately engaged via interventions that promote lasting attitude and behaviour change as well as changes in social norms related to men and masculinities.

– as emphasized throughout different sections of this toolkit – and to always carry out needs assessments to ensure that strategies, materials and services are appropriately tailored.

Finally, many of the norms associated with being a man (e.g. being strong, being a provider) are not inherently negative and should not be characterized as such. The problem arises when domination, coercion and power imbalances exist, or when one gender is portrayed as better or superior to the other (Barker 2005). It is therefore important to not demonize masculinities and to recognize and value the specific and different ways that young men and women experience relationships and sexuality.

"Many of the norms associated with being a man (e.g. being strong, being a provider) are not inherently negative and should not be characterized as such."

ENGAGING MEN AND BOYS TO TRANSFORM GENDER-BASED HEALTH INEQUITIES: IS THERE EVIDENCE OF IMPACT?

A recent WHO literature review assessed the impact of programmes which seek to engage men and boys in health and gender equality, including in the areas of sexual and reproductive health, HIV prevention, and gender-based violence (Barker et al. 2007). Programmes were reviewed and ranked on overall effectiveness, as determined by the evaluation design used and level of impact measured. The review showed that well-designed programmes with men and boys do indeed lead to attitude and

behaviour change. Moreover, programmes which include deliberate discussions of gender and masculinities, and clear efforts to transform such gender norms, seem to be more effective than programmes which merely acknowledge or mention gender norms and roles. The review also found that integrated programmes and community mobilization programmes are more effective in producing behaviour change, highlighting the importance of reaching beyond the individual level to the social context in which men and boys live.

Developing HIV and AIDS programmes for young men with a gender perspective

Many programmes and services to date have had limited impact on the promotion of preventive practices among young men and, thereby on the overall vulnerability of young men and women. One reason for this is that HIV and AIDS programmes have often focused mainly on providing information. However, diverse studies have confirmed that information alone is not enough to promote lasting and meaningful changes in sexual attitudes and behaviours (Boler & Aggleton 2005). Rather, receiving information is only a first step toward behavioural change; other contextual factors, including communication and negotiation skills, access to youth friendly services and SRH commodities, peer influence, gender attitudes, and desensitization to risk³, generally guide if and how a young man acts upon knowledge.

In this context, it is necessary to develop HIV prevention programmes for young men which incorporate a gender perspective – that is, programmes which recognize how gender and masculinity contribute to HIV and AIDS vulnerability for both men and women and which seek to promote more equitable attitudes, behaviours and power structures. This programming approach is referred to as a gender transformative approach and entails moving beyond the individual level to also address socio-cultural, structural and community factors that influence attitudes and behaviours (Gupta 2002). This may include working with individual and peer groups of young men in group workshops to promote critical reflections about gender and socialization while simultaneously carrying out a media campaign to encourage changes in social norms related to gender. In this way, gender transformative programming addresses young men's behaviours – such as condom use, seeking health services, use of violence against a partner – as the consequence of an inter-play of socio-cultural, structural, community, interpersonal and individual factors, instead of focusing on just one specific factor.

"In other words, no young man is an island; his behaviours and attitudes related to sexuality, gender roles and HIV and AIDS are influenced by his social environment."

3. Insensitive or nonreactive

There is a growing array of programmes, research, and policy initiatives in diverse settings which have incorporated or begun to incorporate a gender transformative approach. These initiatives have confirmed that men and boys can and will change when engaged strategically in well-constructed and theoretically-grounded interventions that work at

different levels and address different needs (see box on page 14). However, many of these initiatives have been small-scale, reaching only a handful of men, and have lacked robust evaluation. In sum, the field of engaging men and boys in promoting gender equality is still largely underdeveloped and faces three major challenges:

ASSESSING HIV PREVENTION PROGRAMME FOR YOUTH: GO, READY, STEADY OR DO NOT GO

A global consultation held in Talloires, France in 2004 and organized by WHO, UNAIDS, UNFPA and UNICEF, under the aegis of the UNAIDS InterAgency Task Team on Young People (IATT/YP), marked the launch of a comprehensive review of the evidence on policies and programme related to young people and HIV prevention. As part of this review, interventions were categorized as either Go, Ready, Steady, Do not go, depending on the available evidence of effectiveness in terms of increasing young people's access to information, skills and services, decreasing their vulnerability to HIV and decreasing HIV prevalence.

Some of the main programme recommendations that emerged from the review included:

- There is no one-size-fits-all intervention, and what is needed and possible will depend on the local characteristics

of the epidemic, available resources, capacity and infrastructures, and the socio-cultural context;

- Programmes should give clear and consistent messages about behaviour change, and a national communication strategy in support of HIV and AIDS programmes can make important contributions to achieving this;
- Young people should have access to information and services for STI and pregnancy prevention, in addition to HIV prevention;
- Community interventions are important for reaching vulnerable groups, building acceptance and support, and mobilizing for specific interventions through schools and health services;
- Increased capacity for implementing and evaluating programmes and policies is urgently needed.

Source: Ross et al. 2006

- Many programmes working with men lack technical skills to implement and evaluate strategic, conceptually and theoretically grounded interventions;
- Funding for engaging men and boys has often been piecemeal and short-term;
- There has been a lack of concerted advocacy efforts to create a favourable political and societal environment for engaging men and boys in gender equality.

In practice, these challenges are interlinked. Building the technical capacity of programmes to carry out and evaluate interventions with young men helps to create the evidence base necessary to leverage funding and political and social buy-in. Similarly, the mobilization of funding and political and social buy-in is necessary for strengthening and sustaining programme efforts. To this end, programme planners, advocates, donors, governments and other stakeholders, including men themselves, need to collaborate

"Information alone is not enough to promote lasting and meaningful changes in sexual attitudes and behaviours."

THE WIDER BENEFITS OF APPLYING A GENDER PERSPECTIVE TO WORK WITH YOUNG MEN

Many of young men's behaviours related to HIV and AIDS vulnerability constitute part of a wider male culture of risk-taking which affects both men's and women's health in a number of ways. These behaviours include alcohol and substance use, reckless driving and violence against other men, the latter

two of which contribute significantly to mortality and morbidity rates among young men in Latin America and Caribbean, as well as in other settings around the world. Therefore, applying a gender perspective to HIV prevention programmes can have benefits which extend beyond the epidemic itself.

to create an enabling environment for work with young men which can lead to positive changes in gender norms and reductions in the HIV and AIDS vulnerability of both men and women. The toolkit in hand seeks to contribute to this

enabling environment by serving as a technical resource to programme planners, advocates and others, and a potential springboard for future collaborations and exchanges on engaging young men in HIV prevention.

PARTNERSHIPS WITH THE MILITARY

In 2003, UNFPA conducted a comparative study of an interregional project, "Improving Gender Perspective, Reproductive Health and HIV/AIDS Prevention through a Stronger Partnership with the Military." The project, designed to implement and improve HIV prevention initiatives that engage young enlisted men through gender-equitable programming, was developed shortly after the International Conference on Population Development (ICPD) in 1994, when 179 States adopted a 20-year Programme of Action that underscores the need to engage men as part of a comprehensive HIV/AIDS prevention strategy (UNFPA 2003). It evaluated partnerships with military personnel in the following countries: Benin, Botswana, Madagascar and Namibia in Africa; Ecuador, Nicaragua and Paraguay in Latin America; Mongolia in Asia; and Ukraine in Eastern Europe.

The study identified effective approaches and existing challenges to integrating a gender perspective into sexual and reproductive health programmes in the armed forces. In several developing countries the military is the single

largest employer of young men and, therefore, a strategic community within which to engage large numbers of men in gender equitable strategies to: work with men in HIV prevention, reduce gender-based violence, involve men in reproductive health, and promote gender equity. Developing interventions with the military, however, can present challenges. Military culture is founded upon a hierarchal matrix in which information travels in one direction from higher-ranking patriarchal figures to the novice soldiers. Training in the military is often a didactic experience making it difficult to implement participatory strategies such as peer education. At the same time, military elites are interested in the well-being of their troops and this interest should be leveraged at the highest level to help institutionalize participatory gender-equitable interventions and practices. Projects targeting the military will also impact on the lives of their family and of the civilian population that they come in contact with during conflicts as well as during peace-time operations.

Source: UNFPA 2003b

YOUNG MEN IN A DEVELOPMENTAL PERSPECTIVE



YOUNG MEN IN A DEVELOPMENTAL PERSPECTIVE



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Human development is dynamic and varied. No two individuals pass through life stages in the same way, and these transitions and stages vary tremendously across cultural settings. In some societies, boys and girls take on adult roles relatively early in life: they may begin to work or have children while still young. In other settings, young people may have a prolonged period of extended schooling or preparation for adult work and family life. **While adolescent development is often assumed to be simple, linear, and universal, and based purely on biology, it is extremely varied and depends significantly on cultural and social norms.**

The toolkit focuses broadly on HIV prevention and “young men,” between the ages of 15 and 25. This age range encompasses adolescence, youth, and the beginning of adulthood, and a diversity of psychosocial,

emotional and health needs. **In this section we discuss how the needs and realities of young men change as they develop, grow, and mature, and the implications for HIV and AIDS vulnerability.**

Puberty and Sexuality

Adolescent development refers both to biological changes that occur during adolescence and to changes in social roles and functions. For boys and girls, there are *biologically-based differences* in the timing of puberty and *socially-constructed gender differences* in the meaning of and reactions to puberty (Barker 2000b). Whether becoming sexually active, forming more stable intimate relationships, or moving from dependence upon family towards economic and social autonomy, the developmental experiences of youth are diverse and fluid.

In terms of biological differences, puberty and sexual development generally occur earlier in girls than in boys. The first signs of sexual development in girls are an adolescent growth spurt between 9.5 and 14.5 years, accompanied by visible breast development. The first menstruation (menarche) occurs between 10.5 and 14.5 years. Boys experience a later growth spurt than girls. Testicular enlargement occurs between 10.5 and 13.5 years, and spermarche (a boy's first ejaculation of semen) about one year later. Most boys experience nocturnal emissions, or "wet dreams" during this period (Population Council 1999).

For girls, puberty may bring marked attention to their ability to reproduce and, in some cultures,

may signal a period of greater social exclusion, more attention to movements outside the home and more protection from boys (Mensch et al. 1998). For boys, puberty often seems to go by unnoticed by family and society. **Many boys have doubts or questions about the physical changes they experience during puberty, but are generally not encouraged to talk about them.** In some cases boys may be given more information about women's bodies than about their own. When we discourage boys from talking about their bodies and sexual health at an early age, we may be starting a lifelong tendency of limiting men's discussion about their bodies and their health needs – which has implications for their help-seeking behaviours and health outcomes.

Gender Socialization

Just as there are biological differences between how boys and girls mature, there are also differences in how boys and girls are raised and socialized – that is, how they are taught by their families, cultures, and societies to behave as boys and girls. **Indeed, the roots of many of young men's vulnerabilities related to HIV and AIDS -- whether they negotiate with partners about condom use or whether they seek health care, for example -- are found in the way boys are raised.** We sometimes assume that the way that boys and men behave is biologically-determined -- that "boys will be boys." However, the disrespectful behaviour of some men toward women, their lack of involvement in domestic tasks, their greater number of sexual partners compared to young women, and limited practice of safer sexual behaviours, stem far more from gender socialization and how boys learn to be young men than from biological/genetic influence.

Children first identify themselves as male or female during their earliest years of life and by the age of two or three, begin to imitate the behaviours of same-sex family members. Often, families encourage boys to imitate other boys and men, while discouraging them from imitating girls and women, in some cases, due to fears that their son may become homosexual. **In observing their families, boys may believe that domestic tasks and taking caring of others is "women's work." Moreover, boys who observe fathers**

and other men being violent toward women, or treating women as sex objects, may believe that this is "normal" behaviour for men and may later repeat this behaviour as they grow older. A study in Brazil found that nearly 40 percent of men interviewed said they had seen a man in their household use physical violence against a woman when they were children; this was the factor most highly associated with whether they themselves reported using violence against women (Promundo & Noos 2003).

It is important to emphasize that men are not the only family members who have an important role in gender socialization. Mothers, for their part, may inadvertently reinforce traditional gender roles by not involving sons in domestic tasks or encouraging them to “not cry” or to repress their emotions.

During adolescence, the strongest influence in gender socialization of boys often comes not from family, but from peer groups. Around the world, adolescent boys spend a significant part of their time outside the home and are often unsupervised. Time outside the home represents freedom for boys, and male peer groups are an important source of companionship. For some boys and young men, there is a marked difference between home and street cultures. The home may be seen as a place where issues such as sexuality are not discussed, whereas the peer group may present opportunity for discussion and information about sex. However, while male peer groups may be an important

source of information and companionship, they usually do not encourage boys to talk about their personal needs. These peers may also encourage substance use, unprotected sex, and rigid and sometimes violent versions of manhood.

Although strong forces influence boys to adopt traditional masculinities during gender socialization, it is possible to change this path. Studies find that when boys interact with adults and peers who endorse or promote alternative visions of masculinity -- men involved in caring for children or in domestic tasks, or women involved in providing for households or in leadership positions -- they are more likely to be flexible in their ideas about men's and women's roles (Levine 1993; Pollack 1998; Barker and Loewenstein 1997; Barker 2001). In particular, research emphasizes that fathers and other male family members have an especially important role in raising boys who have more gender-equitable attitudes (Barker 2000b).

IS THERE EVIDENCE THAT “MACHO” ATTITUDES ARE NEGATIVE FOR YOUNG MEN'S HEALTH?

Research confirms that the way boys are raised and the attitudes they learn have direct consequences for their, and for women's, health and sexual behaviours. A national survey of adolescent males ages 15-19 in the U.S. found that young men who had sexist or non-equitable views of manhood were more likely to report substance use, involvement in violence and delinquency,

and unsafe sexual practices than were adolescent boys with more flexible views about what “real men” can do (Courtenay 1998). Similarly, research in Brazil found that young men who had more rigid views about manhood were more likely to have had a sexually transmitted infection and more likely to have used physical violence against a partner (Barker et al 2004).

The developmental stages of boys and young men

Some psychologists suggest that children and adolescents pass through a series of distinct stages:¹

- (1) **Preadolescence, 5-10 years of age:** Concrete thinking, mostly socializing with same-sex peers. Often have a clear and perhaps rigid sense of those things that are “male” and those that are “female.”
- (2) **Early adolescence, 11-15:** Puberty, mostly focused on the present, and self-centred and self-preoccupied.
- (3) **Middle adolescence, 14-17:** Aware of self as a sexually maturing individual, beginning to acquire autonomy from parents.
- (4) **Late adolescence, 17-21:** More long-term or abstract thinking, able to question gender norms.

Although the rigidity of this model makes it questionable, it offers a useful insight into the changing psychology of boys and young men – and girls and young women – as they mature. Specifically, this model suggests that boys display a movement from being more conformist to gender norms toward a more conscientious stage, during which they may question non-equitable views about manhood and womanhood (Steinberg 2002). Indeed, research in various settings in Latin America has confirmed that many young men who are able to question the male peer group and rigid notions of manhood, come to see the “cost” of some non-equitable views of manhood (Barker 2001). That is, they are able to question the rigid socialization or rigid norms around them. An



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important component in this process is cognitive development. During middle to late adolescence, many young people acquire the ability to imagine “what if” and to compare ideals – of justice and equal access to opportunities and income – with the realities of tremendous inequalities. They are also able to question rigid gender norms, and to see how these rigid ideas about men and women can and do limit them and their relationships with each other.

1. For the purpose of this toolkit, we have adopted the same age groupings used by WHO: young people, 10-24 years old; youth, 15-24 years old; and adolescents 10-19 years old. However, programming should consider further refinement in these age ranges, for as discussed in this module, the developmental and health needs of young people aged 15 will differ in some respects from a young person in their early twenties. To this end, the development stages presented here are intended as examples of the range of differences and experiences that exist even within the conventional WHO age ranges.

For most young men, living up to cultural expectations of masculinity is an ongoing challenge that does not end during a specific moment in their development. Demonstrating masculinity is frequently described as a constant objective. Many young men confirm feeling that being and becoming a “man” is never guaranteed; it is constantly questioned and has to be proven. There are numerous versions of manhood that boys and young men perceive, and many are able to question and subvert traditional masculinities. Still, there is a constant refrain among boys and young men of feeling social pressure to satisfy the rigid ideals, or to risk being labelled sissies, girls, or gay, among others.

The meaning of sex

Young men often view sexual initiation as a way to prove that they are “men” and to have status in the male peer group (Marsiglio 1988). In interviews with lower income and lower-middle income young men in Rio de Janeiro, having had heterosexual sex and acquiring employment were seen as the two milestones for becoming a man (Barker and Loewenstein 1997). For many young men, penetrative sex – which is often considered the only sex that counts – is seen as an accomplishment, and something to show off about. Various studies find that boys often share their heterosexual conquests with pride with the male peer group, while doubts or lack of sexual experience and any same-sex sexual experiences are hidden or denied. Not having become sexually active or having just one female partner can be motives for ridicule in the male peer group. Many young men may lie about or exaggerate their sexual experience before their male peers, particularly if they have never had penetrative sex with a woman.

In many settings, young men generally have penetrative sex earlier and with more short term partners before forming long-term relationships than do young women; however, in recent years there has been reduction in the gap between the young men’s and women’s median age of first vaginal intercourse (Singh, Wulf, Samara, and Cuca 2000). After forming relationships, young men are also more likely than young women to have occasional sexual partners outside these relationships due

"Young men often view sexual initiation as a way to prove that they are 'men'."

to different expectations of sexual fidelity for men and women. (Guttmacher 2003).

Some young men have their first sexual encounter and subsequent early sexual encounters with sex workers. They are sometimes strongly pressured to do so by male family members and peers, who may regard the visit as an ‘initiation ceremony’. Indeed, in most such sexual encounters and initiations with sex workers, young men go in groups.



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While there is clearly the element of pleasure in most young men's early sexual experiences, it is important to note the pressure they face to demonstrate sexual prowess. The social pressure on boys is, of course, far different than the overt coercion and sexual abuse and violence that young women experience in many parts of the world. Nonetheless, the social pressure that many boys report calls attention to the question of whether boys have their first sexual encounters for their own pleasure and curiosity – or to fulfil social and peer expectations.

Sexual debut and development can be significantly more complex for young men living with HIV. Young people in general have traditionally not been addressed in sexual and reproductive health programmes, and their experiences and needs have been largely ignored in the body of research on the sexual and reproductive health of people

living with HIV (Guttmacher 2006). Research in Brazil with young people living with HIV and their caregivers found that knowledge and skills for condom use or about reproduction were much lower than expected, especially among those born with HIV, and that the young people often delay or do not communicate to partners that they are HIV positive because of fear of discrimination. Caregivers, in turn, thought that the young people were not ready for complete and honest discussions about sexuality (Paiva et al 2004). As generations are growing up HIV positive from birth and as access to HIV testing expands in many countries, a major programmatic challenge is to ensure that youth living with HIV are connected to care and support systems that can meet their needs for emotional and psychosocial support, counselling, and prevention education while monitoring needs for medical care, nutrition interventions, and ARV treatment (Shears 2005).

"Most research on violence against women has focused on adult couples and women, but some studies suggest that patterns of violent emerge in early dating relationships."

Intimate relationships

In many settings in Latin America and the Caribbean, male-female relationships are described as being tense and full of conflict. In a focus group in Rio de Janeiro, for example, one young man said: "These days, there's nothing no respect for anyone, either men or women." Another young man said: "There are only happy endings... and [intimate] relationships that last in the soap operas (on TV). I don't know anyone here whose mother and father have been together for their whole lives." Another young man said: "I don't know what a relationship based on respect (non-violent relationship between a man and woman) looks like. I've never seen one." (Barker 2005)

Most research on violence against women has focused on adult couples and women, but some studies suggest that patterns of violence emerge in early dating relationships. Young men and women often say that in dating, "things" are less serious and conflicts less frequently lead a young man to use physical violence. However, a couple's first experiences of living together and raising children, often between the ages of 20-24, are frequently stressful and fraught with conflict. As a result, many young men report that they use physical violence against their partners. This violence emerged, they say, when the woman did not "fulfil her part of the bargain." This might include not taking care of children, not taking care of the house, spending too much time with her friends, or when there is suspicion of sexual infidelity.

Indeed, many young men never see models of healthy relationships and are often ill-prepared once they begin to explore their own relationships with others. Lacking basic skills in communication and conflict resolution, they are unable to peacefully coexist with their partners, which is especially troubling when we see that these early relationships set the tone for future adult relationships. While it is important for young people to take responsibility for their actions, it also the duty of societies to better equip young men and women for more stable lives and relationships. If not, there are alarming implications for future families, the care of children, and the quality of life for both partners.

Fatherhood

Many young men in developing countries become fathers in their early to mid-twenties, sometimes even earlier. This act represents, for many, a major role transition, a significant new relationship in their lives, and a new social function. However, all too often, young fathers are often presumed to be negligent, irresponsible, and seeking to shrug their involvement. Indeed, much of the research and discourse about young fathers in low-income settings is negative or relies on negative stereotypes.

Several studies suggest that some young fathers, like young mothers, may face social pressures to drop out of school to support their children and are less likely to complete secondary school than their non-parenting peers (Barker 2000b). Research suggests that many young men may initially deny responsibility and paternity when faced with a

possible pregnancy, in large part because of the financial burden associated with caring for a child. For example, research in Mexico suggests that a young father's employment and financial situation were important factors in determining how the young men reacted to pregnancy and fatherhood (Atkin and Alatorre 1991). Young



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men with stable employment or higher income were more likely to participate in child care and to provide financial support.

A father's reasons for not participating his child's upbringing are often varied and complex. Young fathers often face discrimination from their parents, the parents of their child's mother, the mother herself, and service providers. Young fathers who do not marry the mothers of their children, for example, are frequently seen as being irresponsible. However, research finds that in some cases, young fathers may want to be involved with their child, but the child's mother will not allow their involvement. Young fathers who are unemployed may feel constrained in their parenting role because they do not believe they have the right to interact with their child if they are not financially providing for him or her. Such nuances have not been widely studied and are often neglected in discussions about young fathers (Lyra 1998). Indeed, only recently have a handful of programmes in several parts of the world started to examine the multiple roles of fathers and to promote the greater involvement of fathers in child care and maternal health. Many of these initiatives were started by listening to the voices of fathers. It is surprising, even disturbing, to see how much of the literature or research on young fathers and fathers in general is told by others – mothers, health care staff, and children. Young men can be quite articulate about their experiences and the challenges of fatherhood, but only recently have researchers and programme staff have made concerted efforts to include their views.

While much of the discourse about early childbearing – among young women and men – has focused on

"Young men's roles as fathers or anticipation of fatherhood and high esteem of its responsibilities, can be tapped as important incentives for positive behaviour change."

the negative consequences, there are positive sides to be considered. For some young men, fatherhood is a powerful and positive role transition and an opportunity for organizing their lives. Some young men are able to leave gangs because of fatherhood and describe their child as their "life cause." One gang-involved young father said: "My daughter just pulls at my heart... she makes me want to change. She pulls me up. I feel like my daughter is my purpose to live. I want to be able to give her more" (Barker 1998).

As these young men express, fatherhood can be an important and rewarding role for men. Moreover, young men's roles as fathers or anticipation of fatherhood and high esteem of

its responsibilities, can be tapped as important incentives for positive behaviour change, including safer sexual behaviours (Scalway, 2001; UNAIDS 2000).

Conclusion

The developmental stages of young men and young women are both biological and socially constructed, and thus not rigid experiences. These stages are dynamic across cultures and even individuals. Programming should always take into account the life phase and transitions of the young men with whom they work, including whether these young men have had sexual relations, formed stable relationships or families. As emphasized throughout this toolkit, the attitudes and behaviours related to HIV vulnerability are part of the early socialization of boys, and to this end, programming must also work to promote changes in the social environment, including working with parents, teachers, and other caregivers to question socialization and rigid gender norms.

"The developmental stages of young men and young women are both biological and socially constructed, and thus not rigid experiences. These stages are dynamic across cultures and even individuals."

TOOL

- Table with Different Development Stages of Young Men (10-25 years)

PROGRAMMING



PROGRAMMING: EDUCATIONAL ACTIVITIES



Young men and HIV and AIDS Education: An Overview

Numerous education strategies exist for engaging young men in HIV prevention and promoting positive changes in attitudes and behaviours. Each has its own benefits and advantages, depending on the setting, available resources, and specific profile of young men to be involved. The four most common education strategies are group workshops, school-based programmes, peer education, and entertainment education. Experiences regionally and worldwide have pointed to three common features that contribute to the effectiveness of these education strategies, as described below.

(1) To effectively motivate young men to change, education strategies should have a participatory and experiential learning approach. Experiential learning emphasizes learning through experience, or reflection upon experience. In the context of HIV prevention education with young men, this means that rather than be “told” how they should or should not behave, young men should be encouraged to question and analyze their own experiences to identify the factors that influence their decision-making and vulnerability. This personal

and critical understanding of vulnerability is a key step toward positive behaviour changes.

(2) The content and delivery of education strategies should be relevant to young men's experiences and needs. For example, if the target group of young men are mostly married or in long-term relationships, programme planners should consider including information about couple counselling and/or family planning as entry points to discussions about HIV prevention. Likewise,

if the young men are regular computer users, programme planners should consider the utility of an interactive CD-ROM or website or group education sessions in cyber cafés frequented by young men. Age, sexual experience, schooling, popular leisure activities – these, among others, are all important factors to consider in the design of education initiatives. Involving young men throughout the planning and implementation is one of the best ways to ensure that these factors are considered and that messages and activities are relevant to the target audience. Additional strategies for collecting information about programme target groups are included in the module on needs assessment.

Programme planners should keep in mind that it is usually not necessary to “reinvent the wheel”; most of the time pre-existing resources can be adapted to the specific needs of a target group of young men. Such is the case with the Program H, MAP and Stepping Stones educational curricula, which have been adapted for use with young men in a diversity of cultural settings (see Tools). The possibility of adapting a pre-existing curriculum or material allows programme planners to build upon the lessons learned of other programmes, as well as reduce costs and preparation time. It is important that young men themselves, as well as other stakeholders, be involved in the process of adaptation.

(3) Education strategies should be viewed as only one piece of a broader and more comprehensive approach to engaging young men in HIV prevention. Reflections and messages promoted by any educational strategy should be complemented and reinforced by strategies

at other levels, from local services to national policy. Education strategies provide important opportunities for young men to critically reflect about gender, masculinities, and HIV and AIDS vulnerability as concrete and personally relevant issues, but it is unrealistic to expect that any single educational strategy can lead to long-term changes in behaviours and vulnerability to HIV and AIDS. Programme planners should seek to build partnerships and alliances with other services and organizations working with young men in order to link and reinforce efforts ([Link: ADVOCACY on page 77](#)).

COMMON EDUCATION STRATEGIES FOR ENGAGING YOUNG MEN IN HIV PREVENTION

GROUP WORKSHOPS involve small groups of young men meeting over a period a time to discuss issues related to HIV prevention.

SCHOOL-BASED PROGRAMMES are carried out in school settings, usually as part of a family life or sexual education curriculum.

PEER EDUCATION entails the training and support of young men to reach out to their peers with information and referrals for services, and to distribute condoms and other materials.

ENTERTAINMENT EDUCATION is the use of entertainment channels and vehicles such as radio, television, comic books, and theatre to deliver information and messages about HIV prevention.

Essential elements of an educational curriculum

HIV prevention education limited to simplistic, fact-based messages about modes of transmission and risk behaviours is rarely effective in promoting change. Young men need opportunities to think about and discuss gender roles and sexuality. It is particularly important that they consider the ways their decision-making is influenced by social and religious expectations about sexual activity for men and women. Additionally, young men need accurate sexual and reproductive health information and the necessary skill-building to be able to apply this knowledge in their behaviours and lifestyles. Below are in-depth discussions of these different elements.

REFLECTION ON GENDER NORMS

The foundation for any educational curriculum for engaging young men in HIV prevention should be **critical reflections about societal constructions of gender norms and sexuality, including the impact of rigid masculine stereotypes on young men's behaviours and vulnerability**. Regional and global evidence indicates that concrete and deliberate efforts to engage young men in critical reflections about gender roles, when adequately structured, can lead to measurable changes in attitudes and behaviours related to sexual and reproductive health (Barker 2005/text box on page 14). These critical reflections have two main objectives. One is to increase young men's understanding of how their own socialization can negatively influence their attitudes, behaviours, and health. This involves helping young men identify the associations between the health problems they face, from high rates of STIs to involvement in traffic accidents, and the pressures they feel to act in certain, often self-destructive, ways. These discussions of how masculinity itself can be a risk factor can lead to broader critical reflections on gender norms and help young men drop the defensive stance they might initially bring to activities on gender.

The second objective of critical gender reflections is to **promote young men's empathy for how**

gender inequalities affect young women's health and well-being. However, programme planners and educators need to be conscientious of the language and messages which are presented to young men in regards to gender-equity and avoid language which can reinforce rigid and patriarchal ideals of men's dominance and women's weakness (Grieg, 2003).

INFORMATION ON HIV AND AIDS

Educational curricula should also provide **accurate information about sexual and reproductive health and HIV and AIDS**. Young men tend to be very eager for information about sexuality and sexual health. When talking about sex and HIV and AIDS, they may seem to be quite knowledgeable, but in reality they are frequently uninformed or misinformed. While actual levels of knowledge and awareness may differ across settings and groups of young men, there are some common questions and doubts that many young men often have about relationships and sexual health, sexual pleasure, including penis size, semen loss, and masturbation. Since there are few spaces where young men can comfortably voice these concerns, addressing these in an HIV and AIDS education programme can provide useful entry-points to broader discussions about relationships, gender norms, and HIV prevention.

"Young men have the right to relevant and complete information on sex, sexuality, and HIV and AIDS."

It is important to remember that information should be provided in a non-authoritarian and non-judgmental way. Young men have the right to relevant and complete information on sex, sexuality, and HIV and AIDS, as do all individuals. Moreover, young men do not want to be lectured to on how to live their lives or conduct their relationships. **Prevention options, including condom use, should be presented as parts of discussions in which young men critically weigh the costs and benefits of various behaviours and decide for themselves what is most realistic and appropriate in relation to their values and lifestyles.**

Young men often lack practical information about HIV and AIDS and prevention. It is not necessary to overwhelm them with technical details, but education programmes should provide a basic understanding of transmission how to prevent HIV, testing, disease progression, living with HIV, and addressing stigma and discrimination. Common questions and doubts include the “window period” in HIV testing and the difference between HIV and AIDS. Young men also often have many misconceptions and doubts about condoms, including their efficacy against HIV and AIDS and their impact on sexual pleasure. Education initiatives should provide information about correct condom use, the importance of consistent use and negotiation with partners. As will be discussed below, this information should be linked to skills-based lessons – for example, practicing putting condoms on a model of penis or how to speak with a partner about condom use.

When discussing the relationship between condom use and negotiation and gender-equity, it is relevant to reflect on the female condom as a prevention method. The female condom, like the male condom, is a barrier device used for birth control and protection against HIV and AIDS and other STIs. It is not readily available in all countries, and even where it is, most young men might not be familiar with it. Nevertheless, it should be noted as a prevention method, and used to explore young men's ideas about women's sexuality, negotiation about condom use, and the role of female-initiated methods.

Information about the link between substance use and HIV and AIDS vulnerability is also

important for young men. Worldwide, men account for approximately four-fifths of injecting drug users, and studies have shown that male users are also more likely to share needles and not use condoms (UNAIDS 2000). Males also use other substances at higher rates than females. For many young men, for example, using alcohol or another substance helps prove manhood or fit in with a male peer group.

Finally, although education programmes should aim to make information personally meaningful to young men, they should not be based on instilling fear. Fear has many limitations as a prevention strategy and is ultimately contrary to the larger goal of empowering young men to initiate positive changes for healthier lives and relationships.

"Although education programmes should aim to make information personally meaningful to young men, they should not be based on instilling fear."

TALKING TO YOUNG MEN ABOUT SEXUAL DIVERSITY

Young men need to have the chance to think about and discuss homophobia, both as a human rights issue and because of its impact on many forms of male behaviour. In many Latin cultures, calling a young man "gay" or "queer" is often a way to criticize his behaviour and stigmatize him. This intolerance toward same-sex behaviour and rigidity in how male sexuality is framed has consequences for all young men. For young men who are heterosexual,

this social pressure can reinforce sexual risk-taking as a means to prove that they are "real, heterosexual" men. For young men who are gay, or who have sex with men, this stigmatization causes suffering and exclusion (sometimes even violence), which may lead them to practice their sexuality clandestinely and inhibit them from seeking out sexual health information and services, thus creating situations of extreme vulnerability to STIs and HIV.

"Educational curricula should include the necessary skills-building for young men to reduce risk behaviours and lead healthier lifestyles."

SKILLS-BUILDING

Educational curricula should also include the necessary **skills-building for young men to reduce risk behaviours and lead healthier lifestyles**. For young men, this skills-building should begin with the ability to question idealized norms about manhood and sexuality, particularly within their peer group, and analyze how these norms may negatively affect their decision-making and behaviours. Other important and relevant skills for young men are interpersonal communication, including conflict resolution, and technical skills related to positive health-seeking behaviours, such as how to correctly use a condom and how to access services. Many young men might feel embarrassed or fearful of approaching service providers or visiting clinics and it is important that education strategies help them overcome this, while of course simultaneously supporting efforts to make existing services more young men-friendly.

TALKING TO YOUNG MEN ABOUT THE LINKS BETWEEN HIV AND AIDS AND GENDER-BASED VIOLENCE¹

Discussions with young men about gender-equity and HIV prevention must also include the issue of violence against women, particularly sexual violence. Young men need to understand how forced sex can increase a woman's risk of HIV infection, as well as how different forms of violence and coercion can reinforce unequal power

dynamics in relationships and limit the likelihood that a couple will negotiate sex or preventive behaviours. In addition to this awareness-building, education activities should provide opportunities for young men to practice conflict resolution, so they can learn to appropriately handle and express feelings such as anger or frustration.

1. ...any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women because of being women and men because of being men, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. UN Declaration on the Elimination of Violence Against Women 1994.

Group workshops

Group workshops involve creating dynamic discussion spaces in which young men can reflect critically about gender norms, sexuality, and HIV and AIDS vulnerability, as well as ‘rehearse’ the skills and abilities necessary to reduce risk behaviours and act in more equitable ways. Since young men often experiment with and rehearse masculine roles and behaviours in peer groups, it follows that the group education format, particularly male-only groups, provides the most fitting environment to redefine masculinity and rehearse more equitable models of being a man. Due to its demonstrated results in promoting positive attitude change among young men, as well as reduced HIV and AIDS vulnerability (Barker et al 2007), a large section of this module is dedicated to the design and implementation of group workshops.

Group workshops should be based on a structured curriculum that is organized, flexible, and culturally appropriate to the target group of young men. The curriculum should not be a series of random activities; instead activities should complement each other and reinforce connections between themes. As discussed earlier, group sessions should be participatory and move beyond the provision of information to a stage of prompting reflections and changing attitudes. Participatory activities such as role-plays allow young men to dramatize scenarios and myths and offer a fun and engaging way to explore problems they might not feel comfortable discussing in real life. Such participatory activities can also help young men practice various skills, such as negotiation and decision-making. That said, programme developers should respect the different physical and emotional limits and comfort zones of each participant when role-playing sensitive topics. As an alternative to role-plays, groups can discuss case studies or debate contentious topics where participants are assigned to argue perspectives that they might not normally consider. These various methods also help young men to actively consider the perspective of women and the experiences and challenges they face in terms of reducing their HIV and AIDS vulnerability.

Most young men require high caloric intake for growing – and also enjoy activities with lots of movement. Group education activities should include snacks and lots of physical movement.

During discussions, facilitators should avoid classroom-style sitting arrangements: instead the group should sit in a circle.

Frequently asked questions about group workshops

Below are some of the most common questions or concerns that arise in preparing for and carrying out group workshops with young men.

HOW CAN YOUNG MEN BE MOTIVATED TO PARTICIPATE?

Addressing some of young men's more immediate interests or concerns can help motivate them to participate. For example, many young men might be looking for a job and might be attracted to the group workshops if they also include information and skills-building for securing a job. This is particularly true for older youth, those 20-24 years old. Since some young men may not easily or immediately recognize the benefits to themselves and their partners that would result from their participation in activities about gender and health, programme planners should also seek to attract young men through other interests they may have. Hosting sporting events and providing condoms and/or financial compensation for participation are some ways to recruit participants. Additionally, young men should be invited to give suggestions and feedback on the content of activities and what they would like to discuss in terms of gender, sexuality, relationships, and HIV prevention. This will make the young men feel more connected to the programme and can be an important factor in motivating and sustaining their participation. Finally, workshops must be easily accessible to young men, in terms of both physical location and timing.

Often, the young men who are the least likely to participate are those who are particularly vulnerable to HIV and AIDS and/or stigmatized. These include young men living with HIV and young men who have sex with men. To successfully reach these groups, programme planners should hire or recruit

young men from these groups to participate in the planning, recruitment, and implementation of the workshops.

SHOULD GROUPS BE MALE-ONLY OR CO-ED?

Ideally, young men should have opportunities to work in both single-sex and co-ed groups. Male-only peer groups are valuable and often necessary for the process of young men questioning traditional norms of masculinity. Peers generally play a tremendous role in defining young men's attitudes and behaviours, and in male-only groups this influence can be harnessed for positive change. Moreover, young men may feel more comfortable discussing subjects like sexuality and emotions in male-only groups, or may be able to better express their emotions without women present.

On the other hand, co-ed groups can also be very useful spaces for engaging men in critical reflections about gender and sexuality. These groups can serve as important bridges of communication between young men and women and provide an opportunity for jointly exploring and understanding gender relations and attitudes. Young men who have participated in co-ed group activities often report that they are better able to listen to and understand the perspective of young women as a result of the experience.

HOW MANY YOUNG MEN SHOULD BE IN A GROUP?

Most group activities work better in small groups of 6 to 20 individuals. Programme planners should

also be conscientious of the ages and backgrounds of participants. For example, young men 15-19 years old often have concerns and doubts that are different from those of young men 20-24 years old. Younger men may be more interested in discussing first sexual experiences, whereas the older group may be more concerned with the daily challenges of parenthood or finding employment. Bringing together young men of different ages or backgrounds can be a rich and rewarding educational opportunity, but it is also important that young men have spaces in which they can focus on concerns and experiences relevant to their own daily lives and relationships.

WHAT IS THE ROLE OF THE FACILITATOR?

The role of the facilitator is to create an open and respectful environment in which the young men can feel comfortable to share and learn from their own experiences. As discussed earlier,

"Activities should be designed to generate a process of reflection and participatory learning."

STEPPING STONES: WORKING WITH COMMUNITIES TO PROMOTE GENDER-EQUITY

An interesting educational model that taps into the benefits of both single-sex and co-ed groups is Stepping Stones, a gender and sexuality curriculum which was originally developed in sub-Saharan Africa and has been widely adapted for use in Asia, Europe, and Latin America. At the onset of the group activities, participants are divided into four peer groups based on age and sex – adult men, adult women, young men, and young women. Over a three to four month period, the peer

groups participate in workshops and at fixed intervals convene with the other groups. This provides young men with opportunities to come together with adult men and young women to exchange ideas and debate issues related to gender, communication, relationships, sexuality, and HIV prevention among others.

For more information visit the Stepping Stones website:
www.steppingstonesfeedback.org

the activities should be designed to generate a process of reflection and participatory learning, a process that is facilitated, not taught. Many themes related to HIV prevention– sexuality, violence, substance use – are complex and sensitive. There may be groups of young men who open up and express their feelings easily, while others simply may not want to talk. The key factor throughout this process is the facilitator. The facilitator should be consistently sensitive and responsive to young men's comfort levels and needs and approach the activities with no prior judgments or criticisms of the attitudes, languages, or behaviour of the young men. The facilitator should also be aware when specific young men may need individual attention and, in some cases, referrals to professional services or counselling.

It is recommended that, before beginning activities with young men, the facilitator has a basic grounding in concepts of 'gender' and 'sexuality,' as well as the scientific and social aspects of HIV and AIDS. As part of his/her training, the facilitator should also undergo a process of self-reflection regarding his/her own experiences and struggles around gender, sexuality, and HIV prevention, so as to be prepared to discuss these topics in a relaxed and open manner with the group. The facilitator must have the skills to promote respect and consensus-building amongst the participants, as well as to manage possible conflicts that may arise.

In the tools section, there is a resource sheet with tips for facilitators. It is not intended to be used as a substitute for training, but rather as a review of important points to keep in mind when working with young men in group educational activities.

ARE MALE OR FEMALE

FACILITATORS MORE EFFECTIVE?

Experience has shown that while having a male or female facilitator may have different benefits, it is not necessarily inherently better to have a man as a facilitator of a men's discussion or educational groups. Male facilitators might be seen as more credible and more persuasive by young men, and in terms of sensitive issues, young men might prefer to speak with other men. They can also serve as models of more gender-equitable attitudes and behaviours. On the other hand, experience has shown that young men will also accept women as facilitators if they are informed and open. A third possibility is to work with co-ed facilitator pairs. In addition to bringing two gender perspectives to discussions, this arrangement can provide young men with an immediate model of equitable and respectful interactions between men and women.

HOW OLD SHOULD THE FACILITATOR BE?

There is no defined age range for facilitators. However, in some settings, young men may not feel comfortable discussing certain topics, such as premarital sex, in the presence of an adult. In these cases, peer educators may be more appropriate and effective in engaging young men. Ultimately, the most important characteristics of a facilitator are whether he/she can listen to the young men in a non-judgmental way and model more gender-equitable attitudes and behaviours.

HOW CAN A FACILITATOR DEAL WITH DIFFICULT SUBJECTS?

To encourage true and honest reflections, even about the more difficult subjects, facilitators should encourage participants to move beyond the “politically correct” discourse that some might initially use. He/she should also acknowledge from the onset that discussions about gender roles and norms regarding sexual relations and behaviours can be controversial and sometimes uncomfortable. If a participant makes a loaded statement during a discussion, the facilitator should not try to sweep it under the rug. Rather, he/she should ask the participant for clarification and ask if another participant has a different opinion. In the case that nobody offers a different opinion, the facilitator might offer his/hers with supporting facts.

HOW MANY WORKSHOP SESSIONS ARE NECESSARY?

In order to cover the basic information on gender, sexuality, and HIV prevention, at least 10 sessions of 1-2 hours are generally necessary. The sessions should not be spaced too close together nor too far apart. Weekly sessions seem to provide a good pace in which young men have sufficient time to process information and discussions without losing continuity between sessions. At the start of each session, the facilitator should reserve time for young men to share reflections on what has happened in their lives since the last session, including any relevant discussions or interactions they had with partners, families, friends, etc. Likewise, the facilitator should also reserve a few minutes at the end of each session for feedback from the young men on the content and procedure of the session. This type of feedback can help the facilitator plan future sessions.

WHERE CAN GROUP WORKSHOPS BE CARRIED OUT?

Group educational activities can be carried out in a diversity of settings, including schools, clinic waiting rooms, churches, army barracks, sports clubs, factories, and other workplaces. In selecting a location, programme planners should consider the following: how easily accessible it will be for the young men; whether it has a suitable physical space where activities can be carried out without any restriction of movement; and if it offers sufficient privacy so that participants will feel comfortable discussing sensitive topics and personal opinions.

"The facilitator should reserve a few minutes at the end of each session for feedback from the young men on the content and procedure of the session."

PROGRAM H: AN EDUCATIONAL CURRICULUM FOR WORKING WITH YOUNG MEN TO PROMOTE GENDER EQUITY AND HEALTH

The Program H (H for hombres and homens, the words for men in Spanish and Portuguese) educational curriculum includes a manual and video for working with young men in the promotion of more-equitable attitudes and behaviours. It was originally developed in Latin America and an impact evaluation study in Rio de Janeiro confirmed that participation in the activities had a positive impact on young men's gender attitudes, condom use and self-reported STI symptoms.

Activities in the manual include role-plays, brainstorming exercises, discussions, and individual reflections about how men are socialized, positive and negative aspects of this socialization, and the benefits of changing certain behaviours. The themes of the manuals are sexual and reproductive health; fatherhood and care-giving; violence and violence prevention; mental and emotional health; and HIV and AIDS, including both prevention and care-giving. Most of the themes and activities have proven to be universally relevant and

adaptations of the manual have mainly focused on the revision of case studies to reflect local characteristics and settings.

The video, *Once upon a Boy*, is an entertaining and thought-provoking no-words cartoon that tells the story of a boy and the challenges he faces growing up, including witnessing violence in his home, interactions with his peer group, his first unprotected sexual experience, an unplanned pregnancy and fatherhood. Since the story is told without words, it serves as an interesting discussion tool which can be used across diverse settings and in which young men can be invited to interpret the thoughts and dialogue of the characters.

The Program H curriculum has been used in more than 20 countries and has been adapted for large-scale use in India and Tanzania. Although primarily designed to be used with young men, the Program H materials are also used as training tools for sensitizing and building the capacity of educators and health professionals to work with young men on issues related to sexual and reproductive health. One of the Program H partners, *Salud y Género*, uses the materials as part of a certification course on gender for health professionals and educators.

Some educational activities from the Program H series have been included in the tools section. For further information visit the Promundo website: www.promundo.org.br



School-based programmes

Schools offer many benefits as a setting for HIV and AIDS education, particularly for large-scale and long-term efforts. In many parts of the region, schools already offer health and family life education programmes, and general information on HIV prevention. However, these programmes rarely contain critical reflections on gender and sexuality and how these influence young men's and women's vulnerability to HIV and AIDS. To effectively review and adapt such curricula to more positively engage young men requires both advocacy and technical efforts. Both administrators and educators at the school need to be sensitized on the need to include a gender perspective in the given curriculum. As discussed in the module on Advocacy, this sensitization should emphasize the benefits for both young men and women, as well as the school community as a whole.

The review and adaptation of pre-existing school-based curricula should include students, families, and other stakeholders. The content should be examined for images and messages that reinforce rigid gender and sexuality norms (see box below), and specific activities on gender and masculinity should be added (see TOOLS for examples of such activities).

Where there is not an existing health and family life curriculum, more far-reaching advocacy efforts will probably be necessary. Schools often rely on the presence of national policies and guidelines to determine the extent and content of sexual and reproductive health education, thus it might also be necessary to secure political commitment from a national level body, such as a Ministry or Department of Education. Again, the module on advocacy provides suggestions for carrying out political level advocacy on the need to engage young men in HIV prevention from a gender perspective. As with adaptation of existing curricula, the design of a new curriculum should involve all stakeholders, from teachers to students, to provide everyone with a sense of ownership.

REVIEWING SEXUAL HEALTH CURRICULA

In carrying out a review of sexual health curricula it is important to consider if images and messages:

- Polarize women and men, and if so, are men presented as the bad guys?
- Address emotional aspects of male sexuality, or do they present male sexuality as primarily physical?
- Present a narrow definition of what it means to be a man?
- Prescribe roles for men that are restrictive or constraining?
- Represent male sexual desire as more potent, more urgent than female sexual desire?
- Visually promote heterosexuality as the only norm?

Source: Sex Education Forum Fact Sheet 11

In either case, it will be necessary to provide sensitization, comprehensive training and support for school staff, especially for teachers or other educators who will be directly involved in implementation, on gender, sexuality and HIV and AIDS vulnerability. Many teachers might not be sensitized on the need to work with young men, or on how to carry out activities on gender and sexuality in appropriate and sensitive manners. As with facilitators for group education, it is important that training for teachers provides the space for them to examine their own attitudes about young men, gender, and sexuality. Furthermore, many teachers and educators may not be versed in non-didactic and highly participatory teaching methodologies and for this reason will need to develop the

relevant facilitation skills. Partnerships with local organizations that are accustomed to health education using participatory methods can be established to support teachers in learning and incorporating these techniques.

It is important to keep in mind that teachers are often overburdened and to ensure buy-in and support for a school-based programme, it can be helpful include incentives and structures of support. For example, providing a certification or training course can better prepare teachers to carry out the curriculum and contribute to their professional development.

Finally, the implementation of health and family life curricula with a gender perspective should not

RETHINKING PRINCE CHARMING: AN EXPERIENCE FROM BRAZIL

Experiences from the field-testing of this toolkit with teachers at a high school in Macaé, a city situated in Rio de Janeiro state in Brazil, demonstrated the importance of developing education strategies that could be easily integrated into ongoing activities. Upon participating in a basic training on the content and strategies of the toolkit, teachers were invited to develop an action plan for carrying out HIV prevention education which engaged young men. The annual student end-of-year play presented itself as a strategic opportunity to reach the student body on a large scale. The planned production for that

year was to be a modern-day adaptation of the classic tale of Cinderella, a fairy tale about a distressed young woman who is rescued by Prince Charming. The teachers and a group of students made several adaptations to the story, including an unplanned pregnancy for the princess and prince, to provoke reflections about social norms and expectations of how young women and young men should behave in relationships and how these norms influenced young people's HIV and AIDS vulnerability. The play provided an excellent example of a low-cost strategy for engaging young men and women in a school setting.

be an isolated effort. It should be complemented and reinforced by broader efforts to promote a more gender-equitable school environment. For example, policies for reporting and responding to sexual harassment should be established

and educators should be sensitized on how to be more gender equitable in the classroom, including how to encourage girls and boys to participate in activities traditionally dominated by one sex or the other.

Peer education

Peer education is one of the most widely used strategies for HIV prevention among youth. It entails training and supporting members of a particular group to effect change among members of the same group. The premise in using peer education with young men is that they are “experts” in working and communicating with other young men, particularly those with whom they share something in common, be it socioeconomic or religious background or belonging to a specific environment, such as school, workplace, the army, a sports club, or a neighbourhood. Moreover, young men might feel more at ease than adults in challenging traditional norms or discussing taboo topics, while their peers, in turn, may be more receptive to listening to someone their own age as well.

Peer education can be particularly useful for reaching groups of young men who do not have access to or are not actively tied to any formal institutions such as schools, clinics, or workplaces. Often, these young men are the most vulnerable to HIV and AIDS. Due to the flexibility and possible mobility of peer education programmes, a diversity of young men, including the more vulnerable, can

be targeted – this includes men who have sex with men, youth involved in gangs, youth who live on the streets, and youth in prison.

Numerous resources and guides have been developed, including UNFPA's Y-PEER programme, on the design and implementation of peer education programmes.

EXAMPLES OF PEER EDUCATION ACTIVITIES FOR YOUNG MEN

- Facilitate group education activities in schools, sports clubs, army barracks, clinics, workplaces and other settings
- Carry out sensitization trainings for educators, service providers, and other stakeholders on importance of working with young men
- Coordinate community-based distribution of condoms
- Develop posters, graffiti art, and other visual media for use in schools, sports venues, cyber cafés, and other spaces young men frequent
- Host informational booths at dances, games, and other community events

Entertainment education

An especially popular and dynamic approach to engaging young men in HIV prevention is to package messages and activities in the form of entertainment. Possibilities include music, comic books, sports, dance, and the internet. Entertainment can be an especially good avenue for broaching sensitive topics. Moreover, young men in low-income communities often lack recreational and sporting activities; education initiatives that incorporate these into their activities are likely to attract larger numbers of young men (Rivers and Aggleton 2002). Programme planners should first carry out an assessment of young men's interests and hobbies before selecting a specific entertainment modality ([Link: CAMPAIGNS](#)).

SEXUAL HEALTH TO A SAMBA BEAT: INTEGRATING GENDER AND SEXUAL HEALTH IN POPULAR CULTURE

BEMFAM, the IPPF/WHO affiliate in Brazil, identified Mangueira, a popular samba school based in a low-income community in Rio de Janeiro, as an ideal place to engage large numbers of young men on issues related to sexual and reproductive health and HIV prevention. Mangueira, most well-known for its spectacular Carnival samba parades, attracts many young men to its activities and serves as a health and education centre for the local community, filling important gaps in services.

The project entailed training samba instructors to serve as positive, gender sensitive role

models and to integrate messages about sexual and reproductive health into the music and dance activities offered at the school. Youth leaders were also identified and trained to facilitate discussions with their peers. The outreach, though originally intended to focus exclusively on young men, now reaches further into the community, including young women, and parents.

For more information visit the BEMFAM and IPPF/WHO websites:

www.bemfam.org.br

www.ippfwho.org

"ROCK AND MALE ROLES": USING INFORMATION TECHNOLOGY TO ENGAGE YOUNG MEN IN REFLECTIONS ABOUT GENDER AND SEXUAL HEALTH

APROFA, the IPPF/WHO affiliate in Chile, developed a multimedia educational CD-ROM, "Rock and Male Roles," to help young men look critically at gender and how it influences their sexual and reproductive health. The innovative idea of creating a computer-based educational tool was based on a survey of young men's information-seeking habits and computer use. Findings showed that many young men used computers to search for information about their bodies and sex, and nearly all used computers for entertainment purposes.

The CD-ROM presents an MTV-style music video, stories, quizzes, and reference documents in an entertaining and accessible way that challenges young men to analyze their

attitudes, beliefs, and behaviours in relation to gender, gender relations and sexual health. Moreover, the medium of a CD-ROM allows young men to explore these issues at their own pace and in a private setting.

A survey of 400 young men between 15 and 19 year old showed that a large majority found the CD-ROM helpful. In particular, it motivated them to improve their relationships with women, and to seek out further health information from a variety of sources.

For more information visit the APROFA and IPPF/WHO websites:

www.aprofa.cl

www.ippfwho.org



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Partnerships and collaborations

In many settings, youth sexuality can be a contentious and taboo topic. Key gatekeepers, such as parents, family, teachers, religious leaders, and policymakers may feel uncomfortable addressing the issue directly or even supporting youth's access to information or services. They may be uncertain of the links between gender and HIV and AIDS vulnerability and may doubt the need or utility of strategies for specifically engaging young men. Ongoing advocacy efforts are necessary to ensure an enabling and supportive environment for work with young men, and to reduce potential resistance to the messages and changes promoted. Gatekeepers and other partners should be invited to participate in and contribute to programmes from the onset.

As discussed earlier, experiences show that comprehensive, multifaceted projects can reach wider audiences of young men and have a more powerful and lasting impact when addressing change on various levels, including individual, environmental, and structural. To the extent

possible, education efforts should always be integrated with other interventions, including health services and social communication campaigns, as well as other social systems and structures, including schools and vocational training programmes.

ENGAGING GOVERNMENT AS PARTNERS

Government can serve as an important partner in the implementation of HIV prevention education programmes. Support from the government can help to: 1) remove policy barriers to communication of consistent and explicit messages about sexuality and prevention methods; 2) provide political cover and legitimacy to the programme (especially useful when working with legally marginalized groups such as injection drug users, sex workers, young men involved in gangs, and migrant populations); 3) incorporate findings into local and national policy and institutions (especially advantageous for school-based efforts); and 4) finance activities/programmes as an expression of commitment to the issues. (Link: [ADVOCACY](#) on page 77)

TOOLS

- Group Educational Activity: Act like a man, Act like a woman
- Group Educational Activity: Persons and Things
- Group Educational Activity: Want, Don't Want... Want, Don't Want
- Tips for Workshop Facilitators

PROGRAMMING: YOUNG MEN-FRIENDLY HEALTH SERVICES



Georgios Wollbrecht (<http://www.ssc.hu/profile/Wazari>)

Young men and health services: an overview

Providing young men-friendly health services is an important piece to promoting young men's access to and use of HIV prevention information, methods and support. Unfortunately, throughout the region and the world, there is a lack of youth-friendly health services, particularly those related to sexual and reproductive health. In some settings, where youth sexuality and reproductive health is a taboo topic, laws and policies may restrict young people from accessing sexual and reproductive health services. When these services are made available, they often require the presence or authorization of a parent or guardian, thus prohibiting or limiting opportunities for youth to access confidential services.

Even rarer than youth-friendly services are services which include a gender perspective, that is, an understanding of how gender roles and power dynamics shape attitudes and behaviours related to the sexual and reproductive health of young men and women. Both young men and women have specific needs in terms of their health and development because of the ways they are socialized. As discussed in the introduction, young men may feel pressured to engage in certain risk behaviours, including substance use or unprotected

"There is a lack of youth-friendly health services, particularly those related to sexual and reproductive health."

sex, to prove themselves as “real men.” Moreover, they may view seeking help or services as “unmanly” or a sign of weakness (Armstrong 2003; Hancock 2004; UNFPA 2003). In many settings, young men may only seek out health services in emergency situations or when they need to obtain condoms (Pearson 2003). Many may prefer looking for help and information amongst their peers and at pharmacies rather than formal health services (Barker 2000). Research conducted by Promundo in Rio de Janeiro, Brazil showed that young men living in low-income neighbourhoods are more likely to use “home remedies” or medicines indicated by their colleagues and peers to treat suspected STI symptoms, than seek out formal health services (Promundo 2006). They may also resist using health services because they view facilities as places for only women and children and/or because they do not expect staff to be sensitive to their needs.

Indeed, these perceptions are often reinforced by waiting rooms and services which are mainly targeted at women and staff who are not aware of or trained in sexual and reproductive health issues specific to young men.

In this context, promoting young men-friendly health services requires a dual-sided approach: making health services more responsive and attractive to young men AND working with young men to increase their health-seeking behaviours. The focus of this section is on the former – that is, it outlines strategies and steps for making health services more attractive and appropriate to young men. As depicted on the next page, nevertheless, it is necessary to also work at inter-personal and community levels to ensure that young men engage in healthy behaviours, including the seeking of support and services.

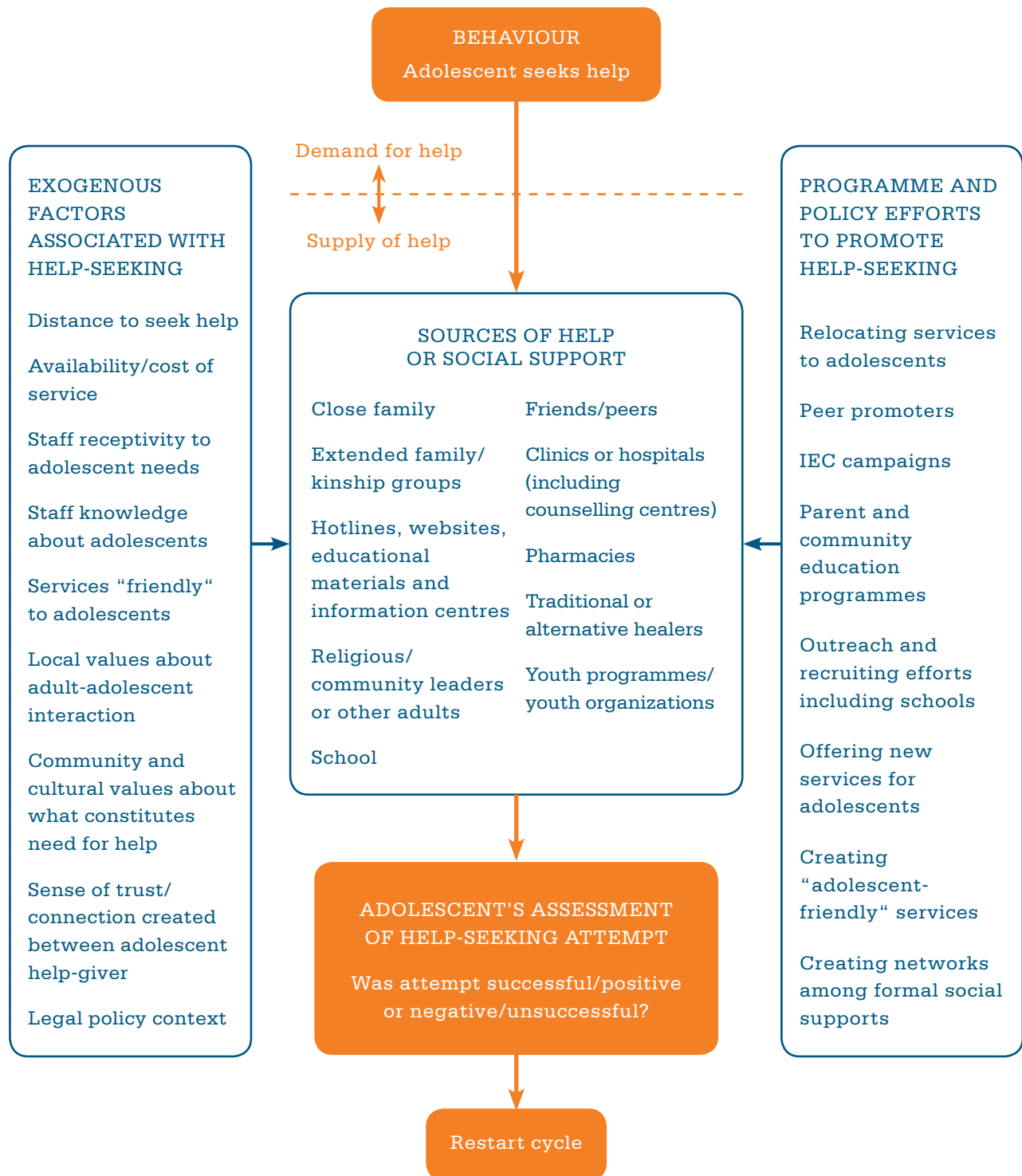
Identifying the needs of young men, services and the community

Conducting a needs-assessment is the first step toward creating or strengthening young men-friendly services. It can help to identify the needs, attitudes and behaviours of the young men to be reached through services, the readiness of services to work with young men and the support of the community to do so. The needs assessment process should be highly participatory and include the input of young men themselves, service providers, families and other stakeholders in the community. The box below presents some sample questions to consider for a needs-assessment and the section on evaluation provides information on specific methods which could be employed for an assessment, including individual interviews, focus group discussions, and community-wide surveys.

Taking an inventory of services

Services that aim to engage young men in HIV prevention should take a holistic approach to young men's health and development. Often, health services that do target young men are limited to condom distribution or STI testing and treatment. It is vital that health professionals and services address HIV prevention within an understanding of the other health risks that young men face, from violence to substance use, and how these risks are also grounded in many of the same rigid gender norms that make young men and their partners vulnerable to HIV and AIDS. Moreover, the underlying goal of services should always be to promote a more equitable distribution of sexual and reproductive health concerns between men and women.

The help-seeking behaviour of young men



The diagram above shows the relationship between the different factors which influence if and how young men seek help, including from health services. [Source: Barker et al 2005]

SAMPLE QUESTIONS FOR A NEEDS-ASSESSMENT

Below is a selection of sample questions for assessing the needs of young men and the readiness of services and the community to address their needs. Resources with more extensive lists of questions are included at the end of this section.

YOUNG MEN

- What are young men's greatest health concerns? Are these concerns different for young men in their mid-teens versus young men in their early 20's? For in-school versus out-of-school young men?
- How do young men view the available health services in their community? When and why do young men seek these health services?
- When young men do come to services, do they come accompanied (by parents, partners, or others) or do they come alone?
- Other than health services, where do young men go for information or support for their health concerns?

SERVICES

- Does the clinic or agency currently serve young men? If yes, which services are currently offered and which are not? If no, what are some reasons why young men are not served?
- Do staff and managers think it is important to engage young men in sexual and reproductive health services? Why or why not?

- Do staff or managers have any objections or concerns with serving young men?
- Is the environment male-friendly? What things make it either male-friendly or not male-friendly?
- Do staff and managers feel prepared and confident to respond to young men's needs and concerns? If not, what do they need?
- Is training provided to staff on how to serve males? If yes, what should be included in the training?

COMMUNITY

- How does the community feel about youth sexual and reproductive health issues?
- How does the community view young men in general?
- Is there support in the community to creating or improving sexual and reproductive health services for young men? If no, why not?
- Do schools offer any programmes related to health, including sexual and reproductive health? Are there current collaborations between schools and services? If not, what would be the necessary steps to establish such collaborations?
- Do other institutions or groups in the community offer information or services related to health, including sexual and reproductive health?

Services should encourage young men to be more caring, equitable and involved partners and provide opportunities for them to develop the relevant communication and negotiation skills, from how to help a girlfriend decide on a contraceptive method to how to talk to a partner about getting tested for HIV/STI.

In taking an inventory of sexual and reproductive services of young men, it is helpful to consider the following categories:

- (1) **Screening:** This entails taking a medical history, including sexual and reproductive history, risk of STI and HIV and AIDS, substance use and mental health needs (See TOOLS – Taking a Comprehensive Sexual History).
- (2) **Information and Counselling:** This includes providing information and counselling on various topics related to sexual and reproductive health and HIV and AIDS, including men's and women's anatomy, genital health and hygiene, basic fertility, contraceptive methods, STI and HIV prevention, pre-natal and postpartum care and inter-personal communication skills, including how to discuss condom use and VCT with partners.
- (3) **Clinical Diagnosis and Treatment:** This is the provision of services and/or referrals for the diagnosis and treatment of problems detected during the screening procedure. This includes STI and/or HIV diagnosis, treatment for impotence, fertility evaluations and vasectomies.

Source: UNFPA 2000



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"Services should encourage young men to be more caring, equitable and involved partners."

It is not necessary for any single clinic or agency to directly provide all of these services, but it is important to have a sense of the range of services which young men need and to be prepared to provide referrals for those services which are not provided on-site. Likewise, it is worthwhile to consider including sexual and reproductive care within a broader menu of services as a way to attract young men. Offering other types of services can help to reduce embarrassment or stigma of going to a sexual and reproductive health or HIV prevention clinic. For example, the Young Men's Clinic in New York City, mostly catering to young Latino men, primarily provides sexual and reproductive health-related services, yet, it also provides a limited range of other services, including general physical examinations and treatment of sports injuries and acne. These "other" services provide important entry-points for engaging young men in more delicate and intimate

questions about sexuality, reproductive health and HIV prevention (Armstrong 2003).

In the design and implementation of services, it is important to also keep in mind that there are a range of developmental experiences and behaviours among young men (see DEVELOPMENT). Young men in their mid-teens generally have different needs and expectations from services than young men in their early 20's. For example, young men in their early 20's are generally more sexually active and have higher rates of STIs (Sonenstein 2000; CDC 2006). Likewise, their reproductive health needs might extend beyond contraceptive use to education and counselling on pregnancy and child-care (Sonenstein 2000). Since young men in their early 20's are often not enrolled in school, health services are one of the few spaces where they can receive information and support on these issues.

WHAT SHOULD SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR YOUNG MEN INCLUDE?

- Risk assessment based on sexual and reproductive health history
- Testing, education, counselling and treatment for STIs/HIV
- Counselling for sexual dysfunction
- Screening for testicular and penile cancer (see TOOLS)
- Information on abuse or dependence on alcohol and other drugs
- Screening for depression and referral for mental health support
- Counselling on the prevention of gender-based violence
- Sexuality and sexual orientation counselling
- Counselling about having a safe and satisfying sex life
- Counselling on and access to family planning methods
- Infertility counselling
- Information on pre-natal and post-partum care and support
- Parenting skills
- Communication and negotiation skills-building
- Vasectomies

HIV PREVENTION SERVICES:

INFORMATION AND ACCESS TO CONDOMS

Condoms are effective in preventing HIV and AIDS when used correctly and consistently. Often, young men may go to health services specifically to obtain condoms and it is important that health providers take advantage of this opportunity to provide accurate information and education on condom use, as well as materials and information on other available services. Since sexually active young men are often concerned about unplanned pregnancies, health professionals and educators should promote condom use in the context of dual protection – that is, emphasizing that condoms are suitable for the prevention of pregnancy, as well as STI's and HIV and AIDS.

In some countries male condoms are distributed for free through the public health system. However, free distribution of condoms does not necessarily equate to no cost for young men. There are often indirect costs, including long waiting lines, bureaucratic paperwork processes, and unpleasant interactions with judgmental or unfriendly staff. It is important that young men feel comfortable coming to the clinic or health post for condoms (and lubrication) since it will help them feel more welcome to come back for other questions or needs.

"It is important that young men feel comfortable coming to the clinic or health post for condoms."

ARE MALE-ONLY SERVICES NECESSARY?

Should services for young men be integrated into existing services, or should young men be served in separate male-only clinics? Experiences have shown that both strategies can be successful. In some countries, custom and tradition dictate the need for separate services for young men; others have succeeded in expanding services within existing facilities. In terms of sustainability, it can be very costly to have space and staff dedicated exclusively to working with young men and successful models have usually been based in urban areas, where there is a larger public of young men. Ultimately, decisions on which model works best should be informed by consultation with the community to determine its preferences, young men's needs and the setting they are most likely to use, and, of course, available resources.

Source: UNFPA 2000

The process for getting condoms at the local clinic or health post should be quick and simple. Registration should require only a minimum amount of information, such as name, age, and how the young man found out about the distribution of condoms. It is important to be sensitive to the amount of information requested so as not to generate long and bureaucratic processes and to respect young men's possible concerns about confidentiality. To fast-track condom distribution, it can be helpful to train peer educators and/or receptionists on the registration process and how to demonstrate condom use. Signs saying "condoms available" (for sale or free) should be displayed at the reception desk or another area where young men are more likely to view them. If possible, services should also try to have a broad variety of condoms available for distribution (different flavours, sizes, textures, etc.). Unlike women, men generally have a very limited range of contraceptive options. Offering a variety of condoms can help to motivate young men's uptake and can serve as an example of how dedicated staff are to promoting condom use and other healthy behaviours amongst young men (Hancock 2004).

In addition to distribution, services should offer demonstrations on correct condom use and opportunities to build communication and negotiation skills. It can also be useful to speak with young men about the female condom. The female condom is a polyurethane sheath or pouch which lines the vagina and, like the male condom, helps to prevent pregnancy, STI's and HIV and AIDS. It is still not as widely available as the male condom in most countries but it can serve to generate discussions about equitable roles and decision-making in intimate male-female relationships.

HIV PREVENTION SERVICES: VOLUNTARY COUNSELLING AND TESTING

Voluntary counselling and testing (VCT) is a key part of effective HIV prevention. When young men know their HIV serostatus, they can disclose it to their partners and take the necessary measures to protect themselves and their partners, be it from infection or, in cases where young men and/or their partner(s) are HIV positive, from re-infection. Unfortunately, while routine gynecological and family planning care, including pre-natal services, provide a common entry-point for promoting VCT services for young women, there are generally

"Services should try to have a broad variety of condoms available for distribution (different flavours, sizes, textures, etc.)"

no comparable entry-points for offering VCT to young men. Therefore, it is important that services seek to identify and make the most of opportunities for engaging young men in VCT services, from routine physical exams to condom distribution schemes.

Services which provide VCT should always have referrals on-hand for treatment and support. It is important to remember, however, that treatment may not be readily available or accessible in many settings, and the promotion and provision of testing might lead to various ethical considerations in terms of follow-up

services. Also, depending on local guidelines and laws, parental permission might be necessary to administer the HIV test to a young man under the age of 18, or the legal adult age in country. In some countries, policies are flexible enough to allow some called “mature minors” to decide for themselves to be tested. The term can refer to those younger than 18 years who are married, pregnant, parents, engaged in behaviour that puts them at risk, or in other relevant situations (such as orphaned and head of a household). If parental consent is required, offer to talk to young men’s parents or guardian (Fisher et al 2005).



This poster was part of a series developed by the South African Men as Partners Programme (coordinated by Engender Health) in partnership with Men Can Stop Rape. It is designed to raise awareness of the importance of the HIV test and highlight the vital role men can play in reducing the risk of HIV infection in their relationships and communities. (Link: [CAMPAIGNS page 65](#))

For more information visit the Engender Health website:

www.engenderhealth.org

or the Men Can Stop Rape website:

www.thestrengthcampaign.org

TIPS FOR PROVIDING VCT

PRE-TEST COUNSELLING

--Discuss what HIV and AIDS are, how the HIV virus is transmitted, and what behaviours could lead to transmission.

--Explain how the HIV test is done. The young man may be concerned that it will hurt or cause discomfort. Answer any questions he has about the test and its accuracy. Explain that the test's reliability depends on the last time he may have been exposed and that it can take up to three or even six months after exposure to HIV — the “window” period — for the virus to be detected by the test.

--Emphasize that the test is voluntary and confidential.

--Encourage the young man to think about who he will turn to for support. Partners? Parents? Other family members? Religious leader? Trusted friends? Help him determine who would be most supportive and him them practice how to talk to these people about being HIV-positive.

-- Encourage the young man to speak with his partner(s) about counselling and testing.

IF THE RESULT IS NEGATIVE

--Acknowledge the young man's feelings of relief. Explain that a negative result means that HIV was not detected but emphasize that he could still be at risk if he practices unsafe behaviours or if he has practiced unsafe behaviours in the last three months. Suggest that if he has engaged in any risky behaviours — unprotected sex, use of injecting drugs — in the last three months, he should return to confirm the results by taking another test in one to three months, depending on the date he may have been exposed to HIV.

--Reinforce any healthy behaviours he reported

in the pre-test session — such as using condoms and being faithful to one partner — and help him develop a plan to change any risky behaviours and maintain his HIV-negative status.

--Refer the young man, as necessary, for ongoing medical care, counselling, support, or development of life skills such as self-esteem, problem-solving, and dealing with peer pressure.

IF THE RESULT IS POSITIVE

--It can be very difficult to tell a young man that he has tested positive for HIV. Try to deliver the news in a caring but not overly emotional way. Give the young man the hopeful message that a person with HIV can remain healthy for a long time if he practices positive living habits.

--Review what a positive test result means. Explain that he has the HIV infection, but that he probably has not yet developed AIDS — unless he appears with an opportunistic infection or other clinical signs that may suggest he has AIDS. Review the difference between HIV and AIDS.

--Allow the young man to express his feelings. Give him as much time as necessary. He might be angry, depressed, or afraid. He might feel betrayed by his partner or refuse to accept the test result. Listen to him, offer empathy, and show that you care about what he is going through.

-- Encourage the young man to tell his status to any sexual partner(s) he has had and/or — if appropriate — to anyone with whom he shared a needle. Acknowledge his fears about doing so. Offer to role-play; try first acting as the young man, so that he can learn how to explain his or her status. Then, allow the young man to practice by pretending that you are the person he needs to tell.

SOURCE: Boswell and Baggeley 2002

As part of VCT services for young men, it is worthwhile to encourage them to speak with their partners about VCT, and if possible, to offer couple counselling. It can provide a useful time for a couple to think together about risk and prevention, including secondary prevention if one partner does turn out to have the HIV virus. Moreover, couple-counselling reinforces the importance of equal responsibility and decision-making in sexual and reproductive health and disease prevention. At the same time, health professionals should be sensitive to power dynamics in the relationship and ensure that neither partner is being coerced into or during the counselling and test.

MATERNAL AND CHILD HEALTH SERVICES: MEN AS PARTNERS

It is increasingly accepted that involvement of fathers in the lives of their children has

benefits for the children, young men and their partners. However, as a result of cultural norms about men's participation in maternal and child health, men's involvement in matters is still rather limited and few initiatives within the health care sector have focused specifically on engaging men as fathers. It is important that services work to ensure that men are involved in the spectrum of reproductive and maternal and child health services, including PMTCT (preventing mother-to-child transmission of HIV) (Greene et al 2006). Research has shown that male partners can make a real difference in improving women's uptake of PMTCT services. When outreach efforts successfully engage men, they are far more likely to support women in deciding whether to take an HIV test, taking antiretroviral drugs and practicing safer infant feeding methods (Horizons Report 2003).



Jon Spaul

Staff and Training

One of the most essential elements for young men-friendly services is a staff which is gender-sensitive and prepared to respond to young men's health concerns and needs. As discussed earlier, a needs assessment can help to identify the degree to which staff are committed and prepared to working with young men. The entire staff should receive training on the importance of working with young men, including the opportunity to deconstruct their own gender beliefs and how they might impact their professional interactions with young men. For example, it is important that staff are able to move beyond stereotypes that frame male sexuality as irresponsible and uncontrollable or predatory. These stereotypes about male sexuality can often limit the extent to which health professionals reflect critically on and address the specific sexual and reproductive health and needs of young men. Moreover, many health professionals frequently work from the premise that all boys are heterosexual. As a result, health services might be limited to heterosexual needs and realities, thus denying visibility to the needs of young men who have sex with men (MSM). For young men who are gay, or who have sex with men, stigmatization can lead them to practice their sexuality clandestinely and inhibit them from seeking out sexual health information and services, thus creating situations of extreme vulnerability to STIs and HIV. Furthermore, due to this stigmatization, health services might not be welcoming of same-sex or bi-sexually attracted young men and young women or might not be prepared to deal with questions and concerns related to sexual diversity.

As mentioned above, it is imperative to involve all staff who will interact with young men in the services setting in sensitization and training activities. This includes direct-services professionals such as doctors, nurses and social workers as well as administrative staff such as receptionists and security guards. The administrative staff is very often the first contact that young men will have with services and the way in which they are welcomed, or not, by these individuals can often determine whether young men will return.

Finally, there is the question of the role male staff can play in the provision of young men-friendly services. It is sometimes assumed that just having male health professionals on staff is sufficient for considering services "male-friendly." In other cases, it might be assumed that without male staff it is not possible to have male-friendly services. The answer, however, is somewhere in the middle.

"It is imperative to involve all staff who will interact with young men in the services setting in sensitization and training activities."

Indeed, having males on staff can present an image of services being male-friendly and can help attract young men. Some young men may hesitate to share intimate, especially sexual, information with a woman and to this end, having a man or men on staff can be important for ensuring that young men feel comfortable. At the same time, being a man in and of itself is not necessarily a qualification to working with young men. The quality of service, that is, whether the providers and staff have the necessary knowledge, skills and sensitivity is what matters. Ultimately, young men want health professionals who have positive attitude towards them and will be able to answer their questions or refer them to someone who can.

"Health professionals should have positive attitudes towards young men and be able to answer their questions or refer them to someone who can."

Facilities and physical environment

The first impression that young men have of services should be one that is inviting and welcoming. They should be greeted warmly when they walk in and should see wall posters and images of diverse young and adult men engaging in healthy and gender-equitable behaviours (e.g. giving a bottle to a child, speaking to a partner about the HIV test). Reading materials in the waiting room should be appealing to males and include information on services they might seek.

EXAMPLES OF HOW YOUNG MEN CAN BE INVOLVED IN DESIGN AND DELIVERY OF SERVICES

- Participate in the sensitization and training of health services staff.
- Mobilize young men and stakeholders to participate in focus groups and interviews for needs-assessment.
- Make suggestions for making the space more young men-friendly and welcoming.
- Greet young men at entry to services or in waiting room.
- Facilitate educational activities, or informal discussions, in the waiting room.
- Coordinate condom distribution process, including registration and demonstrations of condom use.
- Coordinate outreach activities to attract young men to health services.

SOURCE: Raine 2003

Outreach

Once services, staff, and the facilities are prepared to receive young men, the next step is to develop outreach strategies to attract young men to services. These strategies should be diverse, from the dissemination of catchy promotional materials to the linking of services to vocational training, sports and other activities directly related and beneficial to young men's lives. The availability of services for young men should be clearly announced in as many different materials and venues as possible. As will be discussed in the following section, solid community buy-in and support is a fundamental prerequisite to such successful and sustained outreach efforts.

A key and highly cost-effective outreach strategy is word of mouth. As young men attend services and have a positive experience, they, in turn, pass on positive comments to their male peers, thus creating a "snowball" effect which can increase the uptake of services by young men (Pearson 2003). Likewise, girlfriends and wives should be encouraged, when appropriate, to invite their partners to appointments. These visits can be opportunities to engage young men as equal partners in sexual and reproductive health decision-making and initiate discussions about their own health needs.

Ensuring that young men are aware of and using services can often require going outside the health post or clinic space to meet with young men in their own settings. These can include schools, sports fields, community centres, bars and other places where young men tend to congregate. It is not necessary to offer a complete menu of services in these settings, but rather, young men should have access to basic information and materials on health and services, including condom use and VCT. Peer promoters can be especially strategic partners in reaching young men in their different settings and can provide valuable support in the design and delivery of outreach activities and services.

"Girlfriends and wives should be encouraged, when appropriate, to invite their partners to appointments."

Community support and collaboration

It is essential to involve the community in the provision of young men-friendly services. Families, schools, religious and community leaders should be consulted and involved throughout, from the needs-assessment to the outreach efforts to attract young men to services. This process helps to foster an environment that legitimizes youth's access to sexual and reproductive health services and ensures that services are provided in a culturally-sensitive manner (Flores 2004).

The poster below was part of a project to increase young men's use of health services in low-income communities in Rio de Janeiro. The picture and message is intended to deconstruct the idea that health posts are only for women and children or only for the sick. The picture depicts a young man being greeted at the door to a community health post and the message describes the post as a place where young men can ask questions, take care of themselves and

get condoms. The poster incorporates local cultural expressions including graffiti art and slang. It was painted as a mural on one of the outdoor walls of a community health post and printed on postcards which were distributed at community activities along with informational materials on available services.

For more information visit the Promundo website: www.promundo.org.br



Chega junto, cara!

No posto de saúde, você se cuida, tira dúvidas, troca idéias e recebe camisinha de graça.

(Translation: Come on in, dude! At the health post you can take care of yourself, ask questions, and get free condoms)

Families are important allies in helping to promote positive help-seeking behaviours among young men and should be included in outreach efforts. Experiences throughout the region have shown that young men often go to health services with their mothers or aunts, yet these individuals often have very little knowledge of the specific health and development needs of young men.

Schools are another important ally in attracting young men to services. Family life and sexual education classes provide a valuable opportunity for services-affiliated peer promoters or health educators to facilitate informational sessions on services available and to train teachers, counsellors and other staff on how to provide referrals. In addition to schools, services should identify other social services and institutions in the community which have access to young men, from religious groups to sports clubs. It can be worthwhile to contact these institutions to discuss possible collaborations and to invite representatives to training and planning sessions to exchange experiences and brainstorm strategies for engaging young men in HIV prevention.

TOOLS

- Checklist for young man-friendly services
- Survey for Health Services Staff
- Taking a comprehensive sexual history
- Informational handout on preventative exam for testicular cancer
- Informational handout on preventative exam for cancer of the penis

Below is an example of an educational material, developed by Promundo, NESA, PAHO and municipal health secretariat specifically for families, which emphasizes the importance of health services for young men and the role that families could play in encouraging their use.

For more information visit the Promundo website: www.promundo.org.br



(Translation: When a boy grows up he thinks that he can take care of himself but he still needs support.)

PROGRAMMING: CAMPAIGNS



Young men and campaigns: an overview

Campaigns are coordinated sets of activities which aim to promote changes in individual behaviours and/or the socio-cultural and political norms necessary to support these changes. Among the most distinguishing features of campaigns are that they often include some form of media and target large numbers of people. This section presents images, messages and strategies from diverse campaigns which have targeted young men and important stakeholders, including families, coaches and the general public. Key to the success of these campaigns have been two features: 1) they move beyond simple information provision to address underlying norms and perceptions related to behaviours and 2) they are linked to inter-personal activities which allow for individual reflection and skills-building and promote access to services.

"Among the most distinguishing features of campaigns are that they often include some form of media and target large numbers of people."

Media-based campaigns and social marketing

In the last few decades, there have been rapid developments in communication technologies, multiplying the available media channels for reaching audiences, particularly youth (Macdowall and Mitchell 2006). From billboards and radio to internet and mobile phones, youth are constantly exposed to a large amount of information and messages. These can have a powerful influence (both positive and negative) on social norms about what it means to be a young man and how a young man should behave or aspire to behave. To be effective in this crowded media environment, it is necessary to package campaigns in ways that can easily catch the attention of young men and other stakeholders, and most importantly, persuade them to adopt and promote healthy and more-equitable attitudes and behaviours.

WHAT IS CONDOM SOCIAL MARKETING?

In the mid-1980's condom social marketing emerged as a popular HIV prevention strategy (UNAIDS 2000). It is a specific form of social marketing which promotes the availability, affordability and acceptability of condoms. In Latin America and the Caribbean, and other settings, a variety of condom social marketing programmes have demonstrated success in raising general awareness of HIV and AIDS transmission and prevention, increasing sales of marketed condom brands as well as affecting attitude change towards condom use in targeted groups, including young men (Horizons 2004; JHUCCP 1997; UNAIDS 2000 – see example of Hora H on page 72).

Traditional public health campaigns have focused solely on “informing” people of unhealthy behaviours and their consequences and have often employed dictating or moralizing tones to do so. However, experience has shown that these types of campaigns are rarely adequate for effectively engaging audiences and motivating behaviour change (Hornick 2002; Randolph and Viswanath 2004). To this end, public health campaigns are increasingly using principles from commercial marketing to “sell” healthy behaviours and lifestyles. Social marketing, as this approach is called, entails making specific behaviours and lifestyles more attractive to a given audience through an emphasis on benefits and advantages.

To develop a social marketing campaign, it is important to first understand the underlying socio-cultural norms which contribute to and support particular behaviours¹. Much of people's behaviour is influenced by their perceptions of what is “normal” or “typical,” that is, what they believe most of their peers do. However, many individuals, including youth, often misperceive the typical behaviours or attitudes of

1. There is a specific form of social marketing known as social norms marketing which is based on applying social marketing techniques to social norms theory. The central concept of social norms theory is that much of people's behaviour is influenced by their perceptions of what is “normal” or “typical.” To this end, the premise of social norms marketing is that informing people that the majority of their peers are acting in a positive or healthy way can create an environment in which people actively strive to emulate what they believe is typical of their peers. This approach has proven effective in areas such as preventing tobacco use and drinking and driving, among other issues. For more information visit the Most of Us website at www.mostofus.org.

their peers. For example, young men may believe that a majority of their peers engage in certain risk behaviours, such as excessive drinking, when in most settings the majority of young men do not (Perkins et al 2005). Often, these misperceptions are fuelled by the media or social norms of what is considered a “real” man. These misperceptions, in turn, may make young men more likely to engage in these behaviours themselves. In this sense, it is important that campaigns address misperceptions or rigid ideas young men and others (partners, families, etc) may have about typical behaviours for young men and promote more positive norms around what it means to be a man.

Social marketing campaigns can be carried out at local levels through the use of community-based media or at broader levels through the use of mass media. Community-based media, such as street

“Public health campaigns are increasingly using principles from commercial marketing to ‘sell’ healthy behaviours and lifestyles.”

CAMPAIGNS SPOKESPERSONS: CELEBRITY OR EVERYDAY MEN?

A common question about campaigns is whether it is more effective to use celebrity or everyday men as spokespersons. Big-name musicians, athletes and other celebrities often have the attention and respect of large numbers of young men and can be powerful spokespersons for drawing attention to a campaign and the positive attitudes and behaviours it aims to promote. On the other hand, coaches, fathers, religious leaders, and other everyday men who play a role in young men's lives, can also be very engaging and effective spokespersons. Among these everyday

men who can be particularly influential are young men themselves. The peer modelling of certain attitudes and behaviours can help to make them more credible and tangible to young men than those perhaps promoted by celebrities, or even adult men, who may live different realities and face different pressures. As part of the formative research process it is important to work with young men to identify the appeal and influence of different spokespersons and determine who would be most effective in positively influencing young men in a given context.

theatre, often provides more depth and interaction, whereas, mass media, such as TV dramas produced by commercial studios with professional actors and technicians, may offer less depth and interaction, but often provides wider reach of messages. The decision to use community-based or mass media or a combination of both types will depend on available resources and the intended audience and depth of contact expected.

Regardless if a campaign is a local or mass media effort, young men should be involved throughout its development, implementation and evaluation. Often, they and other beneficiaries or stakeholders are only

involved as respondents in the data collection for a needs-assessment or to give feedback during the testing of final messages and images. It is, however, more effective to involve young men throughout all stages, from the design of the formative research questions to the actual development of messages and images. It is also important to involve strategic secondary audiences including families, community leaders, women, policymakers, in these different stages. Given the sensitive nature of many topics related to gender and HIV prevention, the involvement of secondary stakeholders can help to minimize possible backlash (MacDowall and Mitchell 2006) ([Link: ADVOCACY page 77](#)).

THE STRENGTH CAMPAIGN, USA

Developed by Men Can Stop Rape (MCSR), the Strength Campaign employs different media and community outreach and mobilization strategies to engage young men in more positive and equitable behaviours, including as allies in the prevention of dating violence. The campaign's media initiative is organized around the slogan "My Strength Is Not for Hurting," and strives to refocus the traditional perception of male strength as respect and communication, not force and domination. In addition to the media initiative, the Strength Campaign also includes an educational component called the Men of Strength (MOST) Club. Young men in MOST Clubs participate in a series of sessions intended to raise their awareness of the importance of male involvement in rape prevention and mobilize them as active allies in preventing men's violence against women and girls.

Originally started in DC, an important piece to the success of the Strength Campaign has been building connections with school staff and other school-based initiatives. School administrators, teachers and other staff participate in awareness-building workshops and are invited to serve as members of the campaign's advisory committee and participate in the design and management of in-school activities. In this way, campaign efforts are not isolated from other school-based efforts, but rather "owned" and implemented locally.

The campaign focus on promoting positive gender norms allows for it to also be adapted to engage men in other social and health problems. Since the campaign's launch, more than two hundred local, regional, and national organizations have used the campaign posters and materials, creating a nationwide presence. The materials have also been used in other countries.

"Regardless if a campaign is a local or mass media effort, young men should be involved throughout its development, implementation and evaluation."

The Strength Campaign messages present the common male norm of strength as respect and communication, not force and domination. One of the most salient concerns which emerged from the formative research and testing was that young men feared that if they spoke out about violence against women, or changed their ways, they would be alone. For this reason, the campaign images show young men with partners and/or with other young men in order to emphasize the benefits and solidarity related to taking a stand against men's violence and speaking openly about respecting women.

For more information visit the Men Can Stop Rape website:
www.mencanstoprape.org



HORA H. BRAZIL

Developed by Promundo and JohnSnowBrasil, with financial support from SSL International, the Hora H Campaign, which translates into “In the heat of the moment,” builds upon social marketing principles to promote an attractive and more gender-equitable lifestyle for young men. Campaign messages describe a “real” man as one who demonstrates more gender-equitable attitudes in his relationships, particularly in the more challenging moments. The name of the campaign was developed by young men themselves who frequently heard their peers say: “Everybody knows you shouldn’t hit your girlfriend, but in the heat of the moment you lose control” or, “Everybody knows that you should use a condom, but in the heat of the moment....” In this context, the Hora H campaign emphasizes that a “real” man is respectful and caring in his relationship with his partner, or more specifically, he does not use violence, he discusses condom use and he shares parenting responsibilities.

The Hora H Campaign also includes an associated condom brand and although the campaign messages promote condom use as an important behaviour in and of itself, the main emphasis of the campaign is on the lifestyle which is symbolized by condom use. The link between the Hora H condom, a “product”, and a lifestyle draws from principles of commercial marketing in which advertisements for cars,

shoes and other products focus on the lifestyle associated with ownership of the product, rather than the qualities of the product itself. In the case of Hora H, this strategy is used to market healthy and equitable behaviours, such as condom use, as part of a cool and hip lifestyle for young men.

The campaign models, or spokespersons, are the same young men who were involved in the design and implementation of the campaign activities, including the distribution of the media materials and running of information and condom sales booths at community dances. These young men were from the same communities in which the campaign was active and became references in the community, in some ways, local celebrities. They provided “proof” to other young men in the community that these kinds of attitudes and behaviours were indeed possible. At the same time, the campaign also engaged rap musicians who presented messages during their concerts. The endorsement of the campaign by these celebrities helped to bring more mainstream coverage to the campaign and reinforce its appeal among young men (see box on page 69).

The Hora H Campaign posters shown here present messages about gender-equity and relationships through two specific issues:

condom use and fatherhood. The first emphasizes the importance of listening and accepting a partner's decision to use a condom and the second describes the need for young men who are fathers to assume and share responsibility and care.

The campaign logo of the green letter H (for homem, the Portuguese word for man) became a powerful marker of the campaign and the "cool" and gender-equitable lifestyle it promoted. The t-shirt which sported the logo became a popular commodity amongst young men in the community, highlighting the effect of commercial marketing strategies to catch young men's attention and mobilize them.

For more information visit the Promundo website at: www.promundo.org.br

(Translation, top: Man with a capital M.

He listens. He accepts. He cares.

In the heat of the moment: The attitude makes the difference.)

(Translation, bottom: Man with a capital M.

He takes responsibility. He shares. He cares.

In the heat of the moment: The attitude makes the difference.)

Homem com H
Escuta. Aceita. Cuida.



Homem com H
Assume. Compartilha. Cuida.



Entertainment education

Entertainment education integrates education and social messages in popular forms of entertainment, including TV or radio dramas, theatre, music, and interactive computer programmes. It can be a powerful communication tool for catching the attention of young men, legitimizing sensitive topics, and generating public interest and dialogue in a way that traditional educational messages often cannot (UNFPA 2002). Moreover, when entertainment education is linked to interpersonal and group communication strategies, it can enhance learning and behaviour change (UNFPA 2002).

The first step to developing an entertainment education strategy is to evaluate the accessibility and popularity of different entertainment media (e.g. television, radio, magazine) for the target population (Singhal and Rogers 1999). In some settings, for example, youth may have limited access to computers, but may watch lots of TV, or they may have access to various media, but prefer radio. The cost of an entertainment education strategy will depend upon the chosen medium and the proposed level of quality. As discussed earlier, entertainment education and other media-based campaign efforts need to be competitive with the flood of media to which youth are exposed. Otherwise, they may decide to look elsewhere. To guarantee a high-quality product, it may be necessary to involve scriptwriters, actors and creative teams to help with the development of messages, storylines, etc. or to train peer promoters so that they are able to do so. It can also be useful to consider incorporating messages into existing TV or radio programmes or popular magazines, rather than create new shows or materials.

"The first step to developing an entertainment education strategy is to evaluate the accessibility and popularity of different entertainment media (e.g. television, radio, magazine) for the target population."

SEXTO SENTIDO, NICARAGUA

Somos Diferentes, Somos Iguales (We're Different, We're Equal), coordinated by the Nicaraguan NGO Puntos de Encuentro, is an national multi-media campaign to empower youth, promote gender-equity and reduce violence and HIV/STI risk. The centrepiece to the campaign is a nationally broadcasted TV soap opera, "Sexto Sentido" (Sixth Sense), which targets youth and addresses sensitive and complex issues such as sexuality, HIV and AIDS, reproductive rights, and domestic violence by dramatizing them within realistic and entertaining storylines. The soap opera messages are reinforced through interactive and community-based activities which serve as platforms for public discourse and debate. These activities include a daily youth call-in radio programme and cast tours to local high schools around the region and provide youth with opportunities to voice opinions, share experiences, challenge biases, negotiate different viewpoints and make decisions about how and where to create change in their lives (Solárzano 2006). Puntos de Encuentro also partners with a network of youth and women friendly health and social service providers around the country who receive referrals to assist with problems, concerns, or further questions that arise during campaign activities. An evaluation study carried out in 2003-2005 confirmed that there is a cumulative message dose effect: the more messages young people

are exposed to, and the longer the period of exposure, the more likely they are to have a "positive" attitude toward the issue, and to be motivated to change, including in their gender attitudes and HIV prevention behaviours (Solárzano 2006).

The last episode of Sexto Sentido was broadcast in June 2005. The series is currently being repeated in its entirety (80 episodes) on local TV stations around the country and is broadcast on major TV channels in Costa Rica, Guatemala, Honduras and Mexico.

Episodes and further information can be downloaded from the Puntos de Encuentro website at:

www.puntos.org.ni



Puntos de Encuentro | Sexto Sentido

BETWEEN US. BRAZIL



Translation:
Love, Respect
and Equality.
Between us, it's
the best way.
Between Us:
The radio soap
opera that is
going to touch
your heart.

The radio-based soap opera “Between Us,” developed by a group of peer promoters in collaboration with Promundo, addresses issues such as gender roles, first sexual relationships, condom use, unplanned pregnancy, parenthood, and women's empowerment. In addition to community radio stations, the soap opera is played in diverse settings where young people hang out – including college preparatory classes, beauty salons, cyber houses and snack bars. The peer promoters developed discussion guides for each episode and use these to facilitate discussions with other youth following the airing of each new episode.

For more information visit the Promundo website at:
www.promundo.org.br

Sports as a campaign medium

Throughout the world, sports are popular among young men and can serve as a powerful and far-reaching communication medium for engaging them in activities and messages related to gender equity and HIV prevention. At the same time, using sports as a communication venue requires careful handling (Cohen and Burger 2000). Many sports emphasize aggressiveness or competitive masculinity and it is important that campaign or other communication strategies do not reinforce these qualities, but rather emphasize cooperation and respect. There are a variety of ways in which sports can be utilized in or for campaigns – from offering sports to attract young men to participate in educational workshops or services to integrating HIV prevention information and related messages about gender and relationships in sports activities. This latter strategy can include having influential sports role models speak during half-time about HIV prevention and positive and equitable ways of being men, distributing informational materials with key messages about gender-equity and HIV and AIDS at sporting events, and recruiting coaches and/or sports team members to serve as peer educators for other team members and/or the community. As described in the box below, coaches can be powerful allies in engaging young men in HIV prevention and reflections about gender, whether through formal lessons or informal communications (IGWG 2003).

"Coaches can be powerful allies in engaging young men in HIV prevention and reflections about gender."

COACHES AS PARTNERS IN ENGAGING YOUNG MEN IN GENDER-EQUITY AND HEALTH

SOCCER SCHOOLS: PLAYING FOR HEALTH, REGIONAL

The Pan American Health Organization (PAHO) and the World Health Organization (WHO), with financial support from the Johan Cruiff Foundation, coordinate a programme to train soccer coaches on how to incorporate lessons about health, gender equity and rights into soccer activities with boys ages 8 to 12. The programme has been implemented in various countries in Latin America and has received support from ministries of health and sports organizations including FIFA, the international soccer federation.

For more information visit the Pan American Health Organization website:
www.paho.org

COACHING BOYS INTO MEN, USA

Led by the Family Violence Prevention Fund (FVPPF), Coaching Boys into Men is a nationwide multi-media campaign that builds on a sports motif to encourage men to be positive role models for boys and young men and teach them about healthy and respectful relationships. In addition to efforts to engage fathers and other men, FVPPF has also partnered with the National High School Athletic Coaches Association to involve coaches in the campaign effort. This has included the creation of materials to help coaches incorporate messages and discussions about violence against women in the locker room and on the field.

For more information visit the FVPPF and Coaching Boys into Men websites:
www.endabuse.org
www.coaches-corner.org



(Translation: Men for the end of violence against women. Wear this Jersey!)

In 2006, the Brazilian White Ribbon Campaign launched new media materials inspired by the World Cup and collective interest in football. The poster shown here builds upon the idea of solidarity amongst players and between players and fans to engage men

to be allies in the prevention of violence against women.

For more information visit the Brazilian White Ribbon Campaign site:
www.lacobranco.org.br

TOOLS

- Creating Campaigns: Step by Step
- Mapping Young Men's Media and Social Networks

PROGRAMMING: ADVOCACY



Jon Spaul

Young men, HIV and AIDS and advocacy: an overview

In the last 15 years, there has been an increasingly positive international climate for engaging men in HIV prevention efforts, as reflected in a series of milestone conferences and meetings (see box on page 80). The recognition of the gender dimensions of the HIV and AIDS epidemic has led activists, programme planners and others to view men as important allies in reducing the vulnerability of women to HIV infection. Likewise, a growing body of programme experiences and evidence has highlighted myriad strategies for engaging men in HIV prevention, and most importantly, confirmed the benefits for both women's and men's health.

Despite this emergent attention and activity around the issue of male involvement and HIV prevention, there is still a good deal that needs to be done, particularly in terms of advocacy. Advocacy can be defined as the process of building support and positively influencing decision-making on a given issue. It can entail a multitude of strategies and actions and can occur at various levels, from promoting awareness among community leaders of the

benefits of engaging men in HIV prevention to garnering political commitment and support for the scaling-up of successful interventions and policies. The strategies and tips presented in this section draw from general advocacy experiences as well as those related specifically to promoting male involvement in health and development agendas. Topics include engaging community stakeholders, media and government and building alliances.

THE INTERNATIONAL CONSENSUS ON THE NEED TO WORK WITH MEN

In the last 15 years, there have been a series of milestone conferences and meetings which have affirmed the international community's consensus on the key role that men and boys play in empowering women and girls and achieving gender equality. The documents and agreements from these meetings serve as important advocacy tools, especially for leveraging government attention and action for working with men in sexual and reproductive health, including HIV prevention. Among the most cited are:

INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (CAIRO, 1994)

The International Conference on Population and Development (ICPD) marked a shift from a purely demographic approach to family planning to a more holistic health-based framework that links health to gender equality and sustainable development (Cohen and Burger 2000). The ICPD Programme of Action calls for engaging men and boys in innovative and comprehensive ways to achieve gender equality and most important, it does not present men and boys as "obstacles" but as allies in promoting change. As highlighted in the excerpt below, the consensus on working with men in a gender perspective also includes recognition of the need to work specifically with young men.

Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive

lives...Responsible sexual behaviour, sensitivity and equity in gender relations, particularly when instilled during the formative years, enhance and promote respectful and harmonious partnerships between men and women.

ICPD POA Cairo 1994 7.34.

This emphasis on positively involving men in sexuality and reproduction was reaffirmed in the 1995 Fourth World Conference of Women Programme of Action in Beijing.

For more information on the ICPD, visit:

www.unfpa.org/icpd/summary.htm

For more information on Beijing, visit:

www.un.org/womenwatch/daw/beijing

UN COMMISSION ON THE STATUS OF WOMEN 48TH SESSION (2004)

Ten years after Cairo, governments from around the world convened at the 48th session of the Commission on the Status of Women (CSW) to make formal commitments to implementing a range of actions aimed at involving men and boys in achieving gender equality. These include: developing public information campaigns on the role of men and boys in promoting gender equality; ensuring men's access to and utilization of sexual and reproductive health and HIV and AIDS related services and programmes; and evaluating the impact of efforts to engage boys and men in achieving gender equality.

For more information on the CSW 48th session, visit:

www.un.org/womenwatch/daw/csw/

Creating an advocacy strategy

The first step to creating an advocacy strategy for engaging young men in HIV prevention is to carry out a need-assessment on how gender norms influence young men's attitudes and behaviours and the opportunities, programmes and services needed to effectively engage them in HIV prevention ([Link: NEEDS ASSESSMENT](#)). It is then necessary to identify the key stakeholders at different levels, from schools and communities to local and national government, and to develop clear and simple messages for mobilizing them. The core of these messages should be the “why” – in this case, the reasons for applying a gender perspective to work with young men in HIV prevention, including how socialization and gender norms shape young men's attitudes and behaviours and put both themselves and young women at risk. It is essential that the messages be tailored to the specific stakeholder and their standpoint. As will be discussed in the next section, it is particularly important to be aware of the resistances and concerns stakeholders may have in relation to working with young men and to be prepared to address them. For example, feminist groups often want to know how male involvement will directly benefit women, and want to be assured that it will not detract from funding or support for women's issues. Likewise, governments and donors often want to know how working with young men will contribute to broader social and development issues.



Neomi Onaga

Once the relevant stakeholders have been mobilized on the importance of working with young men in HIV prevention, it is necessary to define what needs to be done and how it can be done. This should be determined in collaboration with stakeholders and can range from the promotion of comprehensive sexual education in schools to the campaigning for the decriminalization of same-sex relations. As will be discussed later, building alliances should be an integral part of all advocacy actions, be it within communities and school or health systems or across different communities and institutions.

"Building alliances should be an integral part of all advocacy actions."

YOUNG MEN AND HIV PREVENTION: ADVOCACY ACTIONS

- **Promotion of Condoms** – Reducing costs and increasing availability of male and female condoms; deconstructing common myths about use and efficacy
- **Sex Education in Schools** – Supporting the implementation of comprehensive sexual education curricula in school; engaging teachers and other staff on how to question their own attitudes and behaviours related to gender and carry out effective and gender-sensitive HIV prevention educational activities
- **Young Men-Friendly Services** – Promoting sensitization and capacity-building of health services professionals.
- **Risk-reduction measure for Injection Drug Users** – Expanding access to counselling and care services, sterile injecting equipment and condoms
- **Investment in Research** – Supporting research on gaps in knowledge on young men's needs, attitudes and behaviours, including the developmental differences between young and older adolescents and acceptance among young men of female-initiated prevention methods.
- **Evaluation of programmes** – Building capacity of government, non-governmental organizations and other entities to measure the impact of interventions and policies on young men's attitudes and behaviours and health and well-being of their partners.

Addressing common concerns

Although there has been increasing recognition and evidence regarding the importance of involving men in HIV prevention, there is still some resistance to the idea, including among donors who have no tradition of men's work; women's groups who fear that resources are being shifted from the very pressing needs of girls and women; and NGOs and others who believe young men are difficult to work with (Rivers and Aggleton 2002). Some of the most common concerns and reservations related to working with young men in HIV prevention are described below. It is important to be aware of these and other concerns stakeholders may have and to be prepared to address them.

DOES SEX EDUCATION PROMOTE SEXUAL ACTIVITY AMONG PEOPLE?

Despite the fact that sexual transmission is the primary means by which young men and women are vulnerable to HIV infection, there is a strong reluctance among many parents, religious leaders, and policy-makers to provide comprehensive sexual health information and services to young people. This is often due to a belief that sex education encourages early or increased sexual activity. The evidence shows, however, that promoting information and skills-building related to communication and negotiation of sex and prevention helps to empower young people to make healthier decisions about their lives and relationships. For example, a review of more than 80 impact evaluation studies of curriculum-based sex and HIV-education programmes throughout the world demonstrated that programmes do not hasten or increase sexual behaviours, but, instead, are likely to delay or decrease sexual behaviours and increase condom or contraceptive use (Kirby et al. 2006). It is important that advocacy communication strategies incorporate this type of research and information and emphasize the need for sexual education which also addresses the various underlying social factors which influence young people's sexual behaviours and vulnerability, including gender inequalities and stereotypes ([Link: EDUCATION](#)).



Hora H

WHY SHOULD MEN CHANGE?

A common rebuke to calls for working with men in HIV prevention, or sexual and reproductive health in general, is that it is futile to expect men to change their attitudes and sexual behaviours since they are often the primary beneficiaries of gender inequalities. However, as has been discussed throughout this toolkit, rigid gender norms often also leave men vulnerable to HIV infection. Moreover, other factors, from sexual orientation to socio-economic class, may interact with gender and aspects of masculine identity to further increase vulnerability. Advocacy strategies should therefore call attention to the “double-edged nature” of gender roles – that is, the fact that the benefits and privileges often bestowed on men in patriarchal and sexist societies often also come at a cost to them and even more so for certain groups of men. This should be used as leverage for promoting awareness of the necessity for men to change and the benefits for both men and women of building relationships based on equality and mutual respect rather than fear and domination (Peacock and Levack 2004). It can also be useful to cite the increasing body of evidence that shows that men can and do change as a result of well-designed interventions, principally those which incorporate a gender perspective, and that these changes lead to benefits for both men and women (Barker et al. 2007).

WILL INVESTING IN WORK WITH MEN DIVERT RESOURCES FROM WORK WITH WOMEN?

Many women's groups and others express concern regarding the allocation of scarce health

and development resources for work with men. Indeed, women still bear the greatest burden of gender inequality and sexual and reproductive health morbidity and mortality and should be a priority focus of health and development agendas. However, it is important to keep in mind that many of women's vulnerabilities are rooted in rigid gender roles and power relations. In this context, it is important to remember that promoting women's empowerment is not only a matter of directing resources to women and girls, but, in a broader sense, investing resources to promote changes in the power dynamics and opportunities which influence women's lives and relationships (Kaufman 2003). Thus, money spent on well-designed HIV prevention programmes which seek to promote more gender-equitable behaviours among young men should be viewed as investment in a larger process of gender transformation which also benefits girls and women.

Advocacy Audience: Community Stakeholders

Advocacy is often associated with engaging government and influencing policies. However, the process of building support for working with young men needs to begin at the local level. Community stakeholders, from parents and teachers to religious leaders and popular figures, play an important role in ensuring that programmes and policies are rooted in and relevant to local realities and culture. They can also help to support and reinforce the positive changes in young men's attitudes and practices which are promoted in interventions such as workshops and campaigns. Stepping Stones, originally developed in Uganda and now used in different regions, is an example of an intervention model which incorporates community-based advocacy. The intervention consists of a series of educational workshops with young and adult men and women on gender-roles, communication, relationships and HIV prevention. The first step in the intervention is to engage community leaders and obtain their support. Subsequently, the leaders themselves invite members from the communities to participate in the workshops. This support and involvement of community leaders in implementation lends credibility to the intervention and ultimately, strengthens the community's commitment to sustaining change. Other strategies for engaging community stakeholders are presented below.

It is also important to involve community stakeholders in advocacy actions with media and government, which are described below. Among the most essential community stakeholders to engage in these various advocacy actions are young men themselves. Young men can be particularly valuable and persuasive spokespersons

for addressing media and government and for mobilizing other young men on issues related to gender-equality and HIV prevention (Ingham and Mayhew 2006). To this end, they should be provided with ample opportunities to communicate their ideas and opinions in different fora within and outside the community.

"Young men can be particularly valuable and persuasive spokespersons for addressing media and government and for mobilizing other young men on issues related to gender-equality and HIV prevention."

Advocacy Audience: The Media

Mass media is a powerful medium for shaping attitudes and opinions and can therefore be a strategic advocacy vehicle for influencing public opinion on the importance of engaging young men in HIV prevention. It is necessary, however, to first carry out advocacy directly with the media itself. This entails sensitizing media specialists (journalists, reporters, etc.) on the importance of promoting gender-equitable messages and images and the benefits of working with young men in HIV prevention. Those contacts should then be continually provided with new information on programmes and studies related to work with young men in HIV prevention. Information should be packaged in ways that capture the attention and interest of the public. For example, the dissemination of the Program H impact evaluation results in Brazil included headlines in national newspapers such as “Machismo is bad for one’s health” and “Macho men are more at risk” (see box on page 44).

Another media strategy is to identify and endorse “celebrities” such as sports players and music artists who can use their charisma and credibility to be advocates for the need to work with young men in HIV prevention. For example, the White Ribbon Campaign in Brazil recruited four well-known actors to participate in a public service announcement promoting awareness of the issue of violence against women and urging

men to be allies in prevention. In addition to celebrities, advocacy media efforts should also identify and recruit “everyday” men who can share their stories of how they challenge non-equitable gender stereotypes in their daily lives and relationships. These men can help to mobilize the attention of the general public and reinforce the possibilities for men to make changes in their own lives.

INVOLVING COMMUNITY STAKEHOLDERS

- Present how engaging young men in HIV prevention efforts will benefit the community as a whole.
- Provide concrete suggestions on how they can help support positive attitudes and behaviours among young men and others
- Involve them in baseline analysis of the needs and realities of youth
- Include them on advisory committees for the design and/or evaluation of efforts
- Ask them to participate in reviewing campaign messages, educational curricula and other materials.
- Keep them regularly informed of activities
- Invite them to ceremonial occasions, possibly as guest speakers in workshops
- Encourage them to be advocates for the cause and to speak to others about its value



(Translation: Violence against women is a serious matter)

In 2003, four well-known Brazilian comedy actors lent their images to a national campaign to raise awareness amongst the general public about the issue of violence against women and the need for men to be involved in prevention efforts. The actors appeared in TV and radio spots and the poster shown here.

For more information visit the Brazilian White Ribbon Campaign website at: www.lacobranco.org.br

GLOBAL YOUTH PARTNERS – YOUTH AND ADULTS WORKING TOGETHER

Founded in 2003 by a group of young people from more than 25 countries, Global Youth Partners is a youth-driven advocacy campaign which aims to mobilize local and national governments, NGOs, donors, the media, faith-based organizations and the private sector to prioritize young people in their HIV and AIDS response. It builds on and draws from the philosophy of youth-adult partnerships, in which both youth and adults have the opportunity to make suggestions

and decisions, and the contribution of each is recognized and valued. The youth-adult partnership model not only enhances the effectiveness and sustainability of the campaign, but also provides valuable capacity-building opportunities for the youth involved.

For more information visit the Global Youth Partners page on the UNFPA website: www.unfpa.org/hiv/gyp

Advocacy Audience: Government

In terms of government policies, there is a lack of attention across settings to the gender-specific needs and realities of young men and strategies for their meaningful involvement in the promotion of gender equality and health. Existing gender policies often only contemplate women. Likewise, many youth policies which do recognize gender as a variable also only focus on young women. While it is indeed necessary to have specific policies which promote the empowerment of girls and women and their inclusion in programmes and services, the absence of a gender perspective which also involves men can ultimately detract from the effectiveness of these policies.

UNGASS: ENGAGING GOVERNMENTS IN HIV PREVENTION WORK WITH YOUTH

In June 2001, the governments of 189 countries gathered at the first-ever United Nations General Assembly Special Session on HIV and AIDS (UNGASS). The session aimed to mobilize leadership at the highest levels and intensify international action in prevention, support, treatment and general care of people living with HIV, as well as to combat discrimination against HIV positive individuals, reduce the vulnerability of populations most at risk of contracting HIV (injection drug users, sex workers, mobile populations, and support AIDS orphans. The governments in attendance unanimously adopted a Declaration of Commitment (DOC) which outlined a series of targets and promises for responding to the epidemic. The DOC is an important advocacy tool for promoting policies and programmes which engage young people, including young men, in HIV prevention efforts and garnering support for local and national organizations and networks. It highlights the need to focus

on young people as a fundamental part of the response to the epidemic and calls upon governments to provide youth with access to information and prevention programmes that help develop the necessary life skills to reduce their vulnerability to HIV infection.

In 2006, UNGASS reconvened to confirm and build upon the previously set targets. The documents from the 2006 meeting include strong youth language, demanding increased attention to the growing HIV and AIDS epidemic among youth worldwide, and the promotion of safer sexual behaviours through condom promotion, HIV and AIDS education, mass media interventions, and youth friendly health services.

For more information visit the UNAIDS and UNGASS websites:

www.unaids.org

www.un.org/ga/aids

In this context, it is important to raise the awareness of government on the need to incorporate young men and a broader gender perspective in youth, health and other policies relevant to HIV prevention. For example, one focus of advocacy efforts with the government can be the collection and analysis of gender-disaggregated data related to behaviours and HIV and AIDS vulnerability. Many governments oversee or participate in large-scale censuses or surveys which collect information on incidence of STI's and HIV and AIDS and related behaviour indicators. The gender disaggregation of this information can provide valuable insights for programme planners and advocates on differential behaviours and prevention needs of men and women.

Advocacy efforts with government should also include strategies for integrating successful HIV prevention strategies in government agendas. To date, most successful interventions with young men have been mostly NGO-led, limited in duration and generally only reach several hundred to at most a few thousand. The integration of workshops, campaigns and other activities in government settings such as public schools and the military can help to achieve the large-scale and sustained reach necessary to change existing gender norms and power dynamics related to the HIV and AIDS vulnerability of young men and women.

Building Alliances

Building alliances are a cornerstone to effective and sustainable advocacy. This involves bringing together diverse organizations and stakeholders in advocating for the inclusion of young men and a gender perspective in HIV and AIDS policy and programme agendas. The collective voices of these diverse organizations and stakeholders can help to draw greater attention from government, media, and the general public to the importance of working with young men. Alliances can be local, national, regional or international and can include diverse organizations, from civil society groups and religious institutions to private sector and government.

"It is important to raise the awareness of government on the need to incorporate young men and a broader gender perspective in youth, health and other policies relevant to HIV prevention."

The first step to building an alliance is to identify organizations which would be particularly strategic to include in programme and advocacy efforts related to young men and prevention, including: organizations that have access to young men who are generally hard to reach (e.g. out-of-school or migrants groups); organizations which offer services

that are particularly attractive to young men (e.g. athletic associations) and; organizations which have reach and influence with large numbers of young men (e.g. labour unions, military). The reflection activity included in the tools section is useful for examining the benefits and obstacles of building alliances amongst diverse organizations.

ALLIANCES WORKING TO ENGAGE MEN TO PROMOTE GENDER-EQUALITY

Democracy and Sexuality (DEMYSEX) is a Mexican network of more than 162 civil society, government and academic organizations working in the fields of sexual education and advocacy of sexual rights. The network carries out research, capacity-building and advocacy with government, parents, youth leaders, educators and the general public.

For more information visit the DEMYSEX website:
www.demysex.org.mx

MenEngage is a global alliance of several major international organizations as well as local and national groups with extensive experience in engaging men and boys in gender equality and the reduction of gender-based violence. The goal of the alliance is to increase the number of men and boys reached by interventions that promote and engage them in gender equality and violence prevention. To achieve this, MenEngage implements three complementary strategies: 1) advocacy and policy; 2) a learning and leadership network; and 3) resource sharing in the form of a global online web-based portal.

For more information visit the MenEngage website:
www.menengage.org

TOOLS

- Developing a Fact Sheet about Young Men and HIV prevention
- Reflection Activity: Building Alliances

NEEDS-ASSESSMENT, MONITORING AND EVALUATION



NEEDS-ASSESSMENT, MONITORING AND EVALUATION

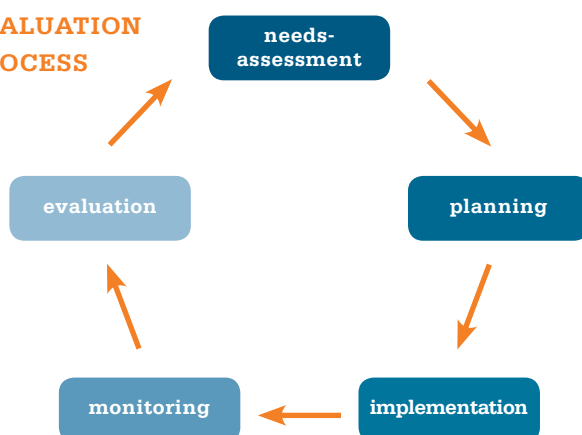


Christine Ricardo

Introduction

Evaluation is a fundamental part of programme efforts to engage young men in HIV prevention. It can demonstrate the impact of activities and help to identify gaps and directions for future work. Moreover, evaluation can bolster advocacy efforts by providing evidence of the benefits related to working with young men. Too often, however, programmes do not carry out adequate evaluation of their activities, for a variety of factors, including lack of financial or material resources; lack of qualified and experienced personnel; lack of organizational experience with evaluation; and the fact that it is not always easy to collect information about issues related to HIV and AIDS or sexual and reproductive health, due to the delicate nature of these topics. To help address these factors, this module provides explanations and tools related to key steps in the evaluation process: (see below).

EVALUATION PROCESS



The evaluation process seeks to answer questions such as “What should we do?”, “Are we on the right path?”, “Did it work? What parts worked and why?” (Chapman 2004)

Needs assessment

A needs assessment is the process of defining the various factors that influence the attitudes and behaviours of young men related to HIV prevention, the gaps in access to and quality of information and prevention services and, subsequently, the types of interventions that would help to address these gaps. It can include carrying out research firsthand and/or collecting and analyzing data from secondary sources (see boxes on pages 100-101). The research and/or data which is used should include the voices and reflections of young men themselves, as well as the diverse actors that interact with them and influence their attitudes and behaviours, such as intimate partners, parents, teachers, community leaders, among others. As part of the needs-assessment process, it is worthwhile to also identify other organizations that work or are interested in working with young men. These organizations might be able to furnish data and instruments from their own studies and can also be valuable collaborators in the design and implementation of interventions and advocacy activities.

OBJECTIVES OF A NEEDS ASSESSMENT

- Define the nature and extent of the problem (e.g. unsafe sexual behaviour; injecting drug use), in the local context
- Map the perceptions and experiences of young men and other stakeholders in relation to the problem
- Identify existing strategies and activities which address the problem
- Identify gaps in existing strategies and activities

It is common to confuse a needs assessment with a pre-test. The objective of a needs assessment is to identify gaps in information, services, etc, and propose an intervention to address these gaps. A pre-test specifically measures knowledge, attitudes and practices of young men who are targets of an intervention before the implementation of the intervention begins.

TYPES OF DATA

There are two types of data that can be used to inform needs-assessments, monitoring and evaluation activities. These are **primary data**, which is collected directly from the target population through quantitative and qualitative methods (see Table on page 100); and secondary

data, which is data that has previously been collected from the target population and can be used to corroborate primary data. Examples of the latter include health records from local health services and national and local epidemiological or Demographic and Health surveys.

EXAMPLES OF HOW YOUNG MEN CAN BE INVOLVED IN THE EVALUATION PROCESS

- Identifying young men and other key informants to participate in the needs assessment.
- Helping to pre-test need-assessment and evaluation questionnaires to ensure that the language and content will be adequately understood by respondents.
- Applying the surveys and/or carrying out interviews and focus groups (as long as they have been trained and do not live in the same community as the respondents).
- Participating in the analysis and dissemination of the need-assessment and evaluation results.

Planning

After the needs assessment, the next step is to develop intervention objectives and strategies (such as educational activities, health services, community campaigns and/or advocacy) and define the duration of the intervention, number and variety of individuals to be engaged, etc. It is also during this planning phase that the monitoring and evaluation plan and instruments are developed. An important tool for planning, as well as monitoring and evaluation, is the log frame (see tools). It entails defining and describing goals, activities, indicators, means of verification and risks/assumptions related to the successful implementation of the project and, when used accurately and consistently, can help to increase the probability that an intervention will be a success.

QUESTIONS FOR PLANNING

- What are the goals of the intervention?
- Who will be the target population(s)? How will they be engaged?
- What strategies will be used to reach these goals?
- What is necessary to ensure that the intervention is a success?
- What indicators will be used to measure success?
- What problems may occur during implementation? How will they be addressed?

Monitoring

Monitoring is the process of ensuring that activities are implemented as planned and identifying necessary adjustments in the work plan and/or use of resources. A monitoring plan should be developed prior to the onset of activities and should include process indicators such as money and time expended (quantitative) and response and feedback from staff and participants (qualitative). For example, the monitoring of educational workshops can include tracking of the number of workshop sessions and participants present at each session (quantitative) and weekly meetings between the evaluation team and the facilitators and activity reports which the facilitators complete after each workshop session (qualitative).

DIFFERENCES BETWEEN MONITORING AND EVALUATION

MONITORING

- Continuous process that is done in parallel with the implementation of the programme.
- Follows the progress of the implementation of activities.
- Focus on inputs to be used.
- Answers which activities were conducted and the results obtained.
- Recommends adjustments to reach the proposed objective.

EVALUATION

- Conducted at specific points in time depending on the type of evaluation.
- Comparative analysis of what was planned and the changes that occurred.
- Focuses on the results obtained.
- Answers how and why specific results were obtained.
- Informs programming and policy discussions

Source: John Snow Brasil 2000 and UNFPA 2004.

Evaluation

Evaluation is defined as “a time-bound exercise that attempts to assess systematically and objectively the relevance, performance and success, or the lack thereof, of ongoing and completed programmes” (UNFPA 2004).

In organizing an evaluation plan, the following questions can be a useful guide (UNFPA 2004):

- (1) **WHY:** What is the goal of the intervention and evaluation and who should benefit from the results? The beneficiaries can include the target population as well as implementing organizations and the broader field of research.

Examples

- Was the intervention successful in preventing the transmission of HIV in young men from a specific community?
- Did the intervention result in a 25% increase in condom usage by young men in their last sexual relation with their fixed partners? Could this increase have been greater if the intervention targeted young men who go to health centres in the community and not only those in school?
- Are young men using condoms more often after the intervention?
- Do the results contribute to a discussion at the federal or local level regarding public policies which address young men?

OBJECTIVES OF AN EVALUATION

DESCRIBE THE RESULTS OBTAINED

What changes were observed in knowledge, attitudes and behaviours among young men and/or others who were reached by the intervention?

ESTIMATE THE IMPACT

Which of these changes were solely attributable to the implementation of the intervention? Would these changes have occurred if there had not been an intervention?

DESCRIBE THE COSTS OF THE INTERVENTION

How much did it cost to reach the planned objectives? How much would be needed to replicate this intervention in another context?

IDENTIFY THE LESSONS LEARNED AND MAKE RECOMMENDATIONS

How can the results of the evaluation inform new actions which can strengthen the intended impact? How can objectives, goals, organizational structures and resources be adjusted and modified?

VALIDATE SUCCESSFUL STRATEGIES AND INTERVENTIONS

How can the evaluation make it possible to replicate the intervention in other contexts? How can the evaluation bolster advocacy efforts for increased involvement of young men in HIV prevention programming and policies?

(2) **HOW:** What would be the best evaluation design? Will there be a pre-test (before the intervention) and a post-test (after the intervention) or only a post-test? Will all the data be quantitative, qualitative or both? Will there be a control group?

(3) **WHO:** Who will coordinate and work on the evaluation? Are they experienced with quantitative and/or qualitative research methods and analysis of data? How will stakeholders and young men be involved (not necessarily the same young men who will be direct beneficiaries of the intervention, but young men representatives)?

(4) **HOW MUCH:** How much money will be needed to carry out the evaluation? In general, qualitative evaluations are less costly, but require more time for analysis. Quantitative evaluations, on the other hand, are generally more expensive due to the cost involved in hiring and training interviewers, producing copies of questionnaires, and entering and cleaning the data. The box on page 99 presents the scale of resources needed for different research designs.

- **Very limited resources** = needs assessment + process evaluation + pre and post qualitative
- **Limited resources** = needs assessment + process evaluation + pre and post quantitative and qualitative
- **Modest resources** = needs assessment + process evaluation + pre and post quantitative and qualitative + control group
- **Sufficient resources** = needs assessment + process evaluation + pre and post quantitative and qualitative + triangulation (e.g. in-depth interviews with young men's partners) + control group

There are two basic questions which an evaluation should answer: were any changes observed during the duration of the project? And can the observed changes be attributed to the intervention?

Evaluation study designs

The choice of an evaluation study design is one of the most important methodological decisions in planning a study.

Among the many types of study designs, the three most common are:

(1) EXPERIMENTAL: This is considered to be the best design, or the gold standard, for measuring the results of a project. It consists of randomly selecting individuals to take part in the experimental group (the one that will participate in the intervention) and the control group (the one that will not participate in the intervention or in a different design and intensity of the intervention). As described in the box on page 99, the control group serves as a marker of the changes that would have occurred without the intervention or with an intervention of a different design and intensity. The main limitations of this design are: (1) drop-out of individuals in the control group due to the fact that they are not participating in an intervention; (2) possible overestimation of the results in the intervention group because only those who are highly motivated are likely to remain to the end; (3) ethical questions, since when only one group is designated to receive an intervention, other individuals are being refused access to the potential benefits of the intervention.

Examples

- In South Africa, 70 villages were randomly selected to participate in the Stepping Stones programme or to be part of a control group. Young men and women (40 from each village) were invited to participate

in 13 educational sessions about gender, relationships, and HIV prevention – using the Stepping Stones educational curriculum – or to participate in the control group and receive a three-hour session about HIV prevention, depending in which village they lived (Jewkes et al. 2007).

A total of 3,274 “uncircumcised” males, between 18 and 24, were randomly selected to participate in an intervention or a control group to evaluate the association between circumcision and HIV prevention. Male circumcision was offered to those that were in the intervention group and those in the control group were only offered circumcision at the end of the study (Auvert et al 2005).

(2) QUASI-EXPERIMENTAL: This study design also includes an experimental and control group, however, individuals are not randomly assigned to the two groups. After the individuals for the experimental group have been selected, a control group is formed of individuals with a comparable profile, or similar characteristics to the experimental group. The main limitation of a quasi-experimental study is that it is difficult to generalize results to a larger population since those individuals selected or recruited for the experimental group are likely to be more motivated or involved than their peers.

Examples

- In Rio de Janeiro, Brazil, the impact evaluation study of Program H involved 780 young men from three low-income communities. In the first community, the intervention included a community campaign and educational workshops. In the second community, another intervention included only educational workshops. The third community served as a control group while activities were ongoing in the first two communities. After the intervention was completed in the first two communities, a reduced number of the educational workshops were then offered to the young men in the third community. Data was collected in all three communities prior to the intervention (pre-test), immediately after the intervention (post-test 1) and six months following the intervention (post-test 2). Data collection methods included the application of a detailed questionnaire with all of the young men and in-depth interviews with a selection of young men and their partners (Pulerwitz et al 2006).

- In Nicaragua, a quasi-experimental design was used to evaluate a five-month violence prevention campaign which targeted men and whose theme was “Violence against women: a disaster we, as men, can prevent”. The design involved applying a pre-test and post-test questionnaire with men from 20 population groups in nine administrative regions. The questionnaires were applied through house to house visits. In the post-test, the questionnaires were also applied to 660 women who had had some contact with the campaign. In-depth interviews and focal groups with selected men, women and local leaders were carried out before and after the campaign, as well as during. (Solórzano 2000)

(3) NON-EXPERIMENTAL: This research design does not use random assignment or a control group. It is a purely descriptive design as it does not allow the researcher to explore cause and effect issues that is, whether the changes or results observed could be attributed to the intervention.

Example

- After a two-hour workshop on safe sex and HIV and AIDS, participants answer a short questionnaire on which points of the presentation were new and/or most relevant to them.

TRIANGULATION

Triangulation is a research process that includes the use of three separate methods to acquire information to help assess the validity and reliability of the findings of a study. It generally includes the use of both qualitative and quantitative methods with the individuals directly reached by the intervention, or the primary study group,

and other stakeholders, such as partners, family members, community leaders or health service providers. In an intervention with young men, for example, triangulation could include applying a questionnaire with the young men themselves and carrying out in-depth interviews with a select number of young men and their partners.

THE PURPOSE AND DESIGN OF A CONTROL GROUP

Control groups provide a basis of comparison from which the researcher can identify which results are attributable to the intervention, and which are attributable to factors external to the intervention. Participants in a control group should have similar characteristics to those participating in the experimental groups and the only significant difference between the two groups should be that the control group does not receive the intervention, or it receives a different “dose” of the intervention. For example, in the Stepping Stones study described above, the experimental group participated in 13 sessions on HIV and AIDS and gender whereas the control group participated in only one session on HIV and AIDS. In this case, the “dose” for the control was a lesser number of sessions and narrower focus in the content (only HIV and AIDS, not gender). This option of a lesser “dose” for a control group rather than no intervention at all is

generally more attractive for ethical reasons since it ensures that all participants in the study design receive some minimal type of information or service.

Randomization is considered the most reliable and impartial method for organizing control and experimental groups. It entails assigning participants to groups by chance not by choice so that each participant has an equal chance of being in either group. In this way, randomization helps to produce comparable groups in terms of general characteristics, such as age, gender and other key factors that may influence how they might respond to the intervention.

If randomization is not possible or feasible, researchers should still try to ensure that the profiles of participants who were selected for the control and experimental groups are comparable.

TYPES OF INDICATORS

TOPICS	KNOWLEDGE	ATTITUDE	BEHAVIOUR
HIV Prevention	Is it possible to get HIV and AIDS eating from the same dish as someone who has HIV and AIDS?	Is it the man who decides whether or not to use a condom?	In the last month, how many times have you used a condom with your regular partner?
HIV Testing	How soon after possible exposure to HIV and AIDS should you take the test?	Is it a sign of distrust to ask a partner to take the HIV test?	Have you ever taken the HIV test? Have you ever spoken to your partner about the test?
Reproductive Health	Are there periods when a woman has a greater chance of getting pregnant?	Should the couple decide together whether they want to have a child?	Have you and your partner ever spoken about preventing pregnancy? Who initiated the discussion?
Violence	Is it against the law for a husband to hit his wife?	Are there situations when a woman deserves to be hit?	When you get angry what is your most common reaction towards your partner?

DATA COLLECTION METHODS (PART I)

QUANTITATIVE METHODS

Describes “when” and “how many times” a certain event or experiences occurs.

Requires a large sample size and staff acquainted with statistical methods.

Data collection instruments are generally closed questions.

- advantages: allows for greater objectivity and accuracy regarding certain events or experiences.
- disadvantages: does not provide an in-depth description of events or experiences.

QUALITATIVE METHODS

Describes the “how” and the “why” of a certain event or experience.

Requires a small sample size and staff acquainted with qualitative analysis.

Data collection instruments are generally scripts with open-ended questions to explore the nuances of an event.

- advantages: provides greater level of depth and detail than quantitative methods.
- disadvantages: fewer subjects tend to be studied which makes it difficult to generalize findings.

DATA COLLECTION METHODS (PART II)

QUANTITATIVE METHODS

Quantitative surveys can be administered in two ways:

Self-administered questionnaire

filled out by the interviewee. It is a less expensive form of data collection but it demands that the interviewees have sufficient writing and reading skills.

- advantages: lower cost than interviewer-administered; interviewee might feel more comfortable to disclose private or intimate information.
- disadvantages: requires some form of supervision to ensure that questions are not skipped or left unanswered; might be difficult to interpret the interviewee's responses to open-ended questions if the handwriting is not clear.

Interviewer-administered questionnaire

the interviewee responds to a questionnaire applied by an interviewer. The interviewer should be trained to not react to or influence the interviewee's answers.

- advantages: questionnaires are more likely to be completed correctly and completely.
- disadvantages: high cost since the interviewers are generally paid; interviewee might not feel comfortable to answer private or intimate questions.

QUALITATIVE METHODS

The most common qualitative methods are:

Focus groups

utilizing scripted questions, a moderator coordinates a "conversation" with 8-12 people to explore a specific topic. Answers are not limited to agree and disagree, but describe why and how a specific event occurs. It is essential to determine the criteria for participation in a group (Young men between 15 and 18? 19 and 24? Only young men with stable partners? Should the groups include young women and young men?).

- advantages: low cost.
- disadvantages: may be difficult to get in-depth answers from participants.

In-depth interviews

similar to the focus group, there is also a script of questions that serve as guide for discussion. But, differently from focus groups, the interview occurs only between the interviewer and the interviewee which allows for a greater depth of information collection.

- advantages: provides opportunity to get in-depth description of an event or experience.
- disadvantages: interviewee might not feel comfortable to answer private or intimate questions.

Practical considerations for conducting a study

Before the questionnaires can be applied or the focus groups carried out, be it for an evaluation or needs-assessment, there are some important preparatory steps to ensure that the study is carried out well, these include:

PRE-TESTING THE STUDY TOOLS: This is essentially the “rehearsal” for the administration of the study instruments (e.g. questionnaire, focus group guide) with people who will not participate in the official study, but who share similar characteristics with those who will. It is the opportunity to confirm that the language and content of the instruments will be understood clearly by the interviewees. Some questions to be considered at this point: Are the questions logical? Is the language appropriate for the interviewees? Are some questions repetitive? What is the average time for filling out the instrument or for carrying out the interview or focus group discussion? Was the questionnaire filled out completely or did anyone give up before the end of the questionnaire? Why did they give up?

ACQUIRING APPROVAL FROM THE LOCAL ETHICS COMMITTEE: In some countries there

are government bodies that regulate how research is carried out, including how information is collected from subjects and how it is handled afterwards. Once the local ethics committee approves the research protocol, a point person or persons should be elected to supervise the field work in order to ensure that approved steps and guidelines for the collection of information are followed.

CREATING AN INFORMED CONSENT FORM: This document serves to inform individuals who will participate in the study on the objectives of the study and how their responses will be analyzed and used, including how the study will help improve their situation. When the interviewees are minors, their guardians (mother or father) should sign the consent form. In the case that the interviewees or their guardians have difficulty reading, it is necessary to get verbal authorization and record it.

DATA INPUT AND CLEANING

- Data input: What software (SPSS, SAS, STATA, Excel, Sphinx, Epi Info, etc.) will be used?
- Data cleaning: This process evaluates the input of data into the data banks, verifying if there are errors, inconsistencies and/or incoherencies among the answers. For example: in a sample of 250 young men, 200 responded to question number 30 saying that they used a condom the last time they had sex with their fixed partner. On the other hand, in question number 25, 197

young men reported having had sex with their fixed partner. Therefore, there is a difference of three young men. In this case, the questionnaires of the three respondents would need to be located to verify whether the discrepancy is a result of error during the input of the data or the administration of the questionnaire. If the error is from the application of the questionnaire, it may be necessary to follow-up with the interviewee to confirm the correct information.

DATA ANALYSIS

After cleaning the data bank, it is possible to start analyzing. The key question here is: what types of analyses will be done? In this phase, you can create some simple frequencies, correlations, regressions, T tests, etc. More sophisticated analyses require a professional with statistical knowledge who will know which tools to use.

CALCULATING FREQUENCIES

The first step is to determine the simple frequencies, in other words, measure the differences in percentages of the answers between pre and post test.

- Example 1 - 60% of young men completely disagreed that it is possible to get AIDS eating from the same plate as someone who has AIDS in the pre-test. In the post-test this number was 85%.
- Example 2 - 50% of young men agrees with the statement that both the man and the woman can propose using a condom in the pre-test. In the post-test, the percentage reached 78%.

IDENTIFYING ASSOCIATIONS BETWEEN VARIABLES

Another type of analysis is to verify the relationship between at least two variables. There are various types of relations that can be made: chi-square, T test, regressions, etc.

- Example 1 – among the 85% that correctly answered the questions about HIV and AIDS transmission in the pre-test, 35% had secondary education, 60% are Black, 80% live with their parents.
- Example 2 – of the 50% of young men that had a more traditional view of gender, 35%

had committed some form of physical violence against their partner

COST-ANALYSIS AND COST-EFFECTIVENESS

After conducting a cost analysis by specifying the cost of the intervention per beneficiary, a cost-effectiveness analysis can also be conducted. Cost-effectiveness analysis seeks to measure the relative cost of different methods of reaching an objective and evaluate whether the maximum result was obtained utilizing the minimum resources possible. It is important to remember that an evaluation that seeks to measure cost-effectiveness requires specialized personnel and a large amount of information.

- Example 1 (Cost analysis) – the total cost of two interventions (one of them combining educational sessions and a community campaign and another with only educational sessions) were US\$35,856.87 and US\$21,060.28, respectively. The cost per young person was US\$138.98 in the first community and US\$84.24 in the second community.
- Example 2 (Cost effectiveness) – In the same study described above, the cost-effectiveness is calculated by selecting an outcome unit that represents change and calculating the cost of the intervention in each location per outcome unit. An example of an outcome unit can be the number of HIV infections prevented. If 500 new HIV infections were prevented in the first community and 200 in the second community, the cost-effectiveness of the combined intervention would be \$71.71 and the cost-effectiveness for the education-only intervention would be \$105.30.

The informed consent form should contain:

- Presentation of the organization that is responsible for the study.
- Presentation of the objective and design of the study and the interview and any risks or benefits.
- Confidentiality of interviewee's answers, or, a guarantee that their answers will not be used with their names.
- Some information about the interviewee and his/her signature agreeing to participate in the study.

SELECTING AND TRAINING THE INTERVIEWERS:

The selection of the individuals who will apply the questionnaires (in the case that they are not self-administered) and who will carry out the interviews and focus groups should be carefully considered. In the case of a needs-assessment study, the interviewers can be the same who are directly involved in organizing the study, however,

in the case of an evaluation study, the interviewers should be individuals who are not directly involved in the intervention itself. A common question that arises in the selection of interviewers is whether they should be the same sex as the interviewees. In the case of intimate issues such as sexual behaviours, it is generally recommended that male interviewers apply questionnaires or carry out interviews and focus groups with men, and vice versa, that female interviewers do so with women. However, what is most important is that the interviewer be sensitized to the issues and able to apply the questionnaire or carry out the interview or focus group in a way that does not induce answers from the interviewees. Training for the interviewers should cover the design and objective of the study and the complexity of the issues at hand, as well as provide ample opportunity for them to become familiar and comfortable with the instruments.

Conclusion

The evaluation process can be a considerable investment in technical and financial terms, but it is highly necessary to ensure that resources are maximized and that programme efforts are effective. There have been many innovative efforts to engage young men in HIV prevention, however, too few of these efforts have been adequately evaluated and documented. For programmatic purposes, as well as funding and advocacy ones, it is important to increase the body of evaluation studies on work with young men as well as the dissemination and exchange of lessons learned and recommendations.

TOOLS

- Sample Logical framework
- The Gender Equitable Men (GEM) Scale: Measuring Attitudes toward gender norms

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DEVELOPMENT STAGES OF YOUNG MEN

	10-15 YEARS		16-20 YEARS		21-25 YEARS
PHYSICAL PHASES	First ejaculation; testicular growth; growth spurt	→	Growth spurt usually ends.		
WORRIES	Will my friends make fun of me? Am I normal? What is happening to my body?	→	Do I have to have sex? Will my friends think that I am a man? Will they think that I am gay?	→	How do I get along with women? Can I live with just one? Do I want children? What kind of relationship do I want? What type of relationship do I want?
WHERE TO REACH ME	School, youth programme, community support groups	→	School, workplace, military, sports	→	Workplace, university, community
RELATIONSHIPS	Usually still nervous with partners; sexual experimentation without penetration in most cases; masturbation—self and with others.	→	First sexual relationship with penetration usually occurs	→	More stable relationships, fatherhood (for many)
SERVICES	Mostly information services for other needs	→	Condoms, STI testing, HIV testing	→	Fatherhood support (accompany partner)

ACT LIKE A MAN, ACT LIKE A WOMAN

This activity is adapted from “Men as Partners: A Program for Supplementing the Training of Life Skills Educators” developed by Engender Health and The Planned Parenthood Association of South Africa. For more information visit the Engender Health website: www.engenderhealth.org/ia/wwwm/wwwmo.html

Objective

To recognize that it can be difficult for both men and women to fulfil the gender roles that society establishes.

Materials required

Flipchart paper, markers, and tape

Recommended time

45 minutes

Procedure

(1) Ask the participants if they have ever been told to “act like a man” or “act like a woman” based on their gender. Ask them to share some experiences in which someone has said this or something similar to them. Why did the individual say this? How did it make the participant feel?

(2) Tell the participants that we are going to look more closely at these two phrases. By looking at them, we can begin to see how society can make it very difficult to be either male or female.

In large letters, print on a piece of flipchart paper the phrase “Act Like a Man.” Ask the participants to share their ideas about what

this means. These are society’s expectations of who men should be, how men should act, and what men should feel and say. Draw a box on the paper, and write the meanings of “act like a man” inside this box. Some responses might include the following:

- Be tough.
- Do not cry.
- Show no emotions.
- Take care of other people.

(3) Now in large letters, print on a piece of flipchart paper the phrase “Act Like a Woman.” Ask the participants to share their ideas about what this means. These are society’s expectations of who women should be, how women should act, and what women should feel and say. Draw a box on the piece of paper, and write the meanings of “act like a woman” inside this box. Some responses may include the following:

- Be passive.
- Be the caretaker.
- Act sexy, but not too sexy.
- Be the homemaker.

(4) Once you have brainstormed your list, initiate a discussion by asking the questions below.

Discussion Questions

- Can it be limiting for a woman to be expected to behave in this manner? Why?
- What emotions are women not allowed to express?
- How can “acting like a woman” affect a woman's relationship with her partner and children?
- How can social norms and expectations to “act like a woman” have a negative impact on a woman's sexual and reproductive health?
- Can women actually live outside the box? Is it possible for women to challenge and change existing gender roles?
- Can it be limiting for a man to be expected to behave in this manner? Why?
- Which emotions are men not allowed to express?
- How can “acting like a man” affect a man's relationship with his partner and children?
- How can social norms and expectations to “act like a man” have a negative impact on a man's sexual and reproductive health?
- Can men actually live outside the box? Is it possible for men to challenge and change existing gender roles?

What would make it easier for men and women to live outside of the boxes?

Closing

The roles of men and women are changing in our society. It has slowly become less difficult to step outside of the box. Still, it is hard for men and women to live outside of these boxes.

PERSONS AND THINGS

This activity is adapted from the Programme H manual developed by four Latin American NGO's: Promundo (Rio de Janeiro, Brazil - coordination), ECOS (São Paulo, Brazil), Instituto PAPAI (Recife, Brazil), and Salud y Género (Mexico). For more information about Programme H see page 44.

Objective

To increase awareness about the existence of power in relationships and reflect on how we communicate about and demonstrate power in relationships.

Materials Required

none

Recommended Time

1 hour and 30 minutes

Procedure

(1) Divide the participants into two groups with an imaginary line. Each side should have the same number of participants.

(2) Tell the participants that the name of this activity is Persons and Things. Choose at random one group to be the "things" and one group to be the "persons."

(3) Read the following directions to the group:
a) THINGS: You cannot think, feel, or make decisions. You have to do what the "persons" tell you to do. If you want to move or do something, you have to ask the person for permission.

b) PERSONS: You can think, feel, and make decisions.

Furthermore, you can tell the things what to do.

NOTE: It might be helpful to ask for two volunteers to first act out for the group how a "person" might treat a "thing."

(4) Ask the "persons" to take the "things" and do what they want with them. They can order them to do any kind of activity.

(5) Give the groups five minutes for the "things" to carry out the designated roles.

(6) Finally, ask the participants to go back to their places in the room and use the questions below to facilitate a discussion.

Discussion Questions

- For the "things," how did your "persons" treat you? What did you feel? Why? Would you have liked to have been treated differently?
- For the "persons," how did you treat your "things?" How did it feel to treat someone as an object?
- Why did the "things" obey the instructions given by the "persons?"
- Were there "things" or "persons" who resisted the exercise?

- In your daily life, do others treat you like “things?” Who? Why?
- In your daily life, do you treat others like “things?” Who? Why?
- Why do people treat each other like this?
- What are the consequences of a relationship where one person might treat another person like an “thing”?
- How does society/culture perpetuate or support these kinds of relationships where some people have more power over other people?
- How can this activity help you think about and perhaps make changes in your own relationships?

Closing

There are many different types of relationships in which one person might have more power over another person. The unequal power balances between men and women in intimate relationships can have serious repercussions for the risk of STIs, HIV and AIDS, and unplanned pregnancy. For example, a woman often does not have the power to say if, when, and how sex takes place, including whether a condom is used, because of longstanding beliefs that men should be active in sexual matters and women should be passive (or that women “owe” sex to men). In other cases, a woman who is dependent on a male partner for financial support might feel that she does not have the power to say no to sex. In cases of cross-generational sex, the age and class differences between men and women can further create unequal power relations that can in turn lead to risk situations.

There are also other examples of power relationships in your lives and communities. Think of relationships between youth and adults, students and teachers, employees and bosses. Sometimes the power imbalances in these relationships can lead one person to treat another person like an object. As you discuss gender and relationships between men and women, it is important to remember the connection between how you might feel oppressed, or treated like “objects,” in some of your relationships and how you, in turn, might treat others, including women, like “objects.” Thinking about these connections can help motivate you to construct more equitable relationships with women in your homes and communities.

WANT...DON'T WANT, WANT...DON'T WANT

This activity is adapted from the Programme H manual developed by four Latin American NGO's: Promundo (Rio de Janeiro, Brazil - coordination), ECOS (São Paulo, Brazil), PAPAI (Recife, Brazil), and Salud y Género (Mexico). For more information about Programme H see page 44.

Objective

To stage situations that occur in negotiating abstinence or sex in intimate relationships, incorporating the arguments on the pros and cons of abstinence.

Materials required

Flip-chart paper and markers

Recommended time

2 hours

Planning tips/notes

During this activity some young men are asked to role play women. This is not always easy for young men and it should be presented as optional (an alternative procedure can be to involve the young men in a debate, rather than role play, based on the scenarios presented). In the case of the role play, it is likely that some young men will laugh during the exercise. It is important to understand how some of this laughter could be due to the awkwardness, or even discomfort, that the young men feel playing the role of women or seeing other young men play the role of women. The facilitator should be flexible to these kinds of responses, and if the moment is appropriate,

he should remind the young men of previous discussions about gender and encourage them to reflect on why we often respond in certain ways when we see men taking on traditional female roles or characteristics.

If time allows, this activity can also be used to have the group stage out the negotiation of condom use in an intimate relationship, or other possible issues such as deciding upon the number of children or how to spend household income.

Procedure

(1) Divide the participants into 4 groups and assign each group a topic of discussion from the table below.

GROUP TOPICS OF DISCUSSION

- | | |
|-----------|---|
| M1 | Reasons why men want to have sex |
| M2 | Reasons why men do not want to have sex |
| W1 | Reasons why women want to have sex |
| W2 | Reasons why women do not want to have sex |

(2) Explain that the groups (or volunteers from the groups) will be paired together to negotiate abstinence

and sex. Allow the groups 5 minutes beforehand to discuss and prepare for the negotiations.

(3a) The first negotiation:

Group M1 (men who want to have sex) negotiates with Group W2 (women who do not want to have sex). Get the individuals or groups to negotiate, imagining that the context is an intimate relationship where the man wants to have sex but the woman does not. After negotiating, ask them how they felt and what they have realized.

(3b) The second negotiation:

Group M2 (men who do not want to have sex) negotiates with Group W1 (women who want to have sex). The discussion is conducted in the same way. In both cases the facilitators write on a sheet of paper the most important arguments, both in favour and against.

(4) Open up the discussion to the larger group.

Discussion Questions

- In which way is this negotiation similar to what happens in real life?
- What makes it easier to negotiate abstinence with an intimate partner? What makes it harder?
- What happens if the negotiation happens in the heat of the moment, rather than before? Does it become easier or more difficult?
- What are the reasons why a young woman would want to have sex? To not have sex?
- What are the reasons why a young man would want to have sex? To not have sex?
- How do young men react if a woman takes the initiative in asking for sex?
- Can men ever say no to sex? Why or why not?
- Can women ever say no to sex? Why or why not?
- What have we learned from this exercise? How can we apply this in our relationships?

Closing

Many factors go into making the decision to be abstinent or to have sex. In the case of women, the fear of losing their partner or low self-esteem might lead them to accept sex. Among men, the decision to have sex might arise from peer or social pressure to prove their manhood. Moreover, communication styles, emotions, self-esteem, and unequal power relations all play a role in if and how we negotiate abstinence or sex with partners. It is important to be conscientious of how these different factors influence our own and our partner's desires and decisions and to remember that negotiation does not mean winning at all costs, but seeking the best situation for both parties.

TIPS FOR WORKSHOP FACILITATORS

- Establish ground rules regarding listening, respect for others, confidentiality, and participation.
- It is important to have a suitable physical space where activities can be carried out without any restriction of movement. Avoid classroom-style sitting arrangements. Instead, have the young men sit in a circle during discussions to promote more exchange. The space should also be private in the sense that young men should feel comfortable discussing sensitive topics and personal opinions.
- Include as much physical movement as possible to keep the participants alert and interested.
- Be friendly and create rapport with your participants.
- Be sure to dress appropriately. You should look approachable, but professional.
- Remember that information should be provided in non-authoritarian, non-judgmental, and neutral way. You should never impose your feelings on the participants.
- Be conscientious of the language and messages which are presented to young men.
- Remember that although young men often act as if they are knowledgeable about sex they often have concerns about relationships and sexual health, including about such things as puberty, penis size, and how to communicate with a female.
- Involve the young men in choosing the themes for discussion and make the themes personally meaningful. Remember to always reflect on activities and ask the participants how they can apply what they have learned in their own lives.
- Young men respond positively to participatory style activities that are entertaining and educational. For example, role plays allow young men to explore problems they might not feel comfortable discussing in other settings. Role plays also help young men practice various skills, such as negotiation, refusal, and decision-making as well as how to use a condom correctly. Remember that some young men may not be comfortable with physical contact during role playing or with taking on the role of female characters. An alternative to role plays is to use debates where participants will need to argue perspectives that they might or might not normally consider.
- Do not aim to instil fear as young men can often “switch off” or feel paralyzed.
- Encourage participants to be honest and open. They should not be afraid to discuss

sensitive issues. Encourage the young men to honestly express what they think and feel, rather than say what they think the facilitator wants to hear.

- If a participant makes an exaggerated statement or gives misinformation/myth during a discussion, try to ask for clarification and be sure to provide accurate facts and information. You can also ask if another participant has a different opinion, or if no one offers a different opinion, you can offer your own along with facts to support your view.
- Check your own assumptions. Be aware of whether young men from particular social, cultural, or religious backgrounds seem to trigger strong emotions in you. Use your reaction as an opportunity to reflect and reach past your own assumptions or prejudices.
- Have regular check-ins. Check-ins usually occur at the beginning of each session. They are a time when you can ask participants:
 - 1) How has it been since we last met?
 - 2) Has anything new happened?
 - 3) Have you talked to anyone about the issues we discussed in our last session?
- Provide further resources which young men can use to obtain more information or support about the issues discussed in the workshop. For example, you may need to tell participants where to obtain condoms or go for voluntary counselling and testing.

If important issues come up during the check-in, do not be too rigid about the planned agenda. Allow some space to deal with the young men's issues.

CHECKLIST FOR YOUNG MEN-FRIENDLY SERVICES¹

- ☐ It is easy for a young man to schedule an appointment.
- ☐ Staff who will be interacting with young men (e.g. health care providers, lab technicians, health educators, social workers, and receptionists) have been trained in how to listen to and counsel young men in a non-judgemental and culturally appropriate manner.
- ☐ During each consultation/visit, clients are provided with comprehensive information and services that respect differences in social class, family values, stages of development, race/ethnicity, and sexual orientation
- ☐ Young men are treated in a holistic manner during each visit – that is, both their medical and social needs are evaluated. Should access to a social worker or referral to a specialist be necessary, this process is as simple as possible for the young man. (This includes identifying specialists and social workers that are accustomed to working with youth, and preferably young men in particular.)
- ☐ The facility is open during hours that do not conflict with school or work. (This often requires evening and weekend hours.)
- ☐ It is easy for young men to acquire condoms or any medications they need.
- ☐ Young men are explained their right to privacy and confidentiality during visits and consultations – and these policies are strictly upheld by all staff.
- ☐ Doctors and nurses feel comfortable speaking with young men about sexual behaviours and prevention of HIV and STIs.
- ☐ Educational activities are conducted where peer educators can discuss the importance of sexual and reproductive health care. Preferably, these are conducted in separate, youth-only spaces, but they may also be conducted in waiting rooms.

1. Adapted from McIntyre (2002) and Armstrong (2003)

- ☐ When educational activities are not being conducted, some form of entertainment is available, e.g., magazines or a TV showing sports or other entertainment shows.
- ☐ The facility décor is attractive to young men and includes pictures of young men engaging in health-promoting behaviours, e.g., young men holding and/or feeding babies.
- ☐ The services provided for young men are well-advertised in the community. For example, the clinic staff frequent community events popular among young men, such as school dances or sporting events, to distribute information regarding clinic services.
- ☐ Referral relationships have been established with organizations and clinics that specialize in male health issues.
- ☐ The service provider recognizes that many young men have fears and anxieties about seeking health care services. Community-specific promotional materials, such as videos or pamphlets, have been developed to address these issues.

SURVEY FOR HEALTH SERVICES STAFF

This activity is Adapted from EngenderHealth's Men's Reproductive Health Problems – Trainer's Resource Book. For more information visit the Engender Health website: www.engenderhealth.org

Instructions

Answer the following questions about your background and your experience in the health care profession. For multiple-choice questions, please check only one box.

(1) I am a...

- ☐ Doctor/nurse practitioner/physician's assistant
- ☐ Nurse
- ☐ Medical assistant/paramedic/nurse's assistant
- ☐ Receptionist/clinic support staff
- ☐ Other (describe)
- _____

(2) I am...

- ☐ Male
- ☐ Female

(3) How many years have you worked at this health care facility? (if less than one year, write 0)

_____ years

(4) How many years have you worked in the health care profession? (if less than one year, write 0)

_____ years

(5) Have you ever attended a training course on the management of young men's sexual and reproductive health problems or concerns?

- ☐ Yes
- ☐ No
- ☐ Not sure

Read the following statements, and decide which of the organs/glands/reflexes listed below is being described. Write the letter of the organ/gland/reflex (A, B, etc.) on the line provided next to the statement. If you do not know the answer, write DK (do not know) on the line provided next to the statement.

- A. Cowper's glands
- B. Cremaster reflex
- C. Epididymis
- D. Hypothalamus gland
- E. Bulbocavernosus reflex
- F. Prostate gland
- G. Scrotum
- H. Urethra
- I. Testes
- J. Valsalva maneuver
- K. Vas deferens
- L. Seminal vesicles

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(6) ____ A client may be asked to do this to check for an inguinal hernia.

(7) ____ This walnut-sized structure secretes fluid that makes up semen.

(8) ____ These are two pea-sized glands located at the base of the penis under the prostate gland that secrete a clear fluid during sexual arousal and before ejaculation.

(9) ____ These are the pair of glandular sacs that secrete some of the fluid that makes up the semen, the white, milky fluid in which sperm are transported..

(10) ____ This is important to check if a client has a history of erectile dysfunction.

(11) ____ This is one of two paired tubes that carry the mature sperm from the epididymis to the urethra.

(12) ____ This structure produces gonadotropin-releasing hormone (GnRH).

(13) ____ This superficial skin reflex is elicited by stroking the skin of the inner aspect of the thigh in an upward motion, causing the contraction of a muscle and elevation of the testicle.

(14) ____ This is one of two highly coiled tubes against the back of the testes where sperm mature and are stored until they are released during ejaculation.

(15) ____ This is a protective skin covering that has a thin layer of muscle, known as the dartos muscle, underneath its surface.

Read the following statements, and decide whether you think each one is true (T) or false (F). Circle the response that more closely matches your opinion about the statement. If you do not know the answer, circle DK (do not know).

(16) Ulcers (sores) on the mouth or lips could be a symptom of a sexually transmitted infection (STI).

☐ T ☐ F ☐ DK

(17) The cremaster reflex is the penile erection response to touch on the lower abdomen.

☐ T ☐ F ☐ DK

(18) Chronic health conditions, such as diabetes, will not affect a man's sexual functioning.

☐ T ☐ F ☐ DK

(19) Depression and stress can cause impotence in men.

☐ T ☐ F ☐ DK

(20) Prolonged, painful erections in the absence of sexual arousal are not a medical concern.

☐ T ☐ F ☐ DK

(21) A couple is not considered infertile until they have been trying to conceive for one year.

☐ T ☐ F ☐ DK

(22) Herpes can be cured with antibiotics.

☐ T ☐ F ☐ DK

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(23) The PSA is a screening test for testicular cancer.

☐ T ☐ F ☐ DK

(24) The skin around a cancerous breast feels like the skin of an orange.

☐ T ☐ F ☐ DK

(25) Scrotal temperatures do not affect a man's fertility.

☐ T ☐ F ☐ DK

(26) All men should be screened for prostate cancer.

☐ T ☐ F ☐ DK

(27) Sperm require 12 days to travel through the epididymis.

☐ T ☐ F ☐ DK

(28) Peyronie's disease is a very common illness in men.

☐ T ☐ F ☐ DK

(29) Zinc is an important mineral for men's sexual functioning.

☐ T ☐ F ☐ DK

(30) When a service provider performs a genital examination, it is important to do the testicle examination at the beginning.

☐ T ☐ F ☐ DK

Read the following statements, and decide whether you strongly agree, agree, disagree, or strongly disagree with each one. Check the answer that most closely matches your opinion about the statement.

(31) I would feel uncomfortable answering questions about male sexuality.

☐ Strongly agree ☐ Agree
☐ Disagree ☐ Strongly disagree

(32) I would feel comfortable speaking to a male client about any sexual and reproductive health issues he may have.

☐ Strongly agree ☐ Agree
☐ Disagree ☐ Strongly disagree

(33) I would feel uncomfortable telling a male or female client to inform all partners (including a spouse) about a diagnosed STI.

☐ Strongly agree ☐ Agree
☐ Disagree ☐ Strongly disagree

(34) I have sufficient knowledge about male fertility to counsel a couple who are having difficulty conceiving.

☐ Strongly agree ☐ Agree
☐ Disagree ☐ Strongly disagree

(35) I can effectively ask specific and appropriate questions to take a male sexual and reproductive health history.

☐ Strongly agree ☐ Agree
☐ Disagree ☐ Strongly disagree

(36) I would feel comfortable talking to a male client about his sexual history and behaviours.

- | | |
|---|--|
| <input type="checkbox"/> Strongly agree | <input type="checkbox"/> Agree |
| <input type="checkbox"/> Disagree | <input type="checkbox"/> Strongly disagree |

(37) I would feel comfortable asking open-ended male sexual and reproductive health questions to get the necessary information to make a diagnosis.

- | | |
|---|--|
| <input type="checkbox"/> Strongly agree | <input type="checkbox"/> Agree |
| <input type="checkbox"/> Disagree | <input type="checkbox"/> Strongly disagree |

(38) I know all the necessary steps to effectively perform a male genital examination.

- | | |
|---|--|
| <input type="checkbox"/> Strongly agree | <input type="checkbox"/> Agree |
| <input type="checkbox"/> Disagree | <input type="checkbox"/> Strongly disagree |

(39) I would feel comfortable explaining to a male client what I am doing while performing a male genital examination.

- | | |
|---|--|
| <input type="checkbox"/> Strongly agree | <input type="checkbox"/> Agree |
| <input type="checkbox"/> Disagree | <input type="checkbox"/> Strongly disagree |

(40) I can easily make a male client feel comfortable during a genital examination.

- | | |
|---|--|
| <input type="checkbox"/> Strongly agree | <input type="checkbox"/> Agree |
| <input type="checkbox"/> Disagree | <input type="checkbox"/> Strongly disagree |

SURVEY ANSWER KEY¹

In the answer key that follows:

- Answers will be circled, checked, and/or written in bold.
- Questions 1 through 6 are demographic questions. They should be used to provide an overview of the participant's experience, not to evaluate the effectiveness of the training.
- Questions 37 through 46 are opinion questions, so there are no right or wrong answers.

Read the following statements, and decide which of the organs/glands/reflexes listed below is being described. Write the letter of the organ/gland/reflex (A, B, etc.) on the line provided next to the statement. If you do not know the answer, write DK (do not know) on the line provided next to the statement.

- A. Cowper's glands
- B. Cremaster reflex
- C. Epididymis
- D. Hypothalamus gland
- E. Bulbocavernosus reflex
- F. Prostate gland
- G. Scrotum
- H. Urethra
- I. Testes
- J. Valsalva maneuver
- K. Vas deferens
- L. Seminal vesicles

(6) J A client may be asked to do this to check for an inguinal hernia.

(7) F This walnut-sized structure secretes fluid that makes up semen.

(8) A These are two pea-sized glands located at the base of the penis under the prostate gland that secrete a clear fluid during sexual arousal and before ejaculation.

(9) L These are the pair of glandular sacs that secrete some of the fluid that makes up the semen, the white, milky fluid in which sperm are transported..

(10) E This is important to check if a client has a history of erectile dysfunction.

(11) K This is one of two paired tubes that carry the mature sperm from the epididymis to the urethra.

(12) D This structure produces gonadotropin-releasing hormone (GnRH).

(13) B This superficial skin reflex is elicited by stroking the skin of the inner aspect of the thigh in an upward motion, causing the contraction of a muscle and elevation of the testicle.

(14) C This is one of two highly coiled tubes against the back of the testes where sperm mature and are stored until they are released during ejaculation.

(15) G This is a protective skin covering that has a thin layer of muscle, known as the dartos muscle, underneath its surface.

1. This examination is taken from EngenderHealth's Men's Reproductive Health Problems – Trainer's Resource Book.

TOOLS YOUNG MEN FRIENDLY HEALTH SERVICES

Read the following statements, and decide whether you think each one is true (T) or false (F). Circle the response that more closely matches your opinion about the statement. If you do not know the answer, circle DK (do not know).

(16) Ulcers (sores) on the mouth or lips could be a symptom of a sexually transmitted infection (STI).

☒ T ☐ F ☐ DK

(17) The cremaster reflex is the penile erection response to touch on the lower abdomen.

☐ T ☒ F ☐ DK

(18) Chronic health conditions, such as diabetes, will not affect a man's sexual functioning.

☐ T ☒ F ☐ DK

(19) Depression and stress can cause impotence in men.

☒ T ☐ F ☐ DK

(20) Prolonged, painful erections in the absence of sexual arousal are not a medical concern.

☐ T ☒ F ☐ DK

(21) A couple is not considered infertile until they have been trying to conceive for one year.

☒ T ☐ F ☐ DK

(22) Herpes can be cured with antibiotics.

☐ T ☒ F ☐ DK

(23) The PSA is a screening test for testicular cancer.

☐ T ☒ F ☐ DK

(24) The skin around a cancerous breast feels like the skin of an orange.

☒ T ☐ F ☐ DK

(25) Scrotal temperatures do not affect a man's fertility.

☐ T ☒ F ☐ DK

(26) All men should be screened for prostate cancer.

☐ T ☒ F ☐ DK

(27) Sperm require 12 days to travel through the epididymis.

☒ T ☐ F ☐ DK

(28) Peyronie's disease is a very common illness in men.

☐ T ☒ F ☐ DK

(29) Zinc is an important mineral for men's sexual functioning.

☒ T ☐ F ☐ DK

(30) When a service provider performs a genital examination, it is important to do the testicle examination at the beginning.

☐ T ☒ F ☐ DK

TAKING A COMPREHENSIVE SEXUAL HISTORY¹

A comprehensive sexual history is important for determining the type of information, counselling and services that a young man should receive. It should include questions about sexual behaviour, condom use, current partners, pregnancy, sexual enjoyment, STI/HIV history as well as negotiation and decision-making in relationships, including instances of intimate partner violence and sexual coercion (Sonenstein 2000). Since most of the questions are very intimate, taking a history requires that the health professional first establish an atmosphere of trust and comfort between himself/herself and the young man. It is important to remember that this is not an occasion to preach or to judge, but rather, an opportunity to help the young man identify his personal risks, as well the resources in his lives and community which could help him to make positive changes (Armstrong 2003; Sonenstein 2000).

- Have you ever had sexual intercourse?
- How many people have you had sexual intercourse with?
- Do you have sex with women, men or both?
- Do you always use condoms with regular sex partners? Do you always use condoms with occasional sex partners? If no, why not?
- When was the last time you had sex? Did you use a condom?
- Have you ever gotten a girl pregnant? If yes, what happened after she got pregnant?
- Do you ever use drugs or alcohol before or during sexual relations?
- Do you use drugs regularly? What kind?
- Are you in a steady relationship now? With a woman or with a man? How long have you been with this person? Do you feel close to this person? How do the two of you decide when you are going to have sex?
- Do you and your main partner want to have a baby soon? If not, what do you two do to keep from getting pregnant?
- How do the two of you resolve differences?
- Have you ever hit or yelled at your partner?
- Has your partner ever hit or yelled at you?
- Do you enjoy your sex life?
- Do you have problems having an erection?
- Have the two of you ever spoken about STI's or HIV and AIDS?
- Have you ever had or been treated for an STI?
- Have you ever been tested for HIV? If yes, When? What was the result? If no, are you interested in being tested?
- Has your partner been tested? If yes, When? What was the result? If no, is he/she interested in being tested?

1. Adapted from Sonenstein 2000

INFORMATIONAL HANDOUT ON PREVENTATIVE EXAM FOR TESTICULAR CANCER

Preventative Exam for Testicular Cancer

Testicular cancer, while seldom discussed, accounts for 1% of cancers in men and is most common among men aged 15 to 35.

Generally, the cancer only affects one testicle and, once removed, does not present any sexual or reproductive complications for the man.

Today, testicular cancer is relatively easy to treat, particularly when detected in the early stages.

The most common symptom is the appearance of a hard nodule about the size of a pea, which does not cause pain.

CARRYING OUT A TESTICULAR EXAM STEP-BY-STEP

- (1) The self-examination should be done once a month after a hot shower – the skin of the scrotum relaxes with the heat, enabling one to locate any irregularities in the testicles.
- (2) Stand in front of a mirror and examine each testicle with both hands. The index and middle finger should be placed on the lower part of the testicles and the thumb on the upper part.
- (3) Gently rotate each testicle between the thumb and the index finger, checking to see if they are smooth and firm. It is important to also palpate the epididymis, a type of soft tube at the back of the testicle.
- (4) The size of each testicle should be noted to verify that they are their normal size. It is common for one testicle to be bigger than the other.
- (5) In case lumps are found, it is important to contact a doctor immediately. Nodules will generally be found on the side of the testicles, but they can also be found in the front. Not every lump is cancerous, but when it is, the disease can spread rapidly if not treated.

INFORMATIONAL HANDOUT ON PREVENTATIVE EXAM FOR CANCER OF THE PENIS

Preventative Exam for Cancer of the Penis

Lack of hygiene is one of the most common causes of cancer of the penis. Thus, the first step to prevent this disease is to wash the penis with soap and water on a daily basis and after sexual relations and masturbation. When discovered at early stages, cancer of the penis can be cured and treated easily. If left untreated or caught late, it can spread to internal areas such as ganglions and cause mutilation or death.

SELF-EXAMINATION OF THE PENIS

Once a month, the man should carefully examine his penis, looking for any of the following signs:

- Wounds that do not heal after medical treatment
- Lumps that do not disappear after treatment and which have secretions with bad odour
- Persons with phimosis who, even after succeeding in squeezing the glands, have inflammation (redness and itching) for long periods
- Whitish stains or loss of pigmentation
- Appearance of bulbous tissues in the groin

These symptoms are more common in adults, and if any of them appear, it is necessary to consult a doctor immediately. Another important precaution is to be examined by a urologist once a year.

CREATING CAMPAIGNS: STEP BY STEP

Below are steps to creating an HIV prevention campaign which incorporates a gender perspective. The length of time necessary for these steps will vary depending on resources available and can range from weeks to months. It is important that young men be involved in all steps. Often they are only involved as respondents in the data collection for a needs-assessment or in the stage of testing campaign images and messages. However, campaigns are more likely to be engaging and effective when youth are involved throughout.

Carry out a needs-assessment

This should include information about young men's gender-related attitudes, knowledge about HIV and AIDS, and behaviors and practices related to prevention. It should also include a mapping of media and social networks which could be tapped into as part of campaign strategies (see other Campaign Tool and section on Needs Assessment).

Develop a profile of a "typical" young man for each of the campaign target areas or populations

A useful technique for laying out the characteristics of the target group of young is to create a character profile. This involves developing a profile of a "typical" young man from the target group, thinking about various characteristics, including: socio-demographics, hobbies, attitudes about gender roles, sexual behaviours including condoms use and number and type of partners, access to and use of social services and programmes, knowledge about HIV transmission, HIV and AIDS risk perception and general aspirations. It can be helpful to give a name to this young man and to create a physical appearance for him. For example, for the development of Hora H campaign in Brazil¹, peer promoters created a fictional character called Calixto, a young man, aged 19, from their community (see box).

Character Sketch for Calixto: Calixto is 19 and likes to play football, to go to funk dances and hang out in the local plaza. He was a young man who likes to take care of himself and keep his hair short. At 13, he had sex for the first time with his cousin Suzi. He does not use condoms often. He once gave his girlfriend a slap because she asked if he would use a condom. He got a bit nervous, thinking that she was not being faithful or she thought he was not being faithful. He talks to his friends about his sexual conquests. Some of his friends use condoms from time to time, but often just the first time in the night, but not the second time. Calixto has the basic information, but he does not worry too much about STIs or HIV and AIDS.

Although this technique requires a degree of generalization about the target group, it is not intended to diminish the diversity that exists among young men, but rather, assist in the process of developing messages and strategies which would be attractive to and appropriate for the target group as a whole.

1. For more information on the Hora H campaign see page 72.

Define sub-themes for the campaign

Within the themes of gender-equity and HIV prevention, it is necessary to identify sub-themes, such as communication with partners about condom use and HIV and AIDS testing, which will be the basis for the campaign. These sub-themes should be defined based on what the needs-assessment identifies as necessary and/or appropriate for the target group.

Develop basic messages for each of the campaign themes

This is the step which often requires the most creativity and time. As discussed in the module, campaigns messages which are positive and action-oriented are often more attractive and inspiring than those which demean men and/or focus only on negative consequences. Constructive examples include the Hora H campaign in Brazil which promotes a “cool” and hip lifestyle for young men based on caring and equitable attitudes and the Strength Campaign in the USA which emphasizes that a man’s real strength is demonstrated through respect and compassion, not force or dominance.

Map sources of influence and information

This involves identifying and understanding the different sources of influence and information which shape young men’s attitudes and behaviours related to gender, relationships and HIV prevention. These sources can be groups of people such as peers and families, institutions such as schools and health services or media vehicles such as newspapers or TV. Again, this should come from information

collected during the needs-assessment and input of young men and other stakeholders involved in the process (see other Campaign Tool).

Define the most strategic media and social channels based on the profile and mapping of influence and information

Building on the profile and the mapping of the influences/information, the next step is to define which media (e.g. radio, magazines, billboards) and social (e.g. peer educators, local celebrities) channels would be the most strategic in reaching the young men and or secondary audiences with messages about positive models of masculinity and HIV prevention. It is important to also keep in mind young men’s access to these different channels and the technical and financial feasibility of utilizing them for the campaign.

Pre-test with young men and secondary audiences

This is the process of confirming that campaign messages are clear and relevant and inform and/or mobilize young men as intended. Involving young men and secondary audiences in the campaign development process helps to ensure the relevance and impact of messages, however it is still necessary to also carry out extensive pre-testing to ensure that messages are widely understood. Pre-testing can be done through one-on-one interviews and/or focus groups with selected young men from the target group itself. It is also important to pre-test messages with secondary stakeholders to ensure that they are acceptable and appropriate and will not generate backlash.

MAPPING YOUNG MEN'S MEDIA AND SOCIAL NETWORKS

The questions below can be useful for identifying the different media and social channels by which campaigns can reach young men. It is important that they first be pre-tested to confirm that they are clear and relevant for the specific context. The section on needs-assessment, monitoring and evaluation provides guidelines on the pre-testing and application of survey questions.

(1) Do you go to school?

- ☐ Yes
☐ No (Skip to Question 3)

(2) Are you involved in any non-academic activities at school? If yes, please describe.

(3) Do you work?

- ☐ Yes
 Where?

 How often (e.g. days/hours per week)?

☐ No

(4) Describe a typical day for you:

Morning

Afternoon

Evening / Night

(5) On weekends, what do you usually do?

(6) Do you practice a sport?

- ☐ Yes
 Which?

 Where?

 How often (e.g. days/hours per week)?

☐ No
 Would you like to practice a sport? Which?

(7) Do you attend sporting events?

- ☐ Yes
 Which?

 Where?

 How often (e.g. days/hours per week)?

☐ No
 Would you like to attend sporting events? Which?

(8) Are you involved in kind of religious activities?

- ☐ Yes
 Which?

 Where?

 How often (e.g. days/hours per week)?

☐ No

(9) Are you involved in any cultural or leisure activities (music, dance group, theatre, etc.)?

☐ Yes

Which? _____

Where? _____

How often (e.g. days/hours per week)? _____

☐ No

Would you like to participate in a cultural or leisure activity? Which?

(10) Do you listen to music?

☐ Yes

What type (e.g. home, cyber house)? _____

Where (e.g. CD, radio, internet)? _____

How often (e.g. days/hours per week)? _____

☐ No

(11) Do you read newspapers, magazines or comic books?

☐ Yes

What type? _____

How often (e.g. days/hours per week)? _____

☐ No

(12) Do you watch TV?

☐ Yes

What kind of shows? _____

How often (e.g. days/hours per week)? _____

☐ No

(13) Do you use a computer?

☐ Yes

Where (e.g. home, cyber house)? _____

How often (e.g. days/hours per week)? _____

☐ No

(14) Do you use the Internet?

☐ Yes

Where (e.g. home, cyber house)? _____

How often (e.g. days/hours per week)? _____

☐ No

(15) Do you have a group of friends with whom you hang out?

☐ Yes

Where (e.g. school, street)? _____

What do you usually do together? _____

How often (e.g. days/hours per week)? _____

☐ No

(16) Do you have someone or somewhere you go to when you have a health-related question?

☐ Yes

Who/Where? _____

☐ No

DEVELOPING A FACT SHEET ABOUT YOUNG MEN AND HIV PREVENTION

An essential tool for any advocacy effort related to young men and HIV prevention is a fact sheet. It should include the “why” and “what” of the issue at hand and should be presented in a straightforward and easy-to-read style. The “why” should include factual and compelling information on the role young men play in HIV prevention. This type of information can be gathered from local organizations working on HIV and AIDS, Departments and Ministries of Health, Demographic and Health Surveys (www.measuredhs.com) and UNAIDS (www.unaids.org), among other sources. The second component of the fact sheet, the “what,” should outline concrete actions that can be taken to positively engage young men in HIV prevention. These suggested actions should be adapted to the target audience and local context. It is also important to include websites and other sources where individuals or organizations can seek additional information on young men and HIV and AIDS.

Below is an example of a short fact sheet designed for health services administrators and professionals. The “why” describes how young men’s sexual and health-seeking behaviours put both themselves and women at risk. The “what” presents several concrete suggestions for promoting young men-friendly health services.

Fact sheet: young men, HIV prevention and health services

THREE COMPELLING REASONS TO ENGAGE YOUNG MEN IN HIV PREVENTION ACTIVITIES¹

1. YOUNG MEN’S BEHAVIOUR PUTS WOMEN AT RISK

On average, young men have more sexual partners than young women. Also, HIV and AIDS is more

easily transmitted sexually from a man to a woman than from a woman to a man. Thus, a young man who is HIV positive is likely to infect more persons than a young woman who is HIV positive.

2. YOUNG MEN’S BEHAVIOUR PUTS THEMSELVES AT RISK

Young men are more likely than women to use alcohol and other substances, behaviours that increase their risk of HIV infection. Additionally,

1. Adapted from Sonenstein 2000 and UNAIDS YEAR.

young men are often negligent about their health and well-being and are less likely than young women to seek health care.

3. THE ISSUE OF MEN WHO HAVE SEX WITH MEN (MSM) HAS BEEN LARGELY HIDDEN.

Surveys from various parts of the world find that between 1%-16% of all men report having had sex with another man, regardless of whether they identify themselves as gay, bisexual, or heterosexual. For young men who are gay, or who have sex with men, prejudice and stigmatization can lead them to practice their sexuality clandestinely and inhibit them from seeking out sexual health information and services, thus creating situations of extreme vulnerability to HIV and AIDS.

YOUNG MEN-FRIENDLY HEALTH SERVICES ARE AN IMPORTANT PART OF HIV PREVENTION

Providing young men-friendly health services is an important piece to promoting young men's access to and use of HIV prevention information, methods and support. Unfortunately, many young men avoid health services because they are not "male-friendly." Below are some suggestions for making your health services more friendly and accessible to young men:

- Decorate the waiting rooms to be attractive to young men. Avoid colours and decorative items that are considered specific to women and babies. Display posters of young men

engaging in health-promoting behaviours such as holding/feeding a baby or wearing a bike or motorcycle helmet.

- Display client-education materials in the waiting and examination rooms that provide information on issues relevant to young men, including the male genital self-examination.
- Provide training for health workers on the importance of working with young men, including the opportunity to deconstruct their own gender beliefs and how they might impact their professional interactions with young men.
- Clearly announce the availability of services for young men in posters and promotional materials which are distributed in the community.
- Make condoms readily available. Display signs saying "Condoms available" (for sale or free) at the reception desk or another area where men are likely to view them. Stocking more than one brand of condom, if possible, helps reinforce that idea that the health services takes men's contraceptive and disease-protection seriously.
- Offer a flexible schedule of services, including evenings and weekends, to accommodate young men and their work and/or school schedules.

REFLECTION ACTIVITY: BUILDING ALLIANCES

This activity is an adaptation of Expanding Alliances, written by Michael Kaufman as part of the Family Violence Prevention Fund's Toolkit for Working with Men and Boys. It is intended to be used with staff and volunteers of organizations at the beginning of planning or discussing new partnerships and alliances. The original activity can be found at <http://toolkit.endabuse.org/Resources>.

Objective

to examine the possibilities, advantages, and challenges of building new alliances to increase the effectiveness and reach of efforts to engage young men in HIV prevention.

Materials Required

Flipchart and markers

Recommended time

Total minimum time is about 90 minutes, but it is recommended that the group reserve up to 3 hours. The activity can be done in one session, but also works well divided in half: Steps 1–3 then 4, or Steps 1–2 then Step 3–4.

Procedure

(1) General reflections on Establishing New Partnerships (20–25 minutes)

The questions below are designed to help generate reflections about expectations and perceived benefits and obstacles of new partnerships. It might be interesting for the group to consider organizations or individuals with whom they think it might be particularly challenging to work with but with whom they believe it would

be worthwhile to try to establish partnerships. It is important that the group keep in mind that these questions are only the first step in a longer process. They should focus only on exploring feelings about possible new partnerships. More specific discussions about potential partners and next steps will come later.

Discussion Questions

- How do you feel about working with other organizations in partnerships and alliances?
- What might be the benefits? What might be the challenges?
- Imagine we might be working closely with people who, in the past, you didn't see as potential allies. How do you feel about working with them?
- How do other organizations perceive our organization (or its constituent parts)?
- How do these perceptions act as obstacles to collaborations?

(2) Success Stories (10 minutes)

The questions below invite the group to reflect on past examples of successful partnerships and how they can learn from these examples to build new partnerships.

Discussion Questions

- How have we worked in the past to break down barriers in building new alliances and involving men and boys? What are some of our success stories?
- Which of our resources, approaches, or past successes open up possibilities for expanding alliances? What do we have to offer?
- What do we have to learn?

(3) Identify Potential Partners

(20–25 minutes)

The goal of this step is to brainstorm potential partners. Prior to the session, the facilitator should write out the column headings below on several sheets of flip-chart paper and invite the group to brainstorm one column at a time. The notes below can help to identify what fits into each column. The group should keep in mind that this is not the time to evaluate or debate the pros and cons of the different potential partners. This will be done in next step.

Column Headings:

- Potential partners
- Benefits/reasons for working together
- Barriers to working together
- Resources and ideas to overcome barriers
- How working with them fits (or doesn't fit) with our priorities and strengths

Potential partners

This can include a wide range of institutions and organizations, e.g., existing men's organizations and service clubs dominated by men; existing

women's organizations and service clubs dominated by women; faith-based institutions; community groups; corporations; trade unions and professional associations; schools; scouts, sports clubs, and other youth organizations; high-profile individuals; different levels of government; non-governmental organizations; and so on.

Benefits/reasons for working together

This includes the reasons and benefits of a partnership with the specific organization or group. For example, you may wish to work with an organization to gain contact to another organization that they are affiliated with. In other cases, the reason to work with a certain organization might be its weight in the community: it's the largest corporation in the area, the only university, and so on.

Barriers to working together

There are the potential obstacles to building a partnership with the specific organization or group.

Resources and ideas to overcome barriers

These include the practical resources and ideas, e.g. personal connections, physical proximity, knowledge which can help to overcome the potential barriers to establishing a partnership with the specific organization or group.

(4) Prioritizing (15–30 minutes)

The facilitator should review the chart developed in Step 4 and invite the group to categorize the potential partners according to the criteria below.

The A List: High potential of partnership. An organization or institution on this list is particularly important and there are tangible benefits to working together. The barriers seem surmountable, and a partnership would fit into your mandate and priorities.

The B List: An organization on this list has some potential, but it's not solid in as many categories, or one category seems daunting.

The C List: There may be few benefits to working with these organizations, or perhaps there are far too many barriers and no resources to overcome them.

(5) An Action Plan (25–60 minutes)

The questions below are designed to help the group develop an action plan. Initially, the group should focus on the organizations in the A List. These same questions can then be repeated at another moment with organizations in the B List.

- How can we involve some of our traditional allies and partners in this initiative, or what information do we need to share with them about what we're doing?
 - Who will take responsibility for drafting a proposal or making the first contact?
-
- Are there specific initiatives, campaigns, issues in the community, or events that we could approach this organization about?
 - Do we want to start with one group, or do we want to approach several groups?
 - If the latter, should we develop separate initiatives or should we try to bring a coalition together? (Keep in mind that your organization will need to meet separately with each group. You've been through a thinking process on this, but they may not have.)

SAMPLE LOGICAL FRAMEWORK¹

A logical framework is a useful tool for planning, monitoring and evaluating projects. It presents key information about the project (e.g. goals, activities, indicators) in a clear, concise, logical and systematic way. The framework should be completed in partnership with donors, beneficiaries and other stakeholders prior to the onset of any activities. It is important to keep in mind that the framework should not be set in concrete – it should be flexible to changes or adaptations that may be deemed necessary during the monitoring process or consultations with donors, beneficiaries and others throughout the life of the project.

The parts to a logical framework are:

GOAL: contribution of the project to a wider problem or situation.

PURPOSE: change that occurs if the output is achieved – the effect.

OUTPUT: specifically intended results from project activities.

ACTIVITY: tasks necessary to achieve the output.

INDICATORS: qualitative and quantitative ways of measuring whether the outputs, purpose and goal have been achieved.

MEANS OF VERIFICATION: how and from what sources of information each of the indicators will be confirmed.

ASSUMPTIONS: external factors on which the success of the project depends and which management has little control.

See other side for a sample logical framework related to providing young men-friendly services.

1. Adapted from <http://vietnam.unfpa.org/documents/2RHIYAVietNamLogframe.doc>; <http://www.gdrc.org/ngo/logical-fa.pdf>
1. UNFPA Vietnam 2004
2. Bond 2003

TOOLS NEEDS ASSESSMENT, MONITORING AND EVALUATION

	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
GOAL To contribute to decreased HIV, AIDS and STI risk of youth in Rio de Janeiro, Brazil.	By 1-2 years after the completion of the project: <ul style="list-style-type: none"> • Reduced rate of HIV and AIDS and STI incidence among youth 	<ul style="list-style-type: none"> • National and Local AIDS Programme statistics • Demographic and Health Surveys 	Government policies and socio-cultural norms support reduced HIV, AIDS and STI risk for youth.
PURPOSE To increase the HIV prevention behaviour/ practices of young men and increase utilization of HIV prevention services by young men in target communities.	By completion of the project: <ul style="list-style-type: none"> • Increase number of young men who used condom at last sex by 30% • Increase number of young men using sexual and reproductive health services by 30% • Increase number of young men who seek HIV and AIDS testing by 30% 	<ul style="list-style-type: none"> • Pre/post intervention survey 	Government policies and socio-cultural norms support positive changes in young men's HIV prevention behaviours.
OUTPUTS (DELIVERABLES) 1) Trained providers and staff at services 2) Upgraded, young men-friendly clinic spaces and services	<ul style="list-style-type: none"> • Change in awareness/ attitudes of provider/ staff regarding young men's health and development needs • Increase in number of young men who perceive spaces and services as friendly and relevant 	<ul style="list-style-type: none"> • Pre/post training survey with providers and staff • Training reports • Pre/post intervention survey • Client surveys 	Service providers and staff committed to engaging young men in health and HIV prevention services.
ACTIVITIES Carry out trainings with providers and staff on young men's health and development needs Organize space and services, including condom provision and VCT, to be friendlier to young men.	<p>Note: The activities are carried out to achieve the outputs therefore, the progress and success of the activities are measured by the indicators at the Outputs level.</p> <p>These "spare" boxes can therefore be used to provide any useful additional information such as Inputs and Budgeting requirements.</p>		Service providers and staff committed to engaging young men in health and HIV prevention services. Services providers and staff have time and interest to participate in trainings. Health clinics have resources, time and interest to adapt spaces.

THE GENDER-EQUITABLE MEN SCALE (GEM SCALE): MEASURING ATTITUDES TOWARD GENDER NORMS¹

Horizons and Promundo developed the Gender-Equitable Men (GEM) Scale to measure attitudes toward manhood and gender norms related to sexual and reproductive health promotion and disease prevention, partner violence, and sexual and intimate relationships, among other topics. The original 35-item scale was validated with a representative sample of men aged 15–60 in three communities—two low-income and one middle-income—in Rio de Janeiro. It was administered as part of a larger household survey which included questions addressing a number of variables that were theoretically related to gender-equitable norms, including socio-demographic status, relationship history, history of physical violence, and current safer sex behaviours. The testing confirmed that the attitude questions held together, meaning that young men answered in fairly internally consistent ways. That is, a young man who said he tolerated or even supported violence against women was also likely to show non-equitable or male-dominant views on other questions, such as believing that taking care of children was exclusively a woman's responsibility. Moreover, young men's attitudes were highly correlated with self-reported use of violence against women, confirming that the ways young men answered the questions were correlated to how they say they act.

The GEM scale can be used both as a needs assessment tool as well as an evaluation instrument. The scale, however, is particularly useful because it can be applied to a large number of young men in a relatively short amount of time. It is, of course, not perfect and it does not capture much of the rich detail or nuances related to gender attitudes and norms which can be explored in focus groups and in-depth individual interviews. However, when time and resources are scarce, the attitude questions can be a relatively fast way to get a

general sense if young men who participate in activities are changing in positive ways. And, by being able to apply the questions to a large number of young men, the data is quite useful for influencing policymakers who are often interested in achieving large scale impact.

The GEM scale

Below are the items for the GEM scale. Answer choices are: Agree, Partially Agree, and Do Not Agree and Do Not Know. Instructions on scoring procedures are described below.

1. Adapted from text written by Julie Pulerwitz. Barker and Pulerwitz 2007

SUBSCALE 1: "INEQUITABLE" GENDER NORMS

1. It is the man who decides what type of sex to have.
2. A woman's most important role is to take care of her home and cook for her family.
3. Men need sex more than women do.
4. You don't talk about sex, you just do it.
5. Women who carry condoms on them are "easy".
6. Changing diapers, giving the kids a bath, and feeding the kids are the mother's responsibility.
7. It is a woman's responsibility to avoid getting pregnant.
8. A man should have the final word about decisions in his home.
9. Men are always ready to have sex.
10. There are times when a woman deserves to be beaten.
11. A man needs other women, even if things with his wife are fine.
12. If someone insults me, I will defend my reputation, with force if I have to.
13. A woman should tolerate violence in order to keep her family together.
14. I would be outraged if my wife asked me to use a condom.
15. It is okay for a man to hit his wife if she won't have sex with him.
16. I would never have a gay friend.
17. It disgusts me when I see a man acting like a woman.

SUBSCALE 2: "EQUITABLE" GENDER NORMS

18. A couple should decide together if they want to have children.

19. In my opinion, a woman can suggest using condoms just like a man can.
20. If a guy gets a woman pregnant, the child is the responsibility of both.
21. A man should know what his partner likes during sex.
22. It is important that a father is present in the lives of his children, even if he is no longer with the mother.
23. A man and a woman should decide together what type of contraceptive to use.
24. It is important to have a male friend that you can talk about your problems with.

Items that Were Dropped (But May Still be Relevant in Other Circumstances)

25. A man always deserves the respect of his wife and children.
26. If she wants, a woman can have more than one sexual partner.
27. If a woman cheats on a man, it is okay for him to hit her.
28. Men can take care of children just as well as women can.
29. Real men only have sex with women.
30. Above all, a man needs respect.
31. If a man sees another man beating a woman, he should stop it.
32. Women have the same right as men to study and to work outside of the house.
33. Women should be virgins until they get married.
34. I think it is ridiculous for a boy to play with dolls.
35. If a man cheats on a woman, it is okay for her to hit him.

Scoring procedures for the Gender Equitable Men (GEM) Scale

- (1) High scores represent high support for gender equitable norms. For subscale 1, Agree would be scored as 1, Partially Agree as 2, and Do Not Agree as 3. A high score represents low support for non-equitable gender norms or, in other words, support for gender equitable norms. For subscale 2, the scores are reserved so that for all items a high score represents high support for gender equitable norms. Do Not Know answers are scored the same as partially agree.
- (2) Scores for the Inequitable Norm and Equitable Norm subscales are calculated separately and then combined into the Gender Equitable Men Scale. Each subscale, based on the sufficient internal consistency reliability, can also be used separately, if desired. The Inequitable Norm Subscale was found to be more reliable than the Equitable subscale in certain circumstances.

The GEM Scale is calculated as follows:

(a) For Inequitable Norms, the possible minimum was 17 and the maximum was 51. For Equitable Norms, the possible minimum was 7 and the maximum was 21.

(b) Responses to each item in each subscale are summed. This gives the GEM Scale score.

(c) Respondents for whom more than one third of the scale items are not answered, if using the full scale, and one third of either subscale, if one subscale is being used, should be dropped from the analysis. For respondents missing less than one third of the scale items, the missing items should be replaced (i.e. imputed) with the mean of the item across all respondents.

- (3) The continuous GEM Scale scores can be used in analyses as is, or it can be recoded into different formats for different types of analyses and interpretations. As one coding option, the continuous GEM Scale is trichotomized into “high,” “moderate,” and “low” support for equitable gender norms by splitting the scale into three equal parts. The range is based on thirds in the range of possible scores: for the GEM Scale, low equity is 1 - 23, moderate is 24 - 47, and high is 48 - 72. Typical analyses include testing associations between the GEM Scale and key variables such as condom use and partner violence, as well as comparisons of GEM Scale scores before and after an intervention.

