Promoting Gender Equity for HIV and Violence Prevention

Results From the PEPFAR Male Norms Initiative Evaluation in Ethiopia

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Published in July 2010.

Suggested citation: Pulerwitz J, Martin S, Mehta M, Castillo T, Kidanu A, Verani F, Tewolde S. *Promoting Gender Equity for HIV and Violence Prevention: Results from the Male Norms Initiative Evaluation in Ethiopia.* Washington, DC: PATH; 2010.

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Results From the PEPFAR Male Norms Initiative Evaluation in Ethiopia

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Acknowledgments

The authors thank the US President's Emergency Plan for AIDS Relief (PEPFAR) Gender Technical Working Group for financial and technical support for this project. We are especially grateful to the current and former project co-coordinators: Laura Skolnik, Sara Wilhelmsen, Diana Prieto, Lisa An, Nomi Fuchs-Montgomery, and Susan Settergren. Support from USAID/Ethiopia, especially from Catherine Hastings, was also much appreciated. We thank Heather Bradley for data analysis support and Monique Widyono for assistance with preparing drafts and finalizing the report. Finally, the authors acknowledge the staff who helped to implement this project and the young men and women who participated in the intervention and evaluation. This document was produced through support provided by the U. S. Agency for International Development, under the terms of Cooperative Agreement No. GPO-A-00-06-00008-00. The opinions herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development

Contents

Executive summary

Certain male gender norms, or social expectations about how men should behave, have been shown to promote HIV risk and related behaviors, such as partner violence. There is growing evidence of the importance—and success—of engaging men and explicitly addressing gender dynamics in HIV/AIDS and violence prevention initiatives.

The US President's Emergency Plan for AIDS Relief (PEPFAR) is supporting interventions to address and evaluate these issues through the Male Norms Initiative (MNI) in Ethiopia, Namibia, and Tanzania. In Ethiopia, the initiative involved implementing and evaluating a community-based project working with young men in Addis Ababa. It also included capacity-strengthening of PEPFAR nongovernmental organization (NGO) partners to offer a variety of male engagement activities and technical assistance for providers of services for preventing mother-to-child transmission (PMTCT) of HIV to promote male involvement. This report highlights results from an evaluation of the community-based project with young men and also describes lessons learned from the capacity-strengthening and technical-assistance components.

Community-based gender equity program with young men

The community-based project with young men addressed harmful male gender norms and related behaviors that increase the risk of negative health outcomes, especially those related to HIV. EngenderHealth and Hiwot Ethiopia led the implementation of the program. PATH led the evaluation of the program in close collaboration with Miz-Hasab Research Center.

Evaluation design and methods

Set in three low-income subcities in Addis Ababa, this quasi-experimental study compared the impact of different sets of program activities (based on experiences from EngenderHealth's Men as Partners program and Promundo's Program H project). Participants were young men ages 15 to 24 years who were members of youth groups. Three groups of young men were exposed to different interventions and followed over six months. One intervention arm consisted of interactive group education with community engagement activities (GE+CE); the second intervention arm included only community engagement activities (CE); and the third arm (a comparison group) did not receive any intervention activities until after the study period ended (a "delayed" intervention).

Surveys were administered in May and June 2008, prior to the intervention (n=729), and after the intervention ended six months later (n=645). The overall response rate was 89 percent. The surveys focused on support for (in)equitable gender norms as measured by the Gender Equitable Men (GEM) Scale, and gender-related behaviors, including violence and HIV risk behaviors. The GEM Scale is a 24-item scale with attitudinal statements about gender roles related to domestic work, sexuality, relationships, violence, and health that has been psychometrically evaluated in Ethiopia. This report includes data from young men who participated at both baseline and endline.

Qualitative, in-depth interviews with a subsample of intervention participants and their primary female sexual/romantic partners were conducted at endline only. Each member of the couple was

interviewed separately. In total, 25 couples from the intervention arms were interviewed. The data were used to explore the process of change due to the intervention, as well as to validate observations of change from the female partners.

Intervention

Hiwot Ethiopia implemented the group education and community engagement intervention activities with technical assistance from EngenderHealth. These activities were intended to promote equitable gender norms and reduce risk of HIV and violence. The group education activities included 19 sessions that were held for about two hours once a week. The community engagement activities included distribution of leaflets, newsletters, and other materials, music and drama skits, community discussions, condom distribution, and an International Father's Day march.

Key findings

At baseline, gender norms varied among young men.

Support for equitable gender norms varied at baseline. Fifty-eight percent agreed that "a woman should tolerate violence in order to keep her family together," 50 percent agreed that "a woman should obey her husband in all things," and 12 percent agreed that "a man should be outraged if his wife asks him to use a condom."

Participants reported moderate HIV risk and limited sexual activity at baseline.

About 35 percent reported having sex in the past, and about one-third had a primary partner over the past six months (which could be sexual or nonsexual). Three-fourths (76 percent) of sexually experienced youth reported condom use during their last sexual encounter.

At baseline, young men reported substantial levels of partner violence.

A large majority of participants (62 percent) reported having been violent toward a primary partner at some point in their lives. More than half (53 percent) reported being violent toward a primary partner during the past six months, with 35 percent having insulted her or made her feel bad about herself and 24 percent having slapped her or thrown something at her that could hurt her.

Intervention led to increased support for more equitable gender norms.

Both intervention arms had a positive, significant impact among participants, with no change in the comparison group. Those who changed became more supportive of equitable norms and less supportive of inequitable norms. Young men in the GE+CE arm were nearly twice as likely as those in the comparison group to increase their GEM Scale score. For example, one young man discussed how his attitudes toward gender norms changed as a result of the group education activities:

> I have learned that a woman is equal like a man. I have learned that a woman is successful in productive work. I have learned to reduce the workload of a woman at home. I have learned all these [things].

Reductions in partner violence were reported in GE+CE and CE-only arms; agreement with more equitable gender norms was associated with reductions in violence.

The percentage of respondents who reported being physically violent toward a female partner over the past six months significantly decreased in both the GE+CE arm (36 vs. 16 percent) and the CE-only arm (36 vs. 18 percent) ($p<0.05$), whereas reported violent behaviors did not change in the comparison arm (7 vs. 14 percent). High equity GEM Scale scores were associated with a 34 percent reduction in the odds of partner violence ($p=0.08$) among all groups.

Young men perceived positive changes in behavior due to participation in the intervention.

The great majority of participants said their behavior had changed due to participation in Hiwot Ethiopia activities. More participants in the GE+CE arm (95 percent) reported positive changes than in the CE-only arm (82 percent). Participants in both intervention groups reported that they are more aware of gender issues, treat women with more respect, have increased their condom negotiation ability and reduced their sexual risk behavior, and have learned how to improve partner communication about HIV risk issues.

Most females reported positive changes in their partners.

Most female partners indicated that they had seen clear changes in their partner's behavior after participation in Hiwot Ethiopia's programs. These changes included open discussions about HIV/AIDS, sex, and protecting oneself from diseases; talking about faithfulness in relationships; helping with household chores; and not engaging in unhealthy behaviors such as smoking. For example, the wife of one young man said:

> My husband told me about unwanted pregnancy, abstinence, and HIV. He told me that we have to take care of ourselves from these, and we have to care for each other. In relation with the program, I can say he now cares about his house[hold] and I can say this program makes everything good.

Capacity-strengthening and technical assistance activities

Various groups received capacity-strengthening trainings and technical assistance from EngenderHealth and Promundo on ways to integrate male engagement activities into ongoing programmatic work and create more "male-friendly" spaces. They included the local intervention partner for the community-based program with young men (Hiwot Ethiopia), a variety of PEPFAR NGO partners, and staff at PMTCT service delivery sites.

Evaluation objective and methods

Key informant interviews were conducted with representatives from these organizations, plus EngenderHealth staff based in Ethiopia (n=17). These interviews were part of a "process evaluation" intended to highlight challenges and successes with implementing MNI activities in Ethiopia and to obtain additional insights into the capacity-building process.

Results

Staff receiving technical assistance perceived positive impact.

Hiwot Ethiopia staff, as well as staff from other PEPFAR partners, reported that the technical assistance had strengthened their ability to address issues related to gender in their work, as well as changing their own attitudes toward women. For example, staff said:

> Men should participate in everything, and my attitude about this idea has changed greatly. In our culture we differentiate things by saying that this is for males and that is for females…but this is not the correct way. [Men] have to participate in HIV-related issues and work together with their wives so this will make their life better....
> – Master trainer, Hiwot Ethiopia

> In the commercial sex workers program we have seen the importance of males and have also observed that they are the decision makers, so we invite…males to participate…and [the training] has helped us to realize where to give focus and what message that we need to convey for them.
> – Support group leader, PEPFAR partner

Successful implementation of activities required ongoing support.

Intervention staff indicated that the technical assistance was resource intensive because local partners were engaging in this type of work for the first time and required ongoing support to successfully implement the expected activities. Local intervention partner staff acknowledged the positive impact of the technical assistance but expressed concerns about the sustainability of success without additional resources.

Conclusions

Findings from the evaluation of the Male Norms Initiative indicate that interventions to promote gender-equitable norms can successfully influence young men's attitudes toward gender norms and lead to healthier relationships. The study also provides empirical evidence that a community-based intervention focused on combating inequitable and risk-supporting gender norms is associated with reductions in partner violence and improvements in risk outcomes for HIV and sexually transmitted infections (STI).

Young men in the intervention groups (but not the comparison group) expressed more equitable gender norms at endline compared to baseline. In addition, participants from both intervention groups reported less violence over time, a change that was not found among the comparison group. Although low amounts of sexual behavior reported by the young men before and during the intervention period limited the amount of quantitative change in sexual risk that could be measured, qualitative reports from both the young men and their female sexual partners support a reduction in HIV risk (e.g., increased ability to negotiate condom use). Both interventions led to changes in key variables, and the combined intervention (GE+CE) was at times more successful.

The technical assistance provided, while resource intensive, was appreciated by recipients and perceived to positively affect their HIV and violence prevention work. Additional resources will be needed to maximize the sustainability of these activities. Overall, findings suggest that confronting inequitable gender norms is an important element of HIV prevention strategies.

Introduction

An estimated one in four people infected with HIV/AIDS worldwide is a young man under the age of 25. In Ethiopia, more than 40 percent of men ages 15 to 24 report having sex before the age of 15, according to 2006 data from the Joint United Nations Programme on HIV/AIDS (UNAIDS).[1] These data highlight the need to develop effective and appropriate HIV prevention programs for young men.

HIV risk and related behaviors, such as contraceptive behaviors and partner violence, have been shown to be influenced by gender norms, or social expectations about how men and women should behave due to their sex.[2] There is growing evidence of the importance and success of involving men and explicitly addressing gender dynamics in HIV/AIDS and violence prevention initiatives.[3,4,5] To date, interventions to address common male gender norms and related behaviors that promote risk of negative health outcomes, such as HIV and sexually transmitted infections (STI), unwanted pregnancies, and intimate partner violence have been small in scale, and few have been evaluated for effectiveness.

The US Government, through the US President's Emergency Plan for AIDS Relief (PEPFAR), supported the Male Norms Initiative (MNI) to provide capacity-strengthening to partners, as well as to implement and evaluate gender-focused programs, in Ethiopia, Namibia, and Tanzania. In Ethiopia, PATH, EngenderHealth, and local partners Hiwot Ethiopia and Miz-Hasab Research Center implemented and evaluated the impact of activities with young men to address male gender norms and related behaviors that increase risk of negative health outcomes, especially those related to violence and HIV. EngenderHealth and Promundo also provided capacity-strengthening and technical assistance to nongovernmental organization (NGO) partners and to staff at sites for preventing mother-to-child transmission (PMTCT) on ways to engage men in HIV and AIDS prevention, care, and support. This report primarily presents results from the evaluation of gender-focused activities with young men, but it also assesses the process and lessons learned from the capacity-strengthening and technical-assistance components.

Community-based gender equity programs with young men

Two programs focused on reducing health risks by confronting and changing gender norms—EngenderHealth's Men as Partners (MAP) and Promundo and partners' Program H—are increasingly recognized as promising programs, because of accumulating evidence of their

[1] UNAIDS. Epidemiological Fact Sheet, Ethiopia. Geneva: UNAIDS; 2006. Available at: http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_ET.pdf.
[2] Campbell CA. Male gender roles and sexuality: implications for women's AIDS risk and prevention. *Social Science Medicine*. 1995;41(2):197–210.
[3] Mehta M, Peacock D, Bernal L. Lessons learned from engaging men in clinics and communities. In: *Gender Equality and Men: Learning from Practice*. Oxford, UK: Oxfam; 2004.
[4] Verma RK, Pulerwitz J, Mahendra V, et al. Challenging and changing gender attitudes among young men in Mumbai, India. *Reproductive Health Matters*. 2006;14(28):135–143.
[5] Pulerwitz J, Barker G, Segundo M, Nascimento M. *Promoting More Gender-Equitable Norms and Behaviors Among Young Men as an HIV/AIDS Prevention Strategy: Horizons Final Report*. Washington, DC: Population Council; 2006.

success in different cultural contexts.[6] PATH has worked with these partners to help refine the intervention strategies and to develop evaluation tools and strategies to successfully capture support for (in)equitable male gender norms and related behavior change. Most notably, the Gender Equitable Men (GEM) Scale[7] was developed and has been applied to and adapted for communities in multiple cultural contexts (e.g., Kenya, Tanzania, South Africa, Mexico, the United States, Brazil, India). The project with young men in Ethiopia aimed to adapt and test the impact of these programs and evaluation strategies in urban settings.

The main objectives of the evaluation were as follows:

- Evaluate the impact of activities to reduce violence and HIV risk, especially through modifying gender norms that can increase risk, on the gender-related attitudes and behaviors of intervention participants (Ethiopian men 15 to 24 years old).
- Test the comparative impact of the two intervention arms: interactive group education plus community engagement activities (e.g., International Father's Day march, distribution of informational materials, music and drama performances, community discussions, and condom distribution) (GE+CE arm); community engagement activities alone (CE-only arm) versus a comparison/delayed intervention arm receiving no activities during the study period.
- Explore the process of change related to support for (in) equitable gender norms and related HIV risk behaviors within relationships, through in-depth interviews with a subsample of male participants and their female sexual/romantic partners.

Methods and study population

Set in three low-income subcities in Addis Ababa, Ethiopia, this quasi-experimental study compared the impact of two sets of program activities to bring about positive changes in attitudes and behaviors among young men ages 15 to 24 years. Three groups of young men were followed over time. Hiwot Ethiopia, the local intervention partner, recruited members of youth groups in the subcities of Gulele, Kirkos, and Bole. These subcities were selected because Hiwot Ethiopia currently works in these locations; the subcities are comparable in terms of population size, ethnic makeup, and number of *kebeles*, or municipalities; and the subcities are distant enough from each other to reduce the risk of contamination between study arms. Each subcity was randomly assigned an intervention:

- Gulele received both group education and community engagement activities (GE+CE arm).
- Kirkos received only community engagement activities (CE-only arm). (See intervention description below.)
- Bole was the comparison site and will receive a delayed intervention after the study period.

This design tested the impact of each arm, as well as the differential impact between the two intervention arms and the comparison site. The study team hypothesized that the two intervention groups would report more change in gender-related attitudes and behaviors than the comparison group and that the combined intervention would have greater impact on some outcomes than the community-engagement intervention alone.

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[6] Barker G, Ricardo C, Nascimento M. *Engaging Men and Boys in Changing Gender-based Inequity in Health: Evidence from Programme Interventions*. Geneva: World Health Organization; 2007.

[7] Pulerwitz J, Barker G. Measuring attitudes toward gender norms among young men in Brazil: Development and psychometric evaluation of the GEM Scale. *Men and Masculinities*. 2008;10:322–338.

Prior to the start of this evaluation, the study protocol was reviewed and approved by the PATH Research Ethics Committee. In addition, the study underwent local ethical review by the Addis Ababa City Administration Health Bureau Ethical Review Committee, which also gave approval.

Quantitative data collection

Baseline surveys (interviewer-administered) were conducted in May and June 2008, and endline surveys were conducted in December 2008. A total of 729 baseline and 645 endline participant surveys were conducted with young men from 11 community-based youth groups in the three subcities. Surveys were administered to a cohort in each site prior to any intervention activities (n=244 in Gulele, 287 in Kirkos, and 198 in Bole) and six months after the intervention began (n=235 in Gulele, 251 in Kirkos, and 159 in Bole). The same groups of young men were followed, for a longitudinal sample. Figure 1 summarizes the study design. Participants were informed about the study objectives, study design, and the need for follow-up interviews. Informed consent was obtained from each participant before participation.

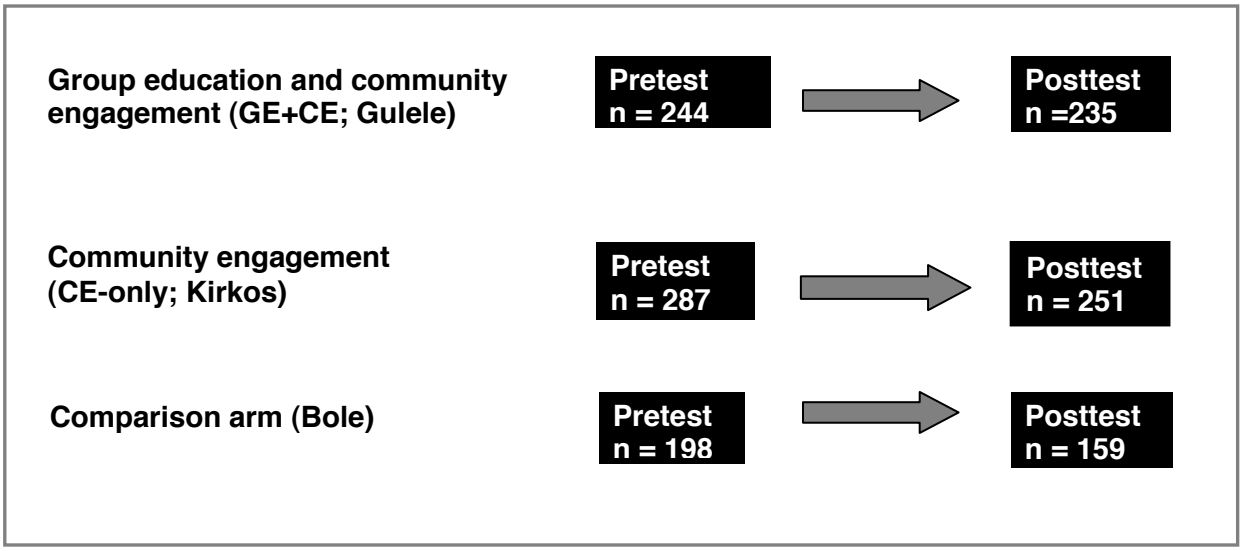


Figure 1. Study design and sample size.

Quantitative change measures (surveys) focused on key indicators to assess program impact, which included support for (in)equitable gender norms as measured by the Gender Equitable Men (GEM) Scale, and gender-related behaviors, including those associated with HIV/STI and violence risk or prevention (e.g., condom use; number of concurrent sexual partners). Information was also collected about exposure to the intervention (e.g., number of activities attended).

The GEM Scale uses a series of statements to understand men's views on the roles and behaviors of men and women. The GEM Scale was originally developed by PATH and Promundo for use with Brazilian young men aged 14 to 25 years.[7] The original scale includes 17 attitudinal statements about inequitable gender roles and 7 statements about equitable gender roles in the areas of domestic life and child care, reproductive health and disease prevention, sexuality, and violence. The study team used a version of the GEM Scale that had been previously adapted and tested with men in Ethiopia by PATH and partners (Johns Hopkins University and the Academy

for Educational Development).[8] Each item on the GEM Scale has three response categories: agree, partially agree, and do not agree. Each item was scored such that one point was given for the least-equitable response, two points for the moderately equitable response, and three points for the most-equitable response. To make the results easier to interpret, respondents were categorized based on their total scores: low equity, moderate equity, or high equity. This categorization was based on the numeric range of responses after scores for individual items were added together. There are 24 items in the GEM Scale, and scores can therefore range from 24 to 72. The low equity category, for example, would range from 24 to 39, the medium equity category from 40 to 55 and the high equity category from 56 to 72. This method for categorization facilitates analysis across multiple cultural settings, as opposed to using the percent of responses from a given study population to separate into categories.

To measure partner violence (both "any violence" and "physical violence") the study team adapted the WHO Multicountry Study tool.[9] The WHO tool has been tested and validated in a variety of cultural settings. Violence was measured by a list of items describing types of violence, which were then added together to form an index for each of the two variables. "Physical violence" includes having (1) slapped her or thrown something at her that could hurt her; (2) pushed or shoved her or pulled her hair; (3) hit her with a fist or with something else that could hurt her; (4) kicked her, dragged her, or beaten her up; (5) choked or burnt her on purpose; (6) threatened to use or actually used a gun, knife, or other weapon against her; or (7) physically forced her to have sexual intercourse when she did not want to. "Any violence" includes physical violence as well as having (1) insulted her or made her feel bad about herself; (2) belittled or humiliated her in front of other people; (3) done things to scare or intimidate her on purpose; or (4) threatened to hurt her or someone she cares about.

Analytic methods

Comparing the three groups, the study team examined baseline-endline differences using single items and constructed key indicators. For the purposes of examining baseline-endline differences between the groups, statistical analysis was limited to the 89 percent of young men who were surveyed at both time points. Sensitivity analyses confirmed that there were no major differences between young men who were and were not followed up. Results are presented only for those who completed baseline and endline surveys.

The study team performed bivariate analysis using chi-square tests for independence and two-tailed t-tests to assess statistically significant differences between baseline and endline. The team also examined potential statistical differences between the three groups using global F-tests. Based on the bivariate findings, four outcomes were examined in more detail: (1) whether the participant's GEM Scale score increased by more than the mean change (which was two or more points) from baseline to endline; (2) whether the participant discussed condom use, HIV, or sex life more during the six months preceding the endline survey (that is, before the intervention, compared with during or after the intervention); (3) whether the participant perpetrated any violence toward his primary partner during the past six months; and (4) whether the participant perpetrated physical violence toward his partner during the past six months. Multivariate

[8] Middlestadt SE, Pulerwitz J, Nanda G, Acharya K, Lombardo B. *Gender norms as a key factor that influences SRH behaviors among Ethiopian men, and implications for behavior change programs*. Unpublished final report.
[9] World Health Organization. *Multi-Country Study on Women's Health and Domestic Violence Against Women*. Geneva: WHO; 2002. Available from: www.who.int/gender/violence/multicountry/en/print.html.

regression models were constructed for each outcome, which allowed us to isolate the effect of the intervention with a variable for intervention group, while accounting for other client characteristics. Both multivariate logistic regression and generalized estimating equations (GEE) models were used for this analysis. GEE models use both baseline and endline observations on the same participants and account for intra-participant clustering.

Study population

Participants in all three study arms were similar. They were young, likely to be single and living at home with their families, and relatively highly educated, having attended secondary school. In all three study groups, more than 50 percent were younger than 20 years old, more than 97 percent were single, and more than 90 percent were Orthodox Christian. More than 67 percent were currently attending school, and the vast majority, close to 90 percent, were still living at home with their families. Table 1 presents sociodemographic characteristics of the baseline participants by arm.

Table 1. Sociodemographic characteristics of participants at baseline, by study arm

	GE+CE (Gulele) (n=235)	CE only (Kirkos) (n=251)	Comparison (Bole) (n=159)
Age*			
15–19 years	57.4	55.8	65.4
20–24 years	42.6	44.2	34.6
Marital status			
Single	97.5	98.8	97.5
Ever married	2.5	1.2	2.5
Religion			
Orthodox Christian	95.3	92.0	89.3
Muslim	1.3	4.8	9.4
Protestant/Catholic/other	3.4	3.2	1.3
Education			
Primary (grades 1–8)	50.2	36.2	42.8
Secondary (grades 9–12)	38.7	53.8	48.4
More than secondary	11.1	10.0	8.8
Currently in school	63.4	68.5	71.7
Living arrangement			
With family	93.6	89.6	89.9
With friends/partner	2.6	7.6	5.0
Lives alone	3.8	2.8	5.1

* The median age for all three study arms was 19.0 years.

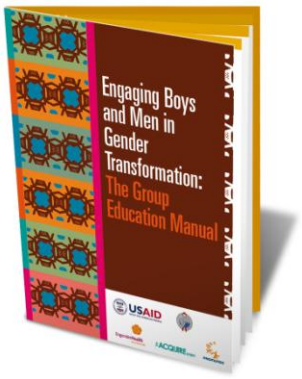
Qualitative data collection

Qualitative, in-depth interviews with a subsample of intervention participants and their primary female sexual/romantic partners were conducted at endline only. Each member of the couple was interviewed separately. Interviews lasted approximately one hour. The data were used to explore the process of change related to support for (in)equitable gender norms and related HIV risk behaviors within relationships (if any), as well as reactions to the intervention (both positive and negative) from the perspective of participants and their female sexual/romantic partners. Twenty-five couples were interviewed from each of the two intervention arms for a total of 50 interviews. This was a convenience sample, where every young man who participated in the intervention was asked to complete a further in-depth qualitative interview if he had a current regular partner/girlfriend/wife at endline. The young man was then asked to contact his partner about participation. If both he and his partner were interested and willing to participate, they were invited to do so. Interviews were scheduled at separate times and dates for men and women to ensure the safety, protection, and confidentiality of female partners. The first couples who agreed (when both agreed) were selected, until the needed sample size was reached. These interviews explored reactions to the intervention and provided detailed information about the process of change related to gender norms and HIV risk within a couple.

In this convenience sample, most men were between 20 and 24 years of age, and most women were less than 20 years of age. Most male and female participants had attended secondary school and were not married.

Intervention

The intervention activities were based on EngenderHealth's Men as Partners (MAP) Program. Promundo, which implements Program H, also provided technical input that contributed to the intervention design. Both programs aim to promote equitable gender norms and to reduce HIV, STI, and violence risk. The interventions focus on promoting critical reflection on common gender norms that can increase risk (e.g., encouragement for men to have multiple sexual partners; acceptance of partner violence under certain circumstances) in order for participants to identify the potential negative outcomes or costs for enacting these norms and the potential positives that may result with more gender-equitable behavior.



Hiwot Ethiopia, a local organization focusing on addressing the needs and rights of children and youth, implemented the intervention over approximately six months with technical assistance from EngenderHealth. Hiwot Ethiopia also provided substantial input into adapting the intervention activities for the Ethiopian context. A manual entitled *Engaging Boys and Men in Gender Transformation* was developed/adapted for the MNI activities.

The two main intervention components were intensive, interactive group education with groups of young men and wider community engagement activities to raise awareness and promote community dialogue. It was hypothesized that combining both would be more effective than community engagement activities alone and that reaching important objectives would require

both types of activities. Another key research question for this project was to determine the degree of impact of the community engagement activities alone. The set of community engagement activities required fewer human and financial resources than group education. There were questions related to potential for widespread scale-up of activities found to be effective.

Identification and training of MNI facilitators

Six "master trainers" from Hiwot Ethiopia—four men and two women with university degrees—were selected to train and support "peer educators," who in turn implemented the intervention activities. EngenderHealth trained the master trainers on both group education and community engagement over eight days. Hiwot Ethiopia then identified, recruited, and trained 68 peer educator, who ranged in age from 15 to 24 years, had previous peer education and HIV/AIDS experience, and were recommended by leaders of their youth clubs.

Peer educators participated in a one-week training involving the same activities that they would later be asked to facilitate. This allowed them the opportunity to reflect on their own attitudes around key issues. At the end of the training, Hiwot staff selected 59 peer educators to continue with the intervention who they felt showed the most promise based on criteria identified by the MAP team (i.e., mastery of the content, effective facilitation skills). Twenty-nine were selected to facilitate group education and community engagement activities in the GE+CE arm, and 30 to facilitate community engagement activities in the CE-only arm.

Group education intervention

Training tools and strategies were designed to assist youth in examining traditional gender norms and their relation to HIV prevention and care. The group education sessions addressed the following topics: Gender, Act Like a Man, Pleasures/Risk, From Violence to Respect in Intimate Relationships, Sexual Consent, What to Do When I Am Angry, Levels of HIV Risk, Alphabets of Prevention, Getting Tested, New Kinds of Courage, and Making Changes in Our Lives and Communities. The activities included role plays, group discussions, and personal reflection.

GE activities took place over four months at youth centers during regularly scheduled youth group hours, usually on the weekends. Youth participating in these activities were divided into small groups of 20 participants. The group education sessions were facilitated by two or three peer educators, with oversight from one master trainer. Peer educators facilitated 19 modules from the group education manual. Similar modules were grouped together for each group education session, resulting in eight two- or three-hour sessions.

Recruitment of young men

Hiwot Ethiopia identified 11 youth clubs from three subcities (Gulele, Kirkos, and Bole) to recruit young men for the intervention, including health-focused, sports, and social clubs ranging in size from small (± 50 members) to relatively large (± 400 members). Selected clubs had good working relationships with Hiwot, were situated in high-risk areas, and reflected the desired target population of men 15 to 24 years old. Individuals eligible to participate (young men ages 15 to 24 years who lived in one of the identified subcities and participated in the local youth clubs) were asked by researchers to complete a consent form and supply contact information. They were then contacted directly by the local research partner, Miz-Hasab Research Center. Participants received refreshments and travel allowances to ensure participation and retention.

Community engagement

The second component of the intervention included community engagement activities to promote more gender-equitable norms and HIV and violence prevention at the community level. The community engagement activities took place over a six-month period, beginning with a march on International Father's Day in June, and continuing with the roll-out of additional activities from July to November, including the distribution of informational materials and condoms, music and drama performances, and community discussions. As described below, these activities involved the entire community and not only members of youth groups.

- International Father's Day march: This one-time event that launched the project included a two-hour radio show focused on fatherhood, a text messaging campaign, distribution of informational materials, and a half-day discussion on gender and fatherhood responsibilities. Media representatives were invited to the event to cover the activities.
- Monthly newsletters and leaflets: Three monthly newsletters and related leaflets were developed and distributed. Each month focused on one of three themes: gender, HIV, and gender-based violence. Approximately 8,000 newsletters and 2,800 leaflets were distributed each month.
- Music and drama skits: Six separate edutainment events were held over a three-month period in both the CE and CE+GE sites. One event was held jointly in the two sites. In total, these seven events reached more than 8,700 people. At least two-thirds of participants were present at each event.
- Community workshops: Meetings were held with community members to discuss gender and HIV-related issues. They were led by master trainers and supported by peer educators. Four discussions were held in each of the two intervention sites (total of eight). More than 175 community members attended these workshops.
- Community Action Teams (CATs): CATs comprised 30 interested volunteers from the community workshops. Eight weekly meetings were led by master trainers and peer educators in both intervention sites to develop skills for identifying and prioritizing issues related to HIV prevention and gender-based violence using the MAP/Promundo manual.
- Condom distribution: Youth clubs distributed 1,100 condoms.

Results

The findings from this study are presented below, beginning with the key baseline results and followed by a presentation of the comparison between baseline and endline findings. Sociodemographic characteristics of participants at baseline are presented in Table 1.

Key baseline results

Gender norms varied among young men at baseline.

At baseline, support for equitable gender norms varied by topic. Participants expressed a great deal of support for the need for violence under various circumstances. For example, most respondents (58 percent) agreed that "a woman should tolerate violence in order to keep her family together," and 40 percent agreed that "it is all right for a man to beat his wife if she is unfaithful." A substantial proportion reported support for gender inequity in decision-making and daily activities, with 50 percent agreeing that "a woman should obey her husband in all things." A moderate number of respondents supported some behaviors that may increase HIV risk, such as men's "need" for multiple partners, with 35 percent agreeing that "a man needs other women,

even if things with his wife are fine." However, condom use was considered relatively acceptable for both men and women, with only 12 percent agreeing that "a man should be outraged if his wife asks him to use a condom."

Participants reported moderate HIV-risk behaviors and limited sexual activity at baseline.

About 35 percent reported having sex in the past, with an average age of 18 years at sexual initiation. About one-third had a primary partner during the six months prior to the survey, although this could be a sexual partner or nonsexual partner. In fact, very few participants reported being sexually active during the six months prior to the baseline survey with either primary partners or secondary partners. The great majority of sexually active respondents reported having one sexual partner during the six months prior to the baseline. Fewer than 10 percent reported any STI symptom over the past six months.

Seventy-six percent of sexually experienced youth reported condom use during their last sexual encounter, and 55 percent reported that they had used a condom the first time they had sex. The main reason for using condoms (indicated by 72 percent of those who used) was to prevent STI and HIV infection. The main reason for not using condoms (indicated by 30 percent of those who did not use them) was that it "shows a lack of trust in my partner." Table 2 summarizes the risk profile of respondents at baseline.

Table 2. Baseline HIV risk factors at time of interview, by study arm

	GE+CE (n=235)	CE only (n=251)	Comparison (n=159)
Partner-related characteristics:			
Had primary partner in past six months (percentage)	25.1	38.6	28.3
Had other partner in past six months (e.g., casual, sex worker, other primary) (percentage)	6.0	6.4	5.0
Had both primary partner and other partner in past six months (percentage)	2.1	4.8	1.9
Ever had sex (percentage)	39.2	39.0	27.7
Sexual risk factors among those who ever had sex:	**n=92**	**n=98**	**n=44**
Median age at first sex (year)	18.0	18.0	18.0
Condom use at first sex (percentage)	54.5	52.0	68.2
Any STI symptom in past six months (percentage)	6.5	10.2	2.3

Participants reported high levels of violence against primary partners at baseline.

At baseline, most participants (62 percent) reported having been violent toward a primary partner. Responses indicated that 28 percent had slapped a partner or thrown something that could hurt her, and 16 percent had pushed, shoved, or pulled the hair of a partner. Even more

men reported verbally abusive behaviors, with 43 percent having insulted or made a partner feel badly about herself and 32 percent having intentionally scared or intimidated a partner.

Fifty-three percent reported some form of violence against a primary partner in the previous six months. Thirty-five percent had insulted a partner or made her feel bad about herself, 29 percent had scared or intimidated her on purpose, 24 percent had slapped her or thrown something at her that could hurt her, and 15 percent had pushed her, shoved her, or pulled her hair.

Post-intervention impact results

Key results from the baseline-endline comparison included changes in GEM Scale scores; discussions on condom use, HIV, or sex life; perpetration of any violence toward primary partners; and perpetration of physical violence toward primary partners. Limited sexual activity did not permit a baseline-endline comparison for number of partners or condom use.

More equitable gender norms can be successfully promoted.

The interventions had a positive, significant impact on attitudes toward gender norms, as measured by the GEM Scale. A similar impact was not seen among the comparison group. More detailed findings are highlighted below.

The GEM Scale is a combination of 24 items that measure support for (in)equitable gender norms. Evaluation of results for individual items showed that some changed significantly and some did not. In the GE+CE arm, for example, 7 items significantly changed in a positive direction, 1 changed negatively, and 16 showed no change. In the CE-only arm, 5 items significantly changed in a positive direction, 1 changed negatively, and 18 showed no change. By contrast, in the comparison arm, no item changed significantly in any direction. Table 3 displays results for various GEM Scale items at baseline and endline.

Overall, when results for all 24 items were combined into the full GEM Scale, participants in the GE+CE arm but not those in the CE-only arm showed significant positive change. Those who changed became more supportive of equitable norms and less supportive of inequitable norms. Participants were split into two groups based on the change in their GEM Scale score: (1) GEM Scale score did not increase by more than the mean change and (2) GEM Scale score increased by more than the mean change. The mean GEM Scale change from baseline to endline was a one point increase. When results were controlled for demographic factors, young men in the GE+CE intervention group were nearly twice as likely as those in the comparison group to increase their GEM Scale score by more than the mean score from baseline to endline. Importantly, GE+CE participants had higher GEM Scale scores at baseline than those in the other two groups, so this further increase was notable. Generally, better educated men were more likely to increase their GEM Scale scores over time.

Table 3. Percentage of respondents agreeing with GEM Scale items at baseline and endline, by study arm

	GE+CE			CE only			Comparison		
	Percentage agree with statement			Percentage agree with statement			Percentage agree with statement		
	Baseline n=235	Endline n=235	p-value	Baseline n=251	Endline n=251	p-value	Baseline n=159	Endline n=159	p-value
Violence									
There are times a woman deserves to be beaten.	19	19	1.00	20	22	0.58	11	13	0.49
A woman should tolerate violence in order to keep her family together.	53	48	0.23	61	52	0.04	61	58	0.57
If someone insults a man he should defend his reputation with force if he has to.	19	18	0.81	36	39	0.41	23	21	0.68
It is okay for a man to hit his wife if she won't have sex with him.	12	10	0.38	23	17	0.12	11	15	0.40
A man using violence against his wife is a private matter that shouldn't be discussed outside the couple.	30	34	0.37	35	32	0.57	30	28	0.71
It is alright for a man to beat his wife if she is unfaithful.	41	39	0.64	41	35	0.20	37	38	0.73
Reproductive health and disease prevention									
It is a woman's responsibility to avoid getting pregnant.	40	43	0.45	47	44	0.42	45	52	0.18
A man should be outraged if his wife asks him to use a condom.	16	9	0.02	12	10	0.67	9	12	0.47
Women who carry condoms on them are easy.	30	19	<0.01	29	18	<0.01	30	25	0.32
Only when a woman has a child is she a real woman.	11	11	0.77	10	4	<0.01	9	11	0.58
A real man produces a male child.	8	9	0.74	10	10	0.88	7	12	0.12
Sexuality									
It disgusts me when I see a man acting like a woman.	30	43	<0.01	43	72	<0.01	48	47	0.82
A woman should not initiate sex.	24	28	0.34	32	33	0.85	33	31	0.81
You don't talk about sex, you just do it.	25	15	<0.01	23	15	0.03	21	17	0.32

A woman who has sex before she marries does not deserve respect.	38	26	<0.01	34	25	0.02	38	36	0.73
Men need sex more than women do.	42	33	0.05	38	31	0.11	36	37	0.91
Men are always ready to have sex.	46	40	0.11	43	44	0.86	44	40	0.50
A man needs other women, even if things with his wife are fine.	37	35	0.50	43	36	0.08	31	40	0.10
It is the man who decides what type of sex to have.	19	16	0.39	14	16	0.62	15	18	0.45
Domestic life and child care									
Giving the kids a bath and feeding the kids are the mother's responsibility.	63	48	<0.01	68	62	0.16	59	59	0.91
A woman's most important role is to take care of her home and cook for her family.	39	34	0.25	41	35	0.14	37	38	0.91
A man should have the final word on decisions in his home.	18	16	0.54	25	19	0.13	19	21	0.58
The husband should decide what major household items to buy.	26	15	<0.01	25	21	0.29	23	22	0.79
A woman should obey her husband in all things.	49	49	1.00	51	49	0.59	52	46	0.31

Responses to the GEM Scale were also split into three groups based on the GEM Scale scores at baseline and endline—representing low equity, moderate equity, and high equity scores. In the GE+CE arm, more young men had high equity scores at endline (40 percent) than at baseline (34 percent). Shifts in responses tended to be from the moderate equity category at baseline to the high equity category at endline. Similarly, in the CE-only arm, more young men had high equity scores at endline (34 percent) than at baseline (27 percent).

The shifts in responses tended to take place from the low equity category as opposed to the moderate equity category. Conversely, in the comparison/delayed intervention group, more young men had low equity scores at endline (33 percent) than at baseline (28 percent). At both baseline and endline, participants in the GE+CE arm were more likely to have high equity scores than were participants in the other two groups. Figure 2 shows detailed results.

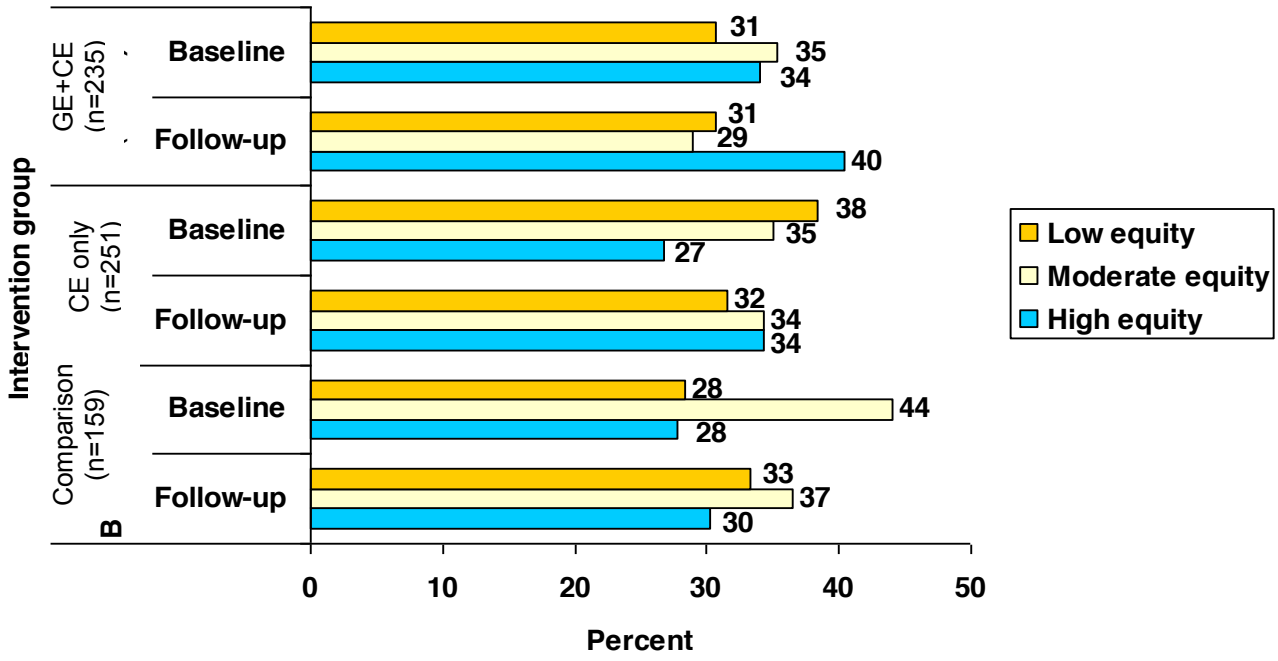


Figure 2. Changes in GEM Scale scores from baseline to endline in each study arm.

During in-depth interviews held with young men in the intervention arms, participants shared their views about how the sessions helped them to reflect on their attitudes around gender norms. When asked about women discussing condoms, one young man from the GE+CE arm stated:

> Before I consider them as a bad girl, but now I am not surprised if I hear them talking about this issue, even I will support them. I think they talk what is important to their life.

Another young man discussed how his attitudes toward gender norms changed as a result of his participation in the Hiwot Ethiopia group education activities:

> I have learned that a woman is equal like a man. I have learned that a woman is successful in productive work. I have learned to reduce the workload of a woman at home. I have learned all these.

Another young man from the GE+CE arm discussed changes related to gender norms that he has experienced since participating in the program:

> I have been changed after I learned here [at Hiwot Ethiopia]. But at the earlier times I leave responsibilities for other members of the household. After I had learned here I am helping not only my girlfriend but also my families, my grandparents, and my mother. I am doing any kinds of work at home. I am doing a range of work including wiping, laundering clothes, cleaning rooms, and I wash household utensils if they are dirty. I am helping my mother in any other task while she is working another task.

A young man from the CE-only arm talked about changes he has made related to gender norms as a result of his participation in Hiwot Ethiopia's community activities:

> Before I participated with my friends in actions like sexual harassment because it was fun for us. But now, I have completely changed…and I advise others…[on how to make similar changes]. In my residence I share chores with my family after I took gender training.

Young men reported significantly more communication about condoms, HIV and sex life.

The interventions encouraged increased communication about HIV risk and related topics with their partners and other important people in their lives. At endline, young men from both intervention groups were much more likely to report increased communication about condoms, HIV, and their sex life with others than were those from the comparison group, with the combined intervention group being significantly more likely. As seen in Figure 3, 71 percent of young men from the GE+CE arm reported increased conversation about at least one of these topics, compared to 67 percent of those from the CE-only arm and 55 percent from the comparison group.

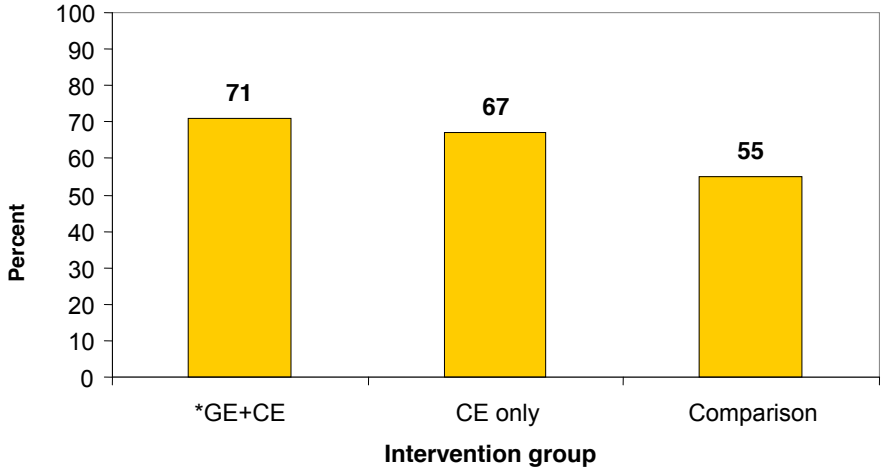


Figure 3. Percentage of young men discussing condoms, HIV, or sex life more in past six months (*p<0.05 for differences between groups).

As shown in Table 4, the bivariate results indicate that young men with increased communication were more likely to be from the GE+CE arm (40 percent) or CE-only arm (39 percent), whereas young men not reporting increased communication were roughly equally divided between the three groups. Young men with higher GEM Scale scores at endline were also more likely to report increased communication. More than 40 percent of those who discussed condom use, HIV, or sex life more in the past six months had high-equity GEM Scale scores, compared to only 27 percent of those not reporting increased discussion. A bivariate analysis was also conducted between communication, (specifically about HIV, condom use, and sex life), and sociodemographic variables, including age, marital status, education and religion. No statistically significant correlation was found between any of them. To further explore the relationship among these variables, multivariate logistic regression was used.

Table 4. Percentages of respondents in each group who reported increased discussion of condom use, HIV, or sex life in the past six months at endline

	Discussed condom use, HIV, or sex life more in past six months*		
	No n=215	Yes n=408	p-value
GEM Scale			
Low equity	37.2	28.2	
Moderate equity	35.4	31.4	
High equity	27.4	40.4	<0.01
Intervention group			
Comparison group	33.0	21.1	
CE only	35.8	39.0	
GE+CE	31.2	40.0	<0.01

*Excludes 22 respondents who have never discussed condom use, HIV, or sex life.

Table 5 shows the results of multivariate logistic regression analysis for increased discussion of condom use, HIV, or sex life in the past six months. These results show that young men with noncohabiting partners were 2.6 times more likely to report increased communication than single or ever-married men. As with the bivariate results, men who had ever had sex were 1.5 times more likely to report increased communication.

Importantly, after controlling for other socio-demographic characteristics in the model, those with high-equity GEM Scale scores were more than twice as likely to report increased communication about condom use, HIV, or sex life. Young men from both intervention groups were much more likely to report increased communication about these issues than were those from the comparison group. Men from the CE-only arm were 1.8 times more likely than those in the comparison group to report increased communication, and those from the GE+CE arm were 1.9 times more likely.

Table 5. Multivariate logistic regression results at endline for increased discussion of condom use, HIV, or sex life in past six months among participants (n=623) with various characteristics*

Variables	Adjusted Odds Ratio	p-value
Age		
15–19 years	1.00	
20–24 years	1.08	0.66
Marital status		
Single	1.00	
Noncohabiting partner	2.62	0.04
Married	0.72	0.58
Ever had sex	1.49	0.03
GEM Scale		
Low equity	1.00	
Moderate equity	1.23	0.33
High equity	2.03	<0.01
Intervention group		
Comparison group	1.00	
CE only	1.77	<0.01
GE+CE	1.90	<0.01

*Excludes 22 respondents who have never discussed condom use, HIV, or sex life.

One young man from the GE+CE arm discussed how he now talks more openly about condoms with his girlfriend as a result of his participation in the group education activities:

> We have brought a change based on the lesson we have got here [at Hiwot Ethiopia]. We were not speaking about some issues, like condom use, openly before this lesson…after we have learned at the Hiwot Ethiopia program, we are talking about condoms a lot. We are discussing it openly.

Significant reductions in partner violence were reported in both intervention arms.

The percentage of young men who reported that they perpetrated violence toward their primary partners decreased in both intervention groups, a change that was not seen among the comparison group (see Figures 4 and 5). In the GE+CE arm, the percentage of young men perpetrating any violence (physical or psychological) toward a primary partner over the past six months decreased from 53 to 38 percent, and the percentage who were physically violent decreased from 36 to 16 percent ($p<0.05$). Similarly, the percentage in the CE-only arm perpetrating any violence toward a primary partner over the past six months decreased from 60 to 37 percent ($p<0.05$), and the percentage who were physically violent decreased from 36 to 18 percent ($p<0.05$). Violent behaviors either stayed the same or increased in the comparison arm.

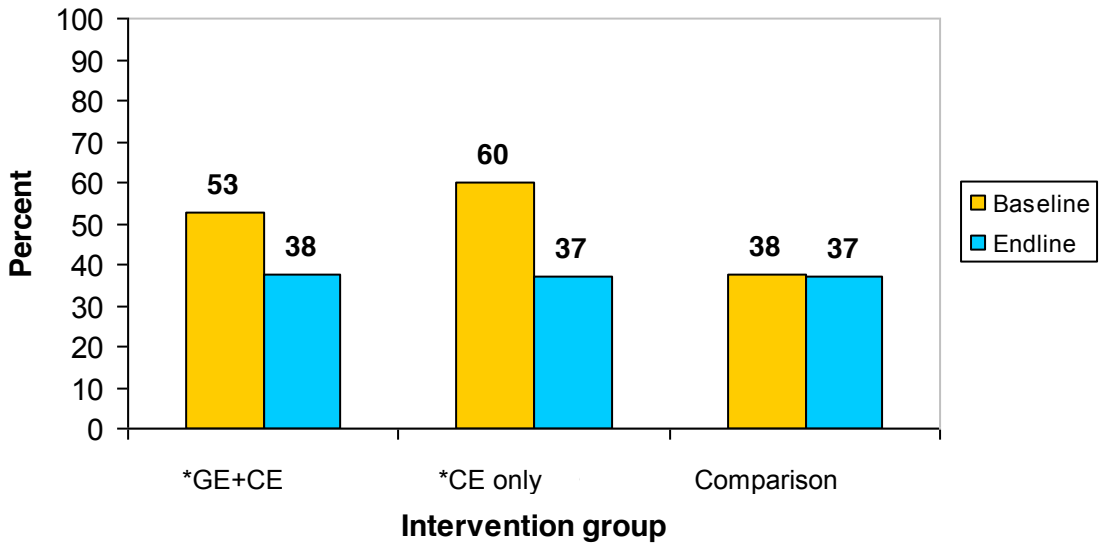


Figure 4. Change in intimate partner violence in past six months (* = statistically significant baseline-endline difference at p<0.05 [within study arm]).

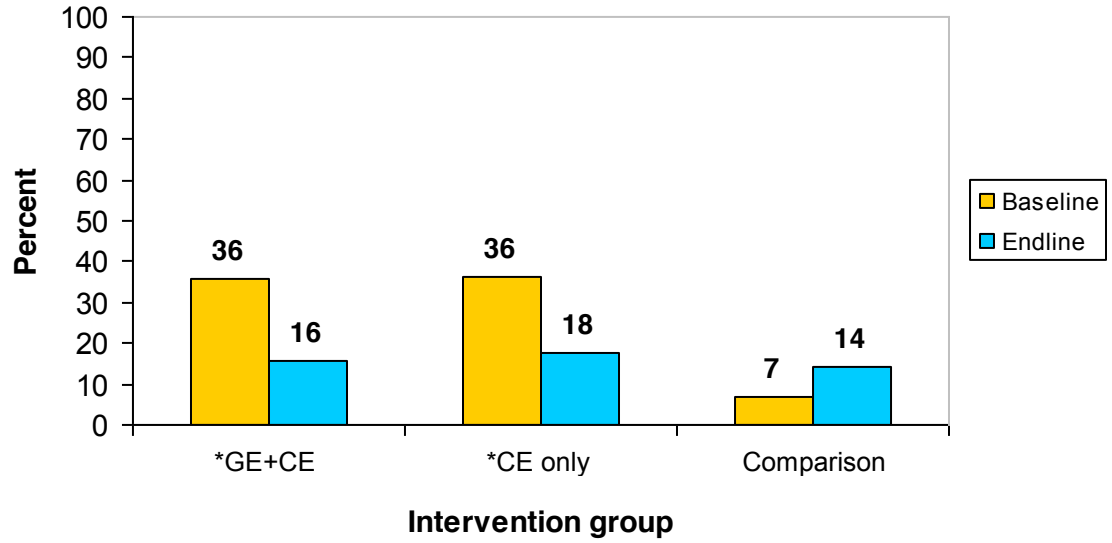


Figure 5. Change in physical partner violence in past six months (* = statistically significant baseline-endline difference at p<0.05 [within study arm]).

It is important to point out, however, that the comparison group had lower baseline levels of violence than either of the intervention groups. Young men from the CE-only arm were 2.7 times more likely to report violence at baseline than those in the comparison arm (p<0.01), and participants in the GE+CE arm were 2.5 times more likely to report violence than those in the comparison arm (p=0.02).

To examine the relevance of the baseline differences in violence, the study team examined decreased violence in the intervention groups in more detail. In a multivariate analysis with GEE logistic regression, after investigators controlled for age, GEM Scale score, intervention group, and time and added an interaction term for time*intervention group, the odds of violent behavior were reduced more over time in the intervention groups than in the comparison group. (A model that includes an interaction term provides a more accurate/specific description of the relationship between the factors in question.) The multivariate results suggest a trend toward violence reduction in the intervention groups. Over time, young men from the CE-only arm were 65 percent less likely to exhibit violence toward their partners compared to participants from the comparison group (p=0.06). Similarly, participants from the GE+CE arm were 55 percent less likely to exhibit violence over time.

Finally, agreement with more equitable gender norms was associated with a trend toward a reduction in physical violence. Specifically, high-equity GEM Scale scores were associated with a 34 percent reduction in the odds of partner violence (p=0.08) among all groups.

Young men perceived changes in behavior due to participation in the intervention.

The endline surveys included open-ended questions about perceived changes in behavior due to the interventions. The great majority of participants reported positive changes in behavior. Almost 95 percent of those from the GE+CE arm and 82 percent from the CE-only arm said their behavior had changed in some way due to their participation in the intervention.

Table 6 summarizes participants' responses about changes in behavior. The most common behavior change reported in both the GE+CE (32 percent) and CE-only (22 percent) groups was increased awareness about HIV or feeling less stigma toward people who are HIV positive. More than one-fifth of young men in both the GE+CE arm and CE-only arm also reported reduced sexual risk behavior as a result of the intervention. Nearly one-fifth also reported increased awareness about gender issues. More than 13 percent in the GE+CE arm said they treated women with more respect as a result of the intervention, compared with nearly 9 percent of those in the CE-only intervention.

Table 6. Reported changes in behavior by participants in intervention arms (percentage)

	GE+CE n=235	CE-only n=251
Behavior changed because of participation	94.9	81.7
Raised awareness about HIV/decreased stigma	32.3	21.5
Raised awareness about gender equality	19.6	17.5
Have more open discussions about sexuality	9.4	12.8
Reduced sexual risk behavior	20.4	21.1
Treat women with more respect	13.2	8.8

The study team conducted qualitative, in-depth interviews with a subsample of intervention participants to explore these issues in more detail. The findings reinforced the survey results concerning perceived changes in behavior. Among males in the GE+CE arm, many reported changes in their relationships with partners as well as in their behaviors toward partners in the previous six months. Many reported that:

- They had stopped supporting traditional gender norms that include undervaluing women and stopped leaving household chores (such as laundry, wiping the floor, washing utensils) only for women.
- They had acquired more knowledge about HIV and AIDS, the skills to negotiate sexual relations, the use of condoms, and how to avoid risky behaviors such as drinking alcohol.
- They had learned about life skills that helped them avoid aggressiveness, develop smooth relationships with their partners, and withstand peer pressure.

The few respondents who were unable to pinpoint specific behavioral changes still emphasized the knowledge they gained from the activities.

One participant indicated that he had made many changes since participating in the group education sessions, saying:

> After I took this training, I made a lot of changes…that I should use a condom, I should be faithful to my "friend," that I should get tested for HIV.

Another young man explained how participation had changed his views about gender roles:

> Women are not solely responsible for work on household chores but also men…. I should do one thing while my spouse does another thing.

One participant discussed how he had previously pressured his girlfriend to have sex and how his attitudes around sex have changed, saying:

> At that time I became angry even if I loved her because there was peer pressure to have sex. And at that time our relationship would be worse while she refused to have sex with me. I recalled that this situation was bad…. At this time I have been changed as sex is something that can be reached any time in the future.

Another young man discussed how his relationship with his girlfriend had changed:

> I believe in refraining from beating a girl. I believe that it is not right to beat a girl if a girl makes you angry…. I have got awareness about these issues from the Hiwot Ethiopia program.

Another man stated:

> Before the program I wasn't good. I didn't have any idea to have one girlfriend. But now after I attend the program, I have one permanent girlfriend still.

Most females reported positive changes in their partners.

Most female partners who participated in the in-depth interviews indicated that they had seen clear changes in their partners' behavior. These changes included openly discussing HIV/AIDS, sex, and protecting oneself from diseases; talking about faithfulness in relationships; helping with household chores; and not engaging in unhealthy behaviors such as smoking or chewing chat, a plant with mildly stimulative properties. For example, the wife of one young man said:

> My husband told me about unwanted pregnancy, abstinence, and HIV. He told me that we have to take care of ourselves from these, and we have to care for each other. In relation with the program, I can say he now cares about his house[hold], and I can say this program makes everything good.

One woman explained how her partner now accepts "no" as an answer to his sexual requests:

> We are in early stage of relationship, so when women say no to having sex, most boys think that we don't love them. But now after he got the awareness, he says, "yes you are correct,'' and we start discussing this. So, all these are changes for me that I saw in him.

After the intervention, men were less reluctant to meet the parents of their female partners. One woman described this as follows:

> Yes, I have introduced him to my parents, and me to his parents. He asks my mother to advise me not to go to bad places, not to be with bad friends. My mother has also noticed this change. She says to me this boy's behavior has changed a lot, he has stopped being with his bad friends himself. I think he told her he had taken a training at a certain club called Hiwot. I have seen some things that are good and I thank God.

Another young woman said:

> Now he has motivation for work…. We discussed he has to work like his friends. Before he used to stand on the street, but now after he comes from work he goes home and when we meet we go to church.

Despite missing intervention activities, positive changes seen.

Nearly 65 percent of young men in the GE+CE arm received written materials from Hiwot Ethiopia, compared to 43 percent of those in the CE-only arm (see Table 7). Participants in both intervention arms attended a median of two (out of four) community discussions and one music/drama skit. Nineteen percent of those from the GE+CE arm and 13 percent from the CE-only arm participated in the Father's Day March activity.

In the GE+CE arm, group education activities took place at youth centers during the regularly scheduled youth group hours over a four-month period. Peer educators facilitated eight sessions, which covered 19 modules from the group education manual. Most participants (68 percent) in the GE+CE arm attended three or fewer of the eight group education sessions, and nearly 62 percent reported missing at least one of the sessions.

Table 7. Exposure to intervention components among those in intervention groups

	GE+CE n=235	CE-only n=251
Percentage receiving written materials from Hiwot Ethiopia*	64.7	43.4
Number of group education sessions attended		
0–1	33.6	-
2–3	34.1	-
4–6	18.4	-
7+	13.9	-
Percentage missing at least one group education session	61.7	-

* Difference between study arms is significant at $p<0.05$.

Capacity-strengthening and technical assistance activities

In Ethiopia, the MNI had strong capacity-strengthening and technical-assistance components. Various group—including the local intervention partner for the community-based program (Hiwot Ethiopia), a range of PEPFAR NGO partners, and staff at PMTCT service delivery sites—received training from EngenderHealth and Promundo on ways to integrate male engagement activities into ongoing programmatic work and create more "male-friendly" spaces. The study team also conducted a "process evaluation" aimed at highlighting the successes and challenges of implementing MNI activities in Ethiopia, obtaining additional insight into the capacity-strengthening process and capturing lessons learned from the initiative to complement the impact evaluation findings. Results from that evaluation are provided in this section.

Intervention

Hiwot Ethiopia staff received eight days of training and ongoing technical assistance focused on program design and implementation, monitoring and evaluation (M&E), materials development, group education, and community engagement facilitation. As highlighted earlier, master trainers were expected to train and support peer educators who would implement the intervention. Local NGO partners referred by PEPFAR were offered (but not mandated to participate in) a one-day training on integrating gender (specifically, male engagement) into ongoing activities. At that training, partners developed action plans and timelines that were shared with EngenderHealth and Promundo trainers. Partners were also offered further technical assistance on an as-needed and individually requested basis in the following areas: program design, strategic planning, needs assessment, curriculum development and review, development of informational materials, implementation, M&E, training in group education, community mobilization and service delivery, policy review and assessment, advocacy, and networking. The actual amount of assistance provided varied greatly. Staff at PMTCT sites received similar one-off trainings from a separate funding mechanism.

Evaluation objective and methods

In April 2009, the study team conducted key informant interviews (n=17) with the local intervention partner (Hiwot Ethiopia), PEPFAR NGO partners, and staff from PMTCT service delivery sites who received capacity-strengthening or technical assistance from EngenderHealth and Promundo. In-country staff from EngenderHealth were also interviewed about their experiences implementing activities related to male engagement and addressing gender equity and gender norms for HIV prevention. These interviews were part of the process evaluation of the capacity-strengthening activities highlighted above.

Interviews were conducted in Amharic, recorded, transcribed, and translated into English. Key informants were asked about the overall mission of their organization, the capacity-strengthening or technical assistance they received, accomplishments and challenges they experienced, and suggestions for improvements.

Transcripts of the interviews were reviewed to draw out specific content and key themes related to partners' experiences with implementation of the intervention in Ethiopia, as well as specific suggestions for improving the program. Quotes drawn from interviews reflecting the wide range of partner organizations are included to further contextualize and elucidate the themes.

Key findings

Technical assistance had a positive impact on partners.

Staff from Hiwot Ethiopia reported that the technical assistance had strengthened their ability to communicate and facilitate discussions with youth, particularly on issues related to gender, as well as changed their attitudes toward women. For example, one master trainer stated:

> Men should participate in everything, and my attitude about this idea has changed greatly. In our culture we differentiate things by saying that this is for males and that is for females…but this is not the correct way. [Men] have to participate in HIV-related issues and work together with their wives so this will make their life better.

In general, Hiwot staff felt that the project had been successful, noting the strong participation and perceived changes in participants' attitudes. However, most felt that the time frame was too short to comment on changes in participant behavior. Hiwot staff also highlighted the close, "smooth" working relationship with EngenderHealth as a factor in the success of the program.

Staff from other NGOs working on HIV prevention and related issues also reported positive outcomes from the technical assistance. Two examples were:

> Earlier, even if gender included both sexes it mainly focused on women, but now it also sees…men with their sexuality and community pressure on them, gender violence, why HIV has an alarming rate and we got the awareness to balance all these things.

> In the commercial sex workers program we have seen the importance of males and have also observed that they are the decision-makers, so we invite…males to participate…and [the training] has helped us to realize where to give focus and what message that we need to convey for them.

Respondents also identified a number of implementation barriers and challenges and offered suggestions for strengthening the Men as Partners intervention, including:

Substantial resources and time need to be committed to ensure effective implementation, scale-up, and sustainability.

Trainers highlighted the need for sufficient resources proportionate to the scope of the intervention and expected outcomes. The intervention was described as short-lived by some, who also noted the need to build sustainability and continuity into programmatic planning, including allocating resources for expansion. A related challenge was the time frame proposed for implementing activities. Staff from one NGO noted that they did not have sufficient time to implement the activities after receiving technical assistance. This challenge was linked in many ways to the difficulty of harmonizing the intervention with different organizations' funding and programmatic cycles. At least one organization received training as it prepared to phase out its activities, for example.

Some asked for resources to be committed for providing consistent technical assistance during project start-up and implementation and offering support for strengthening and expanding the program. Identifying focal points to assist master trainers with challenges would also be helpful.

The selection and training of facilitators is critical.

Respondents highlighted the importance of selecting trainers who understand the role of gender in their lives, are able to facilitate sessions effectively, are well respected in the community, and are supportive of male engagement. Although there are clear selection criteria for peer educators, an important emerging lesson is the need for strengthening the amount and level of training, monitoring, and support during implementation. One respondent highlighted the need to develop facilitators who "can understand and pass the lessons on in a good way to the community." The fact that the selected peer educators received an additional two days of capacity-strengthening training after the initial workshop appears to have contributed to their success in facilitating group education and community engagement activities, but additional support would have further bolstered their competence.

Men are often reluctant to participate in activities focusing on gender.

Respondents noted that many men and community members still believe that gender is only related to women. Many men are therefore hesitant to participate in a program focusing on gender issues. Participants suggested that male engagement work be integrated into ongoing community activities to facilitate reaching out to men and encouraging participation. Many emphasized the need to include women in the intervention activities.

Lessons learned about how to engage men appear to be galvanizing success.

The head of a health center reflected on steps taken to make the environment more appealing to men and the impact on the capacity to deliver male-friendly services:

> We were reorganizing our health center environment into something that can attract men. We were hanging banners and posters that say, "Welcome to Our Health Center, Happy for Being Women Partner." I think these were environments that can attract men. Moreover, we were constructing a park and trying to reveal that we are welcoming and trying to create a conducive environment for men.

Lessons and strategies such as the ones highlighted above appear to be galvanizing success in attracting and engaging men in clinic services. Interviews with service providers at PMTCT sites indicated that the trainings changed their own attitudes toward men and led to their encouraging clients to involve men in clinic services. The director of the HIV/AIDS Prevention Department at one of the health centers observed:

> Before, our PMTCT program only included females…but now, after the training of Men as Partners, the community has become more aware. We can see the changes by looking, for example, at the number of males who come to the antenatal clinic, and the number of males coming for family planning services has increased.

Discussion

Findings from the evaluation of the Male Norms Initiative in Ethiopia indicate that the intervention for young men, focused on promoting gender-equitable norms, successfully influenced participants' attitudes toward gender norms and led to positive health outcomes. The evaluation provided empirical evidence that a group education (GE) and community engagement (CE) intervention focused on combating inequitable and risk-supporting gender norms was associated with reductions in partner violence and improvements in HIV/STI risk outcomes. Further, the model of providing technical assistance to local groups to implement gender-focused HIV and violence prevention activities was well received by partners, and perceived as leading to positive impact. However, addressing complex and deep-seated issues such as gender and violence in HIV interventions required significant resources, and will necessitate additional support to solidify and maintain project gains.

Specifically, young men participating in the two intervention groups—but not the comparison group—expressed more support for equitable gender norms at endline compared to baseline, although only the group exposed to both participatory group education and community engagement (GE+CE) activities reported a statistically significant change in attitudes. Controlling for demographic factors, young men in the GE+CE intervention group were nearly twice as likely as those in the comparison group to increase their GEM Scale score by more than the mean change. Qualitative interviews from a subgroup of participants and their female sexual partners support the finding that views toward gender norms changed, and were reflected in gender-related behavior change in the relationship.

The fact that the combined intervention led to more support for equitable norms than the community engagement activities alone also provides empirical evidence that multiple strategies used simultaneously may be more effective than one strategy alone. Further, evidence from other evaluations of similar activities suggests that the interactive group education component of this intervention may be needed to sufficiently influence often deep-seated and complex gender-related norms.[10] However, it is also important to note that more than two-thirds (68 percent) of participants from the GE+CE arm attended three or fewer group education sessions, out of eight

[10] Pulerwitz J, Michaelis A, Verma R, Weiss E. Addressing gender dynamics and engaging men in HIV programs: Lessons learned from Horizons research. *Public Health Reports*. 2010;125:282–292.

possible sessions. Therefore, the group education component may not need to be very intensive to have an effect.

In addition, participants from both intervention groups reported statistically significant less violence over time, and similar positive change was not found among the comparison group. This is particularly notable because intervention group participants had higher baseline levels of violence than those in the comparison group. Reported prevalence of physical violence decreased by 20 percentage points in the GE+CE arm and 18 percentage points in the CE-only arm. In the multivariate analysis as well, the reduction in violence over time was more pronounced in both intervention arms (GE+CE and CE-only) than in the comparison arm. Further, findings on partner communication indicate that reported interpersonal communication on HIV-related topics (e.g., condom use) increased for both intervention groups, but not the comparison group. These findings highlight that the community-engagement activities alone were sufficient to lead to some key outcomes related to HIV and violence prevention.

Limited sexual activity reported by the young men before and during the intervention period constrained the amount of quantitative change in sexual risk that could be measured. Due to the small sample sizes, there was limited statistical power to analyze baseline and endline differences in specific risk behaviors, in the surveys. However, in an open-ended question in the survey, almost all respondents reported that the intervention had led to changes in their behavior. Specifically, 20 percent of respondents reported that this change was a reduction in their sexual risk behavior.

Reports from qualitative interviews with a subgroup of participants and their female sexual partners also indicate a reduction in HIV risk. Participants from both intervention arms indicated that they were more aware of gender issues, treated women with more respect, had improved condom negotiation ability, had learned how to communicate with their partners about HIV risk issues, and had reduced their sexual risk behaviors. Most female partners indicated that they had seen clear changes in their partners' behavior, and their relationships, since they participated in the intervention. These changes ranged from more open discussions about HIV/AIDS, sex, and protecting oneself from disease, to helping with household chores, to not engaging in other risk behaviors such as smoking.

Directly measuring attitudes toward gender-equitable norms provides useful information about the prevailing norms in the community as well as the effectiveness of any program that hopes to influence or promote a modification of those norms. To address this issue, the project team applied the GEM (Gender Equitable Men) Scale as part of the evaluation. The combination of the 24 items in the scale serves to more fully capture the multi-faceted concept of 'gender norms' than individual items alone. The scale had been adapted for the Ethiopian context in a previous study by one of the authors, and demonstrated good internal consistency. The original GEM Scale had been developed and tested by the same authors, and was found to have good psychometric properties. At the same time, responses to specific GEM Scale items emphasize the complexity of measuring and influencing attitudes toward gender norms. Responses to some items clearly changed in a positive direction, while others did not, indicating that views on some topics may be easier to influence than others.

Further, the strategy of providing technical assistance to local groups to engage men in gender equity promotion, and HIV and violence prevention, although resource intensive, appears to be a promising one. Findings from the process evaluation with Hiwot Ethiopia (the organization that implemented the group education and community engagement activities with young men in youth groups) and other PEPFAR partners indicated that the technical assistance was appreciated by recipients and perceived to positively impact their work. Interviewees cited a number of examples where their HIV and violence prevention work had been strengthened, and shared that it provided useful insights for how to more effectively engage men in related programs. However, the intervention was described as short-lived by some, who also noted the need to build sustainability into programmatic planning. Some interviewees requested that additional resources be committed to provide continual technical assistance during project start up and implementation and to offer support for expanding the program.

To maximize the chances of long-term sustainability of these types of activities, it would be important to regularly reinforce the messages related to alternative forms of masculinity and to further facilitate a supportive environment for these changes. One way to reach a larger audience would be to include discussions of manhood and gender norms in schools and other educational settings. Alliances should also be built for ongoing discourse on men and masculinities on a broader, and ideally national, scale.

This evaluation relied on self-reporting, which is a limitation that should be noted. The inclusion of female partners as part of the evaluation process provided some validation and confirmation of reports from intervention participants, to partially mitigate the limitation of self-reporting. Additionally, as described above, the majority of young men did not report sexual activity during the study period, which, due to small sample size, limited our statistical ability to analyze baseline and endline differences. This suggests that future interventions should focus limited resources on groups at higher current risk of HIV. On the other hand, it is relevant to raise that an important goal of addressing gender dynamics and inequities in HIV and violence prevention, on both the individual and community level, is to influence widespread gender norms and to lay the ground work for future impact on HIV risk and prevention behaviors.

Participation in the Male Norms Initiative activities in Ethiopia was associated with key, positive changes for young men, notably increased support for equitable gender norms, increased interpersonal communication on HIV-related issues, and reduced partner violence. Both interventions led to changes in some key variables, while the combined intervention (community engagement plus group education) at times was more successful. Strengthening the capacity of local groups to implement this and related work also seemed a promising strategy. The findings suggest that confronting inequitable gender norms—whether through technical assistance to groups to take this issue into account in their work or via direct implementation of programs for young men—is an important element of HIV and violence prevention strategies.