Positive Masculinity: An approach for the Angola context

Literature Review

SEARCH FOR COMMON GROUND

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A. Executive summary

Sexual and gender-based violence (*SGBV*) is a multidimensional issue that results from and is propagated by various aspects of community life and society. As such, the ways to respond to and prevent gender-based violence must be just as multidimensional, involving all sectors and members of the community.

The obvious question that arises in seeking ways to diminish and prevent gender-based violence is, "What are the causes of violence against women?" Leading researchers of SGBV argue that the two essential factors underlying violence against women are their subordinate status to men and the general acceptance of interpersonal violence in society.

So far there only a small number of programs addressing gender-based violence have been rigorously evaluated. Instead, there are a handful of promising interventions in the health, justice, education, and community development sectors that, if collectively supported and implemented, could have even more meaningful impacts on the prevention of SGBV. Effecting these changes and ensuring their sustainability means that the foundation for each of these interventions is gender sensitization to promote gender equity, as well as increased understanding of SGBV as a human rights problem that is detrimental to the community as a whole. Other crosscutting conclusions include:

- *A multi-sector approach* that pools efforts from a variety of fields of work is essential in preventing and responding to gender-based violence. Each field or sector has its role to play in helping survivors of SGBV and preventing further incidents: health providers detect cases and treat survivors while promoting healthy relationships through sexual and reproductive health programs; law enforcement puts sanctions on perpetrators of SGBV; and educators impart the message that SGBV is a violation of human rights and should not be tolerated or perpetrated. It is imperative that these roles are coordinated to be fully effective.
- *A multi-level approach* (individual, community, institutional, national, and international) must be taken in any and all sectors addressing SGBV. Common sense practically dictates that changing individual behavior, mobilizing communities, reforming institutional response, as well as reforming laws and policies are all vital strategies to challenging this multi-faceted problem.
- *Top-down as well as bottom-up leadership and mobilization* are necessary. Activities that mobilize citizens of communities and engaged leaders in the community are especially successful in changing attitudes and, at least according to preliminary findings, behavior. Without support from ministries or municipal leaders, however, interventions are less likely to be taken seriously and at times not fully carried out.
  - *Working with men is a key strategy.* Throughout the review, examples made evident that working with men is a key strategy to p revent gender-based violence. Behavior change strategies in the health sector have shown that gender inequitable attitudes can be unlearned. In schools, focusing initiatives on girls as "victims" to be protected without addressing patriarchal attitudes and behavior among boys simply reinforces the notion that girls are responsible for the violence they suffer. Throughout society and the community in general, men are decision makers that can pave the way for change.
- *Targeting youth* is perhaps one of the most efficient ways to prevent gender-based violence, albeit in the longer term. Evidence suggests that youth are more open to change, including their attitudes and behavior regarding violence. (Bott, Morrison, and Ellsberg). Nonetheless, such strategies should not undermine the need to work with the community overall.
- *To promote community ownership* of SGBV as a problem, community mobilization should involve all members of the community, from civilian beneficiaries, to health and legal service providers, teachers, and community leaders. Individual behavior change is not enough; it must be

linked to and reinforced by norms and messages in the surrounding community in order to be sustainable.

- *Preventing gender-based violence is a long-term investment.* Raising awareness is only the beginning of the processes of influencing change (Michau and Naker, 2004). Individual behavior change and community mobilization, as experiences of many programs reviewed made evident, requires long-term follow-up that may take years. Additionally, helping individuals think through alternatives to violence and creating informal and formal systems of accountability and support are essential for individuals to sustain a change in attitude and behavior (Michau and Naker, 2004). Too often, however, limited funding allows for only short-term support.

B. Aim of the review

As mentioned above, the aim of this review is to develop a synthesis of best practices in social norms change programs promoting positive masculinity in comparable contexts around the world with a specific focus on Sexual and Gender Based Violence. This will include the lessons learned from SFCG's own experiences doing similar programs in the DRC, Ethiopia, and Tanzania and academic literature published in peer-reviewed psychology journals. Furthermore, this review will include a range of different variations of "Rape Supporting Attitudes and Beliefs" (RSAB) or "Rape Supporting Attitudes Survey" (RSAS) data collection instruments. This commonly-used evaluation methodology for SGBV programs aims at identifying specific attitudes and beliefs that serve as a proxy indicator for the propensity to either engage in sexual violence, or to tolerate it.

1. Characteristics of Sexual Violence and Survivors of Sexual Violence

1.1 What is Sexual and Gender Based Violence?

There is no single or universal definition of gender-based or sexual violence. Understandings differ according to country, community and legal context. For instance, prevalent definitions of sexual violence exclude children. The lack of a clear and commonly accepted language inhibits the development of an effective reporting system and/or databases, and thus restrains prevention, monitoring and advocacy efforts1 (Baker, 2007). The term sexual and gender based violence, in its widest sense, refers to the physical, emotional or sexual abuse of a survivor. This review focuses exclusively on the sexual elements of abuse, and discusses the management of physical and emotional abuse only where it relates to accompanying sexual abuse. The classification of violence and abuse is explored in more detail in Annex 1. This document adopts the inclusive terminology employed by the World Health Organization, which defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work". The scope of the definition is here expanded to include the forced sex, sexual coercion and rape of adult and adolescent men and women, and child sexual abuse. The definition also includes:

➢ The use of physical violence or psychological pressure to compel a person to participate in a sexual act against their will, whether or not the sexual act is consummated.
➢ A sexual act (whether attempted or consummated) involving a person who is incapable of understanding the nature or significance of the act, or of refusing, or of indicating his or her refusal to participate in the act, e.g. because of disability, or because of the effect of alcohol or other substances, or because of intimidation or pressure.
➢ Abusive sexual contact (WHO, 2003b; Saltzman et. al., 1999).

The term sexual violence is used to represent much behaviour that may otherwise fall under the rubrics of sexual abuse, sexual assault, and any other sexual violations, such as sexual harassment and voyeurism. The term gender-based violence is widely used as a synonym for violence against women, in order to highlight the gender inequality in which much violence is rooted (IGWG of USAID, 2006). However, while this review acknowledges that the overwhelming recipients of violence are female, the term gender-based violence is here used to encompass all women, men, girls and boys who have experienced sexual violence.

1.2 Prevalence, Consequences and risk Factors associated with Sexual Violence

Overview

Social, economic, and gender issues are increasingly recognized as significant factors in countries of d southern Africa that underlie the HIV epidemic, keep maternal mortality and fertility rates high, and increase the likelihood that sex will not be safe, voluntary, or pleasurable. Violence against women and children, of both sexes, has gained international recognition as a serious social and human rights concern affecting all societies. Epidemiological evidence shows that violence is a major cause of ill health among women and girls, as seen through death and disabilities due to injuries, and through increased vulnerability to a range of physical and mental health problems (Krug et al., 2002; Mugawe & Powell, 2006). Female survivors of sexual violence not only sustain physical injuries, but are more likely than other women to have unintended pregnancies, report symptoms of reproductive tract infections, have multiple partners, and less likely to use condoms and other contraceptives (IFPP, 2004; Campbell & Self, 2004). Violence, and the fear of violence, severely limits women's contribution to social and economic development, thereby hindering achievement of the Millennium Development Goals and other national and international development goals. Rape and domestic violence account for 5-10% of healthy years lost by women (WHO, 2001). As described by the World Bank's Gender and Development Group, such violence can include, but is not limited to:

- Physical violence (slapping, kicking, hitting, or use of weapons)
- Emotional violence (systematic humiliation, controlling behaviour, degrading treatment, threats)
- Sexual violence (coerced sex, forced into sexual activities considered degrading or humiliating)
- Economic violence (restricting access to financial or other resources with the purpose of controlling a person).

Both men and women can be survivors or perpetrators of violence. It is important to recognize, however, that although male against female violence is more common, a not insignificant proportion of males, and especially boys, suffer all four types of violence outlined above.

Prevalence

Gender-based violence and forced sex are highly prevalent in the region:

- In Angola, DHS data indicate that 27 percent of ever-married women reported being beaten by their spouse/partner in the past year; this rate reaches 33 percent of 15-19 year-olds and 35 percent of 20-24 year-olds. 59 percent of Zambian women have ever experienced any violence by anyone since the age of 15 years (Kishor & Johnson, 2004).
- In South Africa, 7 percent of 15-19 year-olds had been assaulted in the past 12 months by a current or ex-partner; and 10 percent of 15-19 year-olds were forced or persuaded to have sex against their will (South Africa DHS, 1998).
- In Kenya, 43% of 15-49 year old women reported having experienced some form of gender-based violence in their lifetime, with 29% reporting an experience in the previous year; 16% of women

reported having ever been sexually abused, and for 13%, this had happened in the last year (Kenya DHS, 2003).

- In rural Botswana, 49% of ever-partnered women have ever experienced physical violence by an intimate partner, rising to 59% ever experiencing sexual violence (WHO, 2005).
- In rural Mozambique, 47% of ever-partnered women have ever experienced physical violence by an intimate partner, while 31% have ever experienced sexual violence (WHO, 2005).

Consequences

Such violations of bodily integrity and freedom from violence are of concern as adverse outcomes in/and of themselves, and because they are correlated with poor reproductive health. Studies from diverse settings – e.g., China, Peru, the USA, and Uganda – have found that girls and/or young women who had previously experienced sexual coercion are significantly less likely to use condoms, and more likely to experience genital tract infection symptoms, unintended pregnancy and a higher incidence of unsafe abortion (Gazmararian et al., 1995; Campbell & McPhail, 2002). Lack of sexual autonomy and control stemming from actual or threatened violence, together with fear of repercussion from use of condoms or contraception, are direct pathways to unwanted pregnancy and increased risk of STIs (Kishor & Johnson, 204). Moreover, intimate partner violence has been found to be independently associated with HIV infection (Fonck et al., 2005; Auerbach et al., 2005).

The impact of SGBV resonates further than the primary victim. Research indicates a link between maternal experience of violence and evidence of increased mortality and under nutrition among children of abused mothers (Jejeebhoy, 1998; Ganatra et al., 1998; Asling-Monemi et al., 2003, in Kishor & Johnson, 2004). DHS data from Zambia signifies a link between short birth intervals (less than two years) and the mother's experience of violence. The association between short birth intervals and infant health and survival is well documented (Lawn & Kerber, 2006). This link additionally illustrates the disintegration of reproductive autonomy amongst those who experience violence.

Sexual and gender-based violence both contributes to, and is exacerbated by, the economic and socio-political discrimination experienced by women in many countries. Women's lack of economic empowerment is reflected in lack of access to and control over economic resources in the form of land, personal property, wages and credit (UN-GA, 2006). Power, and the lack of power, is a recurring factor in all types of violence: the powerlessness of survivors, whether women, men or children, is also manifest in their relative lack of resources and access to support institutions.

Causes and risk factors

Certain community and societal-level risk factors are associated with higher or more severe rates of sexual and gender-based violence. The World Health Organization identifies the following evidence-supported factors (Krug et al., 2002):

- Traditional gender norms that support male superiority and entitlement
- Social norms that tolerate or justify violence against women
- Weak community sanctions against perpetrators
- Poverty
- High levels of crime and conflict in society more generally

Importantly

- Research on violence against women in Angola shows an increased risk of current physical or sexual violence among women of a younger age, especially those aged 15 to 19 (Krug et al., 2002; WHO, 2005a; Kishor & Johnson, 2004).

- Women who are separated or divorced (or, to a lesser degree, cohabiting) report a higher lifetime prevalence of all forms of violence (WHO, 2005a).
- Alcohol or drug consumption, and previous experience of sexual abuse, also correlate with sexual violence in adulthood (Krug et al., 2002).

The literature holds differing opinions on the relationship of education to sexual violence. The World Report on Violence and Health (Krug et al., 2002) cites a correlation between higher levels of female education and increased vulnerability to sexual violence. The authors reason that female empowerment is accompanied by a resistance by women to patriarchal norms, which in turn provokes men to violence in an attempt to regain control (Jewkes et al., 2002). However, they suggest that female empowerment confers greater risk of physical violence only up to a certain level, after which it confers protection (Jewkes, 2002). This theory is supported by evidence from the WHO multi-country study, which found that the protective effect of education started only when women's education progressed beyond secondary school (2005a).

Factors increasing men's risk of committing rape

Research into individual-level risk factors indicates violence is a learned behaviour: for instance, boys who witness or experience violence as children are more likely to use violence against women as adults, and a history of sexual abuse distorts perceptions about sexual violence and the risk of HIV infection (IGWG, 2006; Andersson et al., 2004).

Individual Factors	Relationship Factors	Community Factors	Societal Factors
- Alcohol and drug use - Coercive sexual fantasies and other attitudes and beliefs supportive of sexual violence Impulsive and antisocial tendencies - Preference for impersonal sex - Hostility towards women - History of sexual abuse as a child - Witnessed family violence as a child	- Associate with sexually aggressive and delinquent peers - Family environment characterized by physical violence and few resources Strongly patriarchal relationship or family environment - Emotionally unsupportive family environment - Family honor considered more important than the health and safety	- Poverty, mediated through forms of crisis of male identity Lack of employment opportunities - Lack of institutional support from police and judicial system - General tolerance of sexual assault within the community - Weak community sanctions against perpetrators of sexual violence	- Societal norms supportive of sexual violence - Societal norms supportive of male superiority and sexual entitlement - Weak laws and policies related to sexual violence - Weak laws and policies related to gender equality - High levels of crime and other forms of violence

Programmatic flaws

Angola as well as many sub-Saharan African counties lack systematic and reliable data on sexual and gender-based violence. There is need for systematic data collection on the prevalence and forms of SGBV in Angola, which would in turn inform the development of meaningful strategies. Programme design is hampered by the absence of evaluation of the impact of former preventative or responsive

interventions. The overwhelming focus, in both research and programmatic interventions, is on researching and alleviating the impact of sexual violence on women. However, the majority – not the minority – of sexual abuse survivors presenting for services are children of both sexes, and not adult women, who are the default group for whom most services are designed. Programme managers and policy makers continue to see adult women as the norm and modal group. There are limited examples of programmes that have explicitly sought to address the needs of males or other minority groups rather than trying to serve them as an additional or special category..

1.3 Ethical considerations for Research SGBV and masculinity

The ethical principles of confidentiality and respect are especially relevant in the research field of SGBV, due to the traumatic and sensitive nature of the subject material. Ill-conceived or implemented research may have dangerous consequences for the respondents and/or interviewers. Research designs should consider issues of confidentiality, problems of disclosure, and the need to ensure adequate and informed consent (Ellsberg & Heise, 2005). The basic ethical principles of research involving human subjects include:

- Respect for persons (including respect for confidentiality, the need to protect vulnerable populations, and respect for autonomy);
- Nonmaleficence (Do No Harm);
- Beneficence (maximizing benefits); and Justice.

The key ethical principles of research are universally applicable, but the details may need to be adapted to local settings, in order to minimize misunderstandings or potential harm. Researchers are under obligation to consider how the information will be used and reported, and to whom, and who will benefit from it, and when. These considerations may be especially important in conflict environments. The principle of respect for persons incorporates two fundamental ethical principles: respect for autonomy and protection of vulnerable persons. These are commonly addressed by individual informed consent procedures that ensure that respondents understand the purpose of the research and that their participation is voluntary

ETHICAL AND SAFETY RECOMMENDATIONS FOR RESEARCHING SGBV
- The safety of respondents and the research team is paramount and should infuse all project decisions.   - Prevalence studies need to be methodologically sound and to build upon current research experience about how to minimize the underreporting of abuse.   - Protecting confidentiality is essential to ensure both participants' safety and data quality.   - All research team members should be carefully selected and receive specialized training and ongoing support.   - The study design must include a number of actions aimed at reducing any possible distress caused to the participants by the research.   - Fieldworkers should be trained to refer participants requesting assistance to available sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.   - Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.   - Violence questions should be incorporated into surveys designed for other purposes only when ethical and methodological requirements can be met.

2. The Nature, Extent and Effects of Sexual and Gender Based Violence

There are various forms of sexual violence. Rape, the most often cited form of sexual violence, is defined in many societies as sexual intercourse with another person without his/ her consent. Rape is committed when the victim's resistance is overwhelmed by force or fear or other coercive means. However, the term *sexual and gender-based violence* encompasses a wide variety of abuses that includes sexual threats, exploitation, humiliation, assaults, molestation, domestic violence, incest, involuntary prostitution (sexual bartering), torture, insertion of objects into genital openings and attempted rape. Female genital mutilation and other harmful traditional practices (including early marriage, which substantially increases maternal morbidity and mortality) are forms of sexual and gender-based violence against women which cannot be overlooked nor justified on the grounds of tradition, culture or social conformity.

Since perpetrators of sexual and gender-based violence are often motivated by a desire for power and domination, rape is common in situations of armed conflict and internal strife. An act of forced sexual behavior can threaten the victim's life. Like other forms of torture, it is often meant to hurt, control and humiliate, while violating a person's physical and mental integrity.

Perpetrators may include fellow refugees, members of other clans, villages, religious or ethnic groups, military personnel, relief workers and members of the host population, or family members. In many cases of sexual violence, the victim knows the perpetrator. Because incidents of sexual and gender-based violence are under-reported, the true scale of the problem is unknown. The World Bank estimates that less than 10 per cent of sexual violence cases in non-refugee situations are reported.

2.1 Rape supporting attitudes, beliefs and myths

Summary
- Rape myths are attitudes/beliefs that are widely held and serve to justify male sexual aggression against women.
- These attitudes can lead to the minimization of rape experiences or placing blame on the victim.
- Many types of individuals endorse rape myths.
- Rape education programs can reduce rape myth acceptance.

Rape myths and other rape-supporting beliefs, defined as false beliefs about rape, which attempt to deny and in many cases in fact blame the rape victim, have been increasingly involved in the literature as perpetuating or reinforcing violence towards women. The academic paper published by Martha R. Burt (1980 Cultural myths and supports for rape. *Journal of Personality and Social Psychology*) identified a series of such myths including for example *"many women have an unconscious wish to be raped"* or *"any healthy woman can successfully resist a rapist if she really wants to"*.

The findings of the study were divided into two main areas: the complexity of the rape-supportive attitudes and the sexual profiles of the people who approve of these attitudes. The data presented by the study provided fairly straight forward evidence that the attitudes hypothesized to support rape are complex and multidimensional. According to the study, however, it should be pointed out that a relationship between sexual variables and rape-supporting attitudes does not logically imply a connection between sexuality and actual rapist behavior. In other words, both rapists and sexually conflicted individuals may tend to endorse rape-supportive beliefs without being equivalent in their willingness to assault women.

Similar but more specific studies have been conducted in the United States exploring student athlete cultures with respect to specific rape myths. A particular study focused on the subculture of student athletes and used a survey, focus groups, and individual interviews to explore the meaning and role of rape myths. Although the survey indicated a low acceptance of rape myths, the finding was contradicted by the results of the focus groups and individual interviews. Subtle, yet pervasive, rape myths were discovered, as were myths that were unique to the student athlete community (*Sarah McMahon 2007, Understanding Community – Specific Rape Myths, Journal of Women and Social Work; Rutgers, State University of New Jersey*). The findings offer implications for social work practice with college athletes. Currently, many educational programs on sexual assault are generic for college populations, but the results of the study suggest that interventions could be designed as context specific to address the unique aspects of student athlete culture. The findings of the study suggest that it may be beneficial to have separate programs for male and female athletes to address particularly problematic issues.

Considering the false belief that "Women routinely lie about rape" and "Only certain women are raped" it may seem natural to imply that only allegedly "*bad girls*", for example *those who dress provocatively*, are at risk of being raped. Such implicit beliefs create a hostile environment for rape victims by leading individuals to minimize some rape experiences or worse, place blame on the victim for the rape (Burt, 1980). As a direct consequence, some women will not report their rape to the police either because they themselves do not believe that their experience constitutes a rape, or because they fear that the police will not believe they were raped. Researchers have found that individuals who maintain higher levels of rape myth acceptance are less likely to label situations as constituting a rape compared to those who hold lower levels of acceptance (Lonsway & Fitzgerald, 1994).

Consequently, women endorsing rape myths may fail to appreciate the gravity of a rape offence. Similarly, biases are more likely to enter legal decision-making among those individuals in the criminal justice systems who endorse rape myths. Fortunately, there is evidence that expert testimony may counterbalance the effects of rape myth acceptance in the process of legal decision making, by broadening the current definition of rape, and thus increasing conviction rates of various rape offences (Lonsway & Fitzgerald, 1994).

- *Who accepts Rape Myths?*

The acceptance of rape myths is considerably prevalent in Western societies, where it has been studied most extensively. Generally, men maintain higher levels of rape myth acceptance (Lonsway & Fitzgerald, 1994). Additionally, endorsing conservative sex roles is positively related to the acceptance of rape myths. There is also a relationship between ethnicity and rape myth acceptance with African-Americans being more likely to endorse such myths over Caucasians; once more, this difference is more pronounced for men than for women (Johnson, Kuck, & Schander, 1997). Further, some aspects of sexism are related to increased blaming of the victim (Abrams, Viki, Masser, & Bohner, 2003). Overall, attitudes and beliefs that are less critical towards - or even in favour of - rape have been found to be related to a higher acceptance of rape myths (Lonsway, & Fitzgerald, 1994). For more information on the factors associated with rape myth acceptance, refer to Johnson et al. (1997) for a comprehensive review of the literature.

- *Assessing Rape Myths*

Several definitions of rape myth acceptance exist and have led to variations among the measures used to assess the endorsement of rape myth acceptance (Lonsway & Fitzgerald, 1994). However, the two most regarded measures of rape myth acceptance are: the Rape Myth Acceptance Scale (RMAS; Burt, 1980), and Illinois Rape Myth Acceptance Scale (IRMAS; Payne, Lonsway & Fitzgerald, 1999). Recently, a new scale has been developed assessing a broader definition of rape myth acceptation, the

Acceptance of Modern Myths about Sexual Aggression (AMMSA) scale (Gerger, Kley, Bohner, & Siebler, 2007).

- *Reducing Rape Myths*

The reduction of rape myths is a key element in preventing rape and ensuring due legal processing of individuals who are involved in acts of rape. One way to alleviate rape myths is by participating in rape education programs. These programs are known to successfully decrease rape-supportive attitudes by providing information on why and how rape actually occurs (Brecklin & Forde, 2001). Empathy training is also often part of rape education programs, to help individuals relate to sexual abuse victims and decrease endorsement of distortions justifying sexualized violence. Participants in these types of educational programs report significant increases in empathy toward rape survivors and significant declines in rape myth acceptance, likelihood of raping, and likelihood of committing sexual assault (Foubert & Newberry, 2006).

- *Male rape myths and attitudes*

Less is known about rape myths concerning male victims, but previous research has identified the following beliefs: (a) Being raped by a male attacker is synonymous with the loss of masculinity (Groth & Burgess, 1980), (b) "men who are sexually assaulted by men must be gay" (Stermac, Del Bove, & Addison, 2004, p. 901), (c) "men are incapable of functioning sexually unless they are sexually aroused" (Smith, Pine, & Hawley, 1988, p. 103), (d) "men cannot be forced to have sex against their will" (Stermac et al., 2004, p. 901), (e) "men are less affected by sexual assault than women" (Stermac et al., 2004, p. 901), (f) "men are in a constant state of readiness to accept any sexual opportunity" (Clements-Schreiber & Rempel, 1995, p. 199), and (g) "a man is expected to be able to defend himself against sexual assault" (Groth & Burgess, 1980, p. 808). For example, in Smith et al.'s (1988) study, participants perceived a male victim of a female-perpetrated assault as more likely to have encouraged the assault, enjoyed the encounter, and thus experienced little trauma.

Male participants endorsed these perceptions more than women did, but this gender difference disappeared when the perpetrator was another man. Struckman-Johnson and Struckman-Johnson (1992) first attempted to measure these myths by focusing on three general beliefs: (a) Male rape does not happen (e.g., "it is impossible to rape a man"), (b) rape is the victim's fault (e.g., "men are to blame for not escaping"), and (c) men would not be traumatized by rape (e.g., "men do not need counselling after being raped"). Each of these beliefs was presented twice to manipulate the gender of the perpetrator.

Consistent with research on female rape myths, they found that men were more accepting of male rape myths than were women. Furthermore, with the exception of the myth that denies the existence of male rape, male and female participants endorsed male rape myths to a greater extent when the perpetrator was a woman instead of a man.

Despite these interesting initial results, little additional research has been conducted to further understand male rape myths. Thus, it is not clear how these rape myths develop, who believes these myths, and the function these myths have in determining attitudes toward male victims of rape. We speculate that the same attitudes that function to support rape myths about female victims may also function to support rape myths about male victims. Specifically, adversarial sexual beliefs and acceptance of interpersonal violence correlates with participants' support of female rape myths (Lonsway & Fitzgerald, 1995). It may be that individuals who accept inter-personal aggression will accept aggressive behaviour in general, regardless of the victim's gender. Furthermore, many of the items on the Acceptance of Interpersonal Violence Scale depict men as the sexual aggressor.

Participants who believe that men should assert themselves through violence may also be less sympathetic to male victims

2.2 Examples of best practices in social norms change programs promoting positive masculinity

The Men and Gender Equality Policy Project (MGEPP), led by Instituto Promundo and the International Center for Research on Women (ICRW), is a multi-year, multi-country effort to build the evidence base on how to engage men in health, social development and gender equality. Project activities include:

1. A multi-country scan of policies for the degree to which they seek to include men from a gender perspective, presented in the publication What Men Have to Do with it: Public Policies to Promote Gender Equality;
2. the International Men and Gender Equality Survey (IMAGES), a quantitative household survey carried out with men and women in seven countries in 2009-2011, initial results of which are presented in the publication Evolving Men: Initial Results from the International Men and Gender Equality Survey (IMAGES);
3. the Men Who Care study consisting of in-depth qualitative life history interviews with men involved in non-traditional caregiving roles in five countries, presented in this publication;
4. Advocacy efforts and dissemination of the findings from these different components via various formats.

Participating countries in the project as of 2012 included Brazil, Chile, Croatia, India, Mexico, Rwanda, Bosnia and Herzegovina and South Africa. The multiple research components of the project aim to provide policymakers and NGO partners with evidence-based strategies for engaging men in gender equality, particularly in the areas of sexual and reproductive health, ending gender-based violence, fatherhood and maternal and child health, and men's health needs.

Findings from the Men Who Care study were fundamental for the creation of MenCare, a recently launched global campaign that supports men's involvement as non-violent fathers and caregivers. The campaign is conceived as a complement to global and local efforts to engage men and boys in ending violence against women and girls. Together with efforts like the White Ribbon Campaign (www.whiteribbon.ca), it is part of the MenEngage Alliance's global vision to achieve equitable, non-violent relationships and caring visions of what it means to be men.

- *Brazil*

Overall, men in caregiving professions and primary caregivers were motivated to become stronger in their respective roles and had a sense of curiosity and a desire to learn. They felt passion for their work and for caring for others, and noted that they felt satisfied at seeing developments whether it was with children, participants in men's groups, or in policy. Others described their motivations to overcome challenges in their work, such as finding creative ways to address violence against women. One man felt that care work allowed him to understand more about himself and other men, and to get along better with his family. They also relayed examples of how other men they encountered expressed interest in care work. In the case of the youth community leader, other young men and women sought him out for advice, commenting that his job was "cool" and asked how they could do something similar. These examples suggest that while men frequently were able to cite the difficulties of their care work given the rigid gender roles of their environment and Brazilian society in general, they felt satisfied that they were able to break free from societal expectations and do work that fulfilled them.

- *South Africa*

The South Africa interviews confirmed that there is no linear or causal link between care work and belief in and working for the goals of or supporting policies related to gender equity. The gap, then, between practicing care work and believing in gender equity was sometimes explained as having been caused by specific life experiences or contextual factors. Many had issues with their parents and, as Ross Haenfler expressed it, "they reacted to broken relationships with their fathers by creating different ways of being masculine" (Haenfler, 2004). For some men interviewed here, parental neglect prompted them to digress from the patriarchal norms they had learned and encouraged them to be caring. For others, it was a biological development (the onset of illness) or a social parent's commitment and caregiving, and example that served as a catalyst for their own involvement in care work. For many men (interviewed for this study and in South Africa as a whole as well as in other low income contexts), poverty, material insecurity and unemployment were dominant features of life and their lives, attitudes and choices reflected this.

South Africa is a highly diverse country with substantial race and class differences impacting on forms of masculinity as well as masculine ideals (Morrell, 2001). Gender equity as a social value has been promoted by the country's constitution, though it is not clear the extent to which is it embraced by ordinary people and lower level social institutions (Morrell, 2005).

3. Why must our work be focus on men in HIV awareness?

3.1 Overview
Within the fields of sexual and reproductive health, HIV/AIDS prevention and gender equity, there has been a growing consensus of the need to engage men. Many of the major organisations and agencies working in health, gender and HIV/AIDS have all confirmed the importance of engaging boys and men in the promotion of health and gender equity as well as in the reduction of sexual based violence.

3.2 HIV-AIDS awareness & Male Behavior
A growing body of research on young men affirms numerous reasons for focusing attention on their socialization. Worldwide, an estimated 25 percent of new cases of HIV/AIDS are to men under the ages of 25. In most societies, adult and young men have more power in intimate and sexual relationships and generally decide when and how sexual activity takes place. In addition, young men who have sex with other men are generally stigmatized in much of the world and have unmet health needs.

Awareness about HIV/AIDS and access to and use of condoms have all increased in most parts of the world over the last 10 years. Nonetheless, the percentage of men who use condoms consistently is still less than desired—and lower than their reported knowledge about condoms and HIV/AIDS. This gap between knowledge and behaviour suggests a continuing resistance to condom use that can be explained, in part, by how young men view gender roles and sexual activity. In some settings, for example, young men may perceive that risky or unprotected sex is the only sex "that counts" or that reproductive and sexual issues, including condom use, are women's responsibilities.

Other aspects of young men's behaviour put them and their partners at risk. We know from international data that in many parts of the world young men generally have sex earlier and with more partners before forming a stable union than do young women. In some settings, young men have their first sexual experiences with sex workers, potentially creating lifelong patterns of viewing women as sexually subservient. Young men are also more likely than young women to have occasional sexual partners outside of a stable relationship.

Some young men are abusive or violent toward their intimate partners. In a survey research carried out with 750 men in low income areas in Luanda, Angola up to two-thirds of young men believed that violence was acceptable against women when a woman is unfaithful, and a quarter of all men ages 15-65 had used physical violence at least once against an intimate female partner. Young men ages 20-24 had the highest rates of self-reported physical violence against women (in their current or most recent intimate relationship) than any other age range.

We also know that boys are socialized to produce, achieve, and perform—tendencies that have implications for their health and well-being. A review of ethnographic research on male socialization worldwide concludes that nearly all cultures promote an achievement oriented masculinity for boys and men, with the goal that males should become providers and protectors (Gilmore 1990). Many cultures socialize boys to be aggressive and competitive—skills that are useful for being a provider and protector—while socializing girls to be non-violent and sometimes to accept passively men's violence and domination (Archer 1984). In some cultures boys are also brought up to adhere to rigid codes of "honor" and "bravado" that obligate them to compete, fight, and use violence to resolve even minor disputes (Archer 1994).

Studies from around the world find that young men often view their sexual behaviour in terms of achievement as well; sex becomes a way to prove that they are "real men" and to have status in their male peer group (Marsiglio 1988). Many young men also disassociate sex from reproduction and tend to delegate the responsibility for caring for children to women.

This pattern often continues through adulthood. Studies from diverse settings find that fathers contribute about one-third to one- fourth of the time that mothers do to the direct care of children. Research suggests that some young men may initially deny responsibility and paternity when faced with a possible pregnancy, in large part because of the financial burden associated with assuming responsibility for a child (Lyra, 1998).

In terms of their health, boys are generally raised to be self- reliant and not to seek help when they have health concerns. Young and adult men often see themselves as being invulnerable to illness or risk, may just "tough it out" when they are sick, or may seek health services only as a last resort. Yet, being able to talk about one's problems and seek support is a protective factor against substance abuse, unsafe sexual practices, and involvement in violence.

In reviewing this data, however, we must keep in mind that young men and adult men are extremely diverse. For every young or adult man who uses physical violence against a partner, there are several who do not. Indeed, while many men show the patterns we have described, there are many others who do not, as the following quote illustrates.

Ample evidence suggests that how boys are raised to be men – that is their views about what it means to be a man – may have lasting and off lifelong results in terms of how they act in their intimate relationships. This in turn implies that promoting change among young men may have a potentially powerful impact in their own lives, in the present and in the future, and in the lives of their partners. What do we know about promoting change among men?

Studies from various parts of the Americas region have confirmed that on several important dimensions related to gender, some men are in fact changing. For example, in a study in Mexico, 45 percent of men interviewed considered themselves to be less authoritarian and psychologically closer to their children than their fathers were with them (Nava, 1995). In various parts of the world, new social ideals of manhood have emerged, spurred in large part by women's increasing participation in

the labor force and the women's rights movement and secondarily by some men questioning their relatively limited roles in the lives of their families.

What leads to change in terms of men's roles in the family and in intimate relationships at both the individual and societal levels, and how might positive change be promoted? We know that changes in gender norms and individual attitudes are often gradual, with old and new paradigms existing simultaneously. Furthermore, several studies from Latin America confirm a continuing gap between men's discourses about gender roles and their actual behaviour (In reviewing the literature, various common factors seem to contribute to changes in men's changes in attitudes and behaviours related to gender and gender roles.

▪ One study in Chile found that men who showed more gender-equitable patterns reported having fathers or mothers who carried out non-traditional gender roles or tasks. For some men, knowledge mattered; having early experience in carrying for children or carrying out other domestic tasks was a useful step toward actually carrying out these tasks (Almeras, 1977).
▪ Another study found that men sometimes changed in terms of gender roles and norms when they started new relationships, or in other special circumstances, such as the birth of a first child (Olavarria, 2000).

Case studies carried out with young men in a low income setting in Brazil found similar factors associated with more young men having more gender-equitable attitudes:

▪ being part of an alternative male peer group that supported more gender-equitable attitudes;
▪ having personally reflected or experienced pain or negative consequences as a result of traditional aspects of manhood (for example a father who use violence against the mother, or a father who abandoned the family); and
▪ Having a family member or meaningful male role models (or female role models) who showed alternative gender roles (Barker, 2001).

While the research on factors that promote change is still rather limited, it is important to affirm that men can and have changed in positive ways in terms of gender roles. From these examples, two more questions emerge:

▪ What kind of program interventions might promote such change? And,
▪ How might we measure change?

3.3 Gender and HIV-AIDS: It is time for action

Gender has long been recognized as being the key to understanding and addressing HIV and AIDS. The gender roles and relations that structure and legitimate women's subordination and simultaneously foster models of masculinity that justify and reproduce men's dominance over women can exacerbate the spread and impact of the epidemic. Notions of masculinity prevalent in Angola that equate being a man with dominance over women, sexual conquest and risk-taking are associated with less condom use, more sexually transmitted infections, more partners, including more casual partners, more frequent sex, more abuse of alcohol and more transactional sex. They also contribute to men accessing treatment later than women and at greater cost to public health systems. The imperative of addressing the gender dimensions of AIDS has been clearly and repeatedly articulated. Many interventions have been shown to be effective in addressing gender-related risks and vulnerabilities including programmes designed to reach and engage men, improve women's legal and economic position, integrate gender-based violence prevention into HIV services, and increase girls' access to secondary and tertiary education. Despite this, the political will to act has been sorely lacking and not nearly enough has been done to hold governments and multilateral institutions to account. This paper

argues that we can no longer simply pay lip service to the urgent need to act on what we know about gender and AIDS.

Simply put, it is time for action.

Introduction

"Countries should ensure a massive political and social mobilization to address gender inequities, sexual norms and their roles in increasing HIV risk and vulnerability"
(UN Secretary, Ban Ki Moon, 1 April 2008)[1].

Globally, women constitute half of all adults living with HIV, but in sub-Saharan Africa there are 14 infected women for every 10 infected men [2][2]. Gender roles and relations are key to understanding the nature of the epidemic. Sexual and physical violence against women and other controlling behaviours of men, as well as practices of transactional sex and men partnering with much younger women, markedly increase the risk to women of becoming infected with HIV[3]. Ideas of manhood that equate 'being a man' with sexual risk-taking and being in control (of women) have been shown to be associated with more negative attitudes towards condoms and less use, more sexually transmitted infections, more partners, including more casual partners, more frequent sex, more abuse of alcohol and more transactional sex[4]. The stigmatization of men who have non-heterosexual identities or practices has resulted in neglect in prevention programming in most countries and huge barriers to access to services[5]. Lesbian women face widespread "corrective" sexual violence that increases their vulnerability to HIV infection[6].

In addition to the ways in which norms of masculinity encourage men to put their own and their partners' health at risk, these same constructions of masculinity discourage men from seeking healthcare services, including HIV testing and treatment, for fear of appearing weak. Men's reluctance to use HIV and other health services means men typically access treatment later than women, with severely compromised immune systems and advanced opportunistic infections that are difficult and costly to treat. The fact that fewer men get tested than women means that women end up bearing the brunt of the huge burden of status disclosure to men, with attendant risks of stigma and abandonment[7].

The impact of gender inequalities also manifests itself in the low value placed on services aimed at women's health needs, or those of men and women that are seen as 'unmanly'. This is reflected in massive neglect of services for survivors of rape and of mental health services, which results in critical gaps in both preventing HIV infections and supporting those living with HIV.

The imperative of addressing the gender dimensions of AIDS has been clearly and repeatedly articulated. This paper argues that we can no longer simply pay lip service to the urgent need to act on what we know about gender and AIDS. Simply put, it is time to act.

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[1] United Nations Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals. Report of the Secretary-General. 2008 Apr 1;

[2] UNAIDS Global Coalition on Women and AIDS. Keeping the promise: an agenda for action on women and AIDS. UNAIDS; Geneva: 2006.

[3] Pettifor AE, Rees HV, Kleinschmidt I, Steffenson AE, MacPhail C, Hlongwa-Madikizela L, et al. Young people's sexual health in South Africa: HIV prevalence and sexual behaviours from a nationally representative household survey. AIDS. 2005;19:1525–1534

[4] Noar SM, Morokoff PJ. The relationship between masculinity ideology, condom attitudes, and condom use stage of change: a structural equation modeling approach. Int J Men's Health. 2001;1:43–58

[5] UNAIDS Report on the global AIDS epidemic. UNAIDS; Geneva: 2006.

[6] South Africa Human Rights Commission Report of the Public Hearing on School-based Violence. Johannesburg: [Accessed: 14 June 2008]. 2008. Available at: http://www.sahrc.org.za/sahrc_cms/publish/cat_index_41.shtml.

[7] Braitstein P, Boulle A, Nash D, Brinkhof MW, Dabis F, Laurent C, et al. the Antiretroviral Therapy in Lower Income Countries (ART–LINC) Study Group Gender and the use of antiretroviral treatment in resource-constrained settings: findings from a multicenter collaboration. J Womens Health (Larchmt) 2008;17:47–55

Gender and AIDS: who has the power?

The need to address gender in HIV programming has been clearly and repeatedly articulated for much of the past two decades. In 1992, Elizabeth Reid, then Director of UNDP's HIV and Development Program, asserted that 'one of the most striking features of the response to the HIV epidemic to date is how few of the policies and programs we have developed relate to women's life situations.[8]. It is reasonable then to ask: why has it not been done? Who is responsible for the lack of social mobilization to address gender inequities and sexual roles and norms? The UN Secretary-General, in the report quoted above, assigns responsibility to national governments, in line with the national-level framework for leading and coordinating action on HIV/AIDS (the Three Ones) outlined by UNAIDS. Although the call for national 'ownership' is laudable, political will is still sorely lacking. Patriarchal values continue to characterize political cultures and systems the world over. The progress made at the conferences in Cairo and Beijing on securing international agreements on gender equity and women's empowerment is being rolled back. This is particularly conspicuous in the resistance of the US President's Emergency Plan for AIDS Relief (PEPFAR) to promote approaches that integrate HIV and sexual and reproductive health services, resistance to sexuality education and condom promotion for young people, and the promotion of gender-insensitive approaches to HIV prevention such as abstinence.

The past 15 years have seen considerable progress in the development of technical approaches to addressing gender dimensions of AIDS, which are critical in building the capacity to act, but failure of implementation, or lack of impact, has resulted from neglect of the political conditions that are needed to address such dimensions adequately. The literature on gender main-streaming in development programmes emphasizes the limitations inherent in a narrowly technical view of meeting the challenge of addressing the gender dimensions of the HIV epidemic in the absence of attention to institutional cultures, policies and practices[9].

The root of this problem lies with the issue of power. Whereas gender refers to sets of social expectations and ideas about appropriate behaviours of men and women, gender differences are fundamentally underpinned by power inequalities, which result in a subordination of women and their interests in a gender order that privileges men and is organized by male power. We can acknowledge that the experience of power of individual men and women is also fundamentally shaped by a range of other life circumstances, including access to economic resources, education, age, race and geographical location, and that in some circumstances women have considerable power over men and agency, but acknowledging this does not alter the widespread reality of a gendered distribution of power that privilege men over women and heterosexual men over men with other gender identities.

To move beyond the rhetoric and actually to make a difference, the roll-out of technical approaches to addressing gender dimensions of AIDS needs to be integrally linked to a broader political project of demanding greater gender equity at all levels within a country, in a manner that is linked to broader advocacy for service delivery, social justice and human rights. Work for gender equity related to HIV/AIDS will only be successful when there is a foundation of recognition of the value and importance of social justice and respect for human rights generally, and when this does not exist it needs to be built with impact at all levels of society. Gender equity, of necessity, requires an inevitable degree of surrender of male power, and ultimately this is only achievable if support can be won on the grounds that inequity is inherently both unfair and a violation of rights. Achieving this will also require highlighting the costs of rigid norms of masculinity, and then mobilizing men around their investment in less restrictive ways of being men. For example, it will be important to draw

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[8] Reid E. Gender, knowledge and responsibility. UNDP; New York: 1992. HIV and Development Programme Issues paper no. 10.
[9] Porter P, Smyth I. Gender training for development policy implementers: only a partial solution. Oxfam; Oxford: 1998. Oxfam working paper.

attention to the ways in which dominant ideas of masculinity that glorify particular types of strength and risk-taking and denigrate caring are harmful to men's health and wellbeing by, for example, placing harmful psychological pressures on men by expectations that they should be successful providers at home, when very often economic and other circumstances conspire to prevent this; or by drawing attention to the pain caused to men when women they love and care for are harmed through the violent, controlling and risk-taking behaviour of other men.

It is only through support for interventions to address the political dimensions of gender that we will be able to move from a situation in which the institutional architecture of governmental and intergovernmental responses to the HIV epidemic regard gender equity as an additional concern, often embodied in the marginal figure of the gender focal point, rather than as a central foundation for any effective response. Key funders and influential governments, globally and regionally, have a critical role to play in galvanizing such political commitment by supporting initiatives to mobilize from within civil society to build gender equity, as well as ensuring that there is a vigorous civil society presence inside HIV policy machineries advocating for gender equity[10]. Such a presence and pressure is critical for the ability of civil society generally and social movements in particular, to hold governments and donors accountable for action on gender and AIDS, and to counter the active or passive resistance by programme planners and implementers to the principles of human rights and gender equality.

So what can be done to address the gender dimensions of AIDS? There is enough evidence to act now, especially in relation to community norms and gender violence, economic empowerment, access to quality education, health service delivery and the architecture of national AIDS responses. This paper argues that there is evidence to support the integration of action on community norms and gender violence, economic empowerment and access to quality education. It makes specific recommendations for action within these areas.

Interventions at an individual and community level to change ideals of masculinity and femininity and reduce gender-based violence.

Community-based work with men and boys, as well as with women and girls, which promotes new ideals of manhood based on respect for women, responsible sexual behaviour and the non-use of gender-based violence, as well as greater involvement in HIV-related caring, is essential[11]. There are examples of interventions with men and boys that have been evaluated and shown to be successful. A recent review of 57 of these, published by the World Health Organization, found evidence that at least a quarter were effective in transforming harmful gender attitudes and behaviour, and many of the others were regarded as promising[12].

A good example of this kind of intervention is the Stepping Stones programme[13], which is a participatory HIV prevention programme that aims to improve sexual health through building stronger, more gender-equitable relationships. Developed over a decade ago, it has been used in over 40 countries, adapted for 17 settings, translated into 13 languages and used with hundreds of thousands of individuals on all continents[14]. It has just been evaluated with rural youth in South Africa

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[10] Schofield T, Goodwin S. Gender politics and public policy making: Prospects for advancing gender equality. Policy and Society. 2005;25:25–44.

[11] Barker G, Ricardo C, Nascimento M. Engaging men and boys to transform gender-based health inequities: is there evidence of impact? World Health Organization and Instituto Promundo; Geneva: 2007.

[12] Reid E. Gender, knowledge and responsibility. UNDP; New York: 1992. HIV and Development Programme Issues paper no. 10

[13] Welbourn A. Stepping Stones: a training package on HIV/AIDS, communication and relationship skills. Actionaid International; London: 1995. (Strategies For Hope training series no. 1).

[14] Wallace T. Evaluating Stepping Stones: a review of existing evaluations and ideas for future M&E work. ActionAid International; London: 2006.

in a randomized controlled trial. With 2 years follow-up, Stepping Stones lowered the incidence of herpes simplex virus 2 in men and women by approximately 33%, and men reported less perpetration of intimate partner violence across 2 years of follow-up, as well as changes in several other HIV risk behaviors[15]. This is the first HIV behavioral intervention in Africa to be evaluated in a randomized trial and shown to reduce sexually transmitted infections. The evidence suggests that Stepping Stones may have been particularly effective as an HIV preventive intervention because it addressed gender norms and provided communication skills that could be used to build better relationships, which was seen as a valued outcome by both men and women. This project also highlighted the role of interventions with women and girls that empower them with relationship skills and challenge the acceptability of gender-based violence, and help them navigate a safer route between ideals of femininity predicated on subservience to men and empowered femininities that celebrate having multiple partners and engaging in transactional sex, which entail considerable risk of acquiring HIV.

Other examples of successful interventions with men can be seen in the work of Promundo with young men in Brazil, which has successfully challenged norms of masculinity that put them and their partners at risk of HIV infection. Significant shifts in gender attitudes were reported at 6 and 12 months, and those young men with more equitable attitudes were 2.4 times as likely to report using condoms with a primary partner the last time they had sex[16].

There are several examples of programmes in which condom promotion has been used as an important opportunity to educate men about sexual violence and challenge widespread misconceptions about what constitutes sexual consent. It is important to fund and replicate interventions such as Promundo's Program H Alliance[17] and Sonke Gender Justice's One Man Can campaign[18] that use condom education as a vehicle to educate and empower men to take a stand against sexual violence.

The roll-out of male circumcision presents obvious opportunities for programmes that seek to shift social ideals of manhood in a population who have indicated their willingness to change part of their embodied male identity through surgery. The debates about the impact of circumcision for HIV prevention have often been concerned with the much feared consequence of increased risk-taking after circumcision and concerns that male circumcision has been shown to reduce HIV acquisition from women to men, but not as yet transmission from men to women[19]. These have been somewhat countered by mathematical modeling, which reminds us that any intervention that reduces transmission will have a potential general public health impact[20]. The implications for women of men thinking they have surgical protection from HIV are, however, not known and could be wide ranging, from increased risk if men were to think they do not need condoms or to reduce partner numbers, to increased blame if men assume that because they have been circumcised they should be HIV negative. Perhaps of critical importance is also the issue of missed opportunity, as changing ideals of masculinity is critical for building more gender equitable relationships and reducing gender-based violence. Circumcision roll-out presents an opportunity for such an intervention, and now is the time to seize this.

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[15] Jewkes R, Nduna M, Levin J, Jama N, Dunkle K, Puren A, Duvvury N. Impact of Stepping Stones on HIV, HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. BMJ. 2008 in press. [PMC free article] [PubMed]

[16] Pulerwitz J, Barker G, Segundo M. Horizons Research Update. Population Council; Washington, DC: 2004. Promoting healthy relationships and HIV/STI prevention for young men: positive findings from an intervention study in Brazil.

[17] Instituto Promundo [Accessed: June 2008]; Available at: www.promundo.org.br.

[18] Sonke Gender Justice [Accessed: June 2008];One Man Can. Found at: www.genderjustice.org.za/onemancan

[19] Johnson KE, Quinn TC. Update on male circumcision: prevention success and challenges ahead. Curr Infect Dis Rep. 2008;10:243–251

[20] Hallett TB, Singh K, Smith JA, White RG, Abu-Raddad LJ, Garnett GP. Understanding the impact of male circumcision interventions on the spread of HIV in southern Africa. PLoS ONE. 2008;3:e2212.

- **RECOMMENDATION 1**: Scale up interventions that empower women and men to protect themselves against HIV by transforming harmful gender attitudes and behaviour, and challenge the acceptability of gender-based violence.
- **RECOMMENDATION 2**: Provide interventions to transform harmful gender attitudes and behaviour as part of programming of the roll-out of male circumcision as an HIV prevention intervention and condom promotion.

Economic empowerment of women

Poverty and gender interact in devastating ways to increase vulnerability to HIV infection and the impacts of AIDS. Women produce two-thirds of the food in the developing world but own less than 15% of land worldwide[21]. In the many societies where women are denied the right to own, buy or inherit land and other economic assets, they often lose their homes, inheritance, possessions and livelihoods when their husbands die[22]. A study in Uganda found that women's lack of property and inheritance rights meant that female-headed households were more vulnerable to the impact of AIDS than male-headed counterparts[23]. When women's property and inheritance rights are upheld, women acting as heads or primary caregivers of HIV-affected households are better able to mitigate the negative economic and social consequences of AIDS[24].

There is also a growing recognition of the need for legislative and policy change securing women's rights in terms of credit access, property ownership and inheritance rights in order to reduce their vulnerability to HIV and its impacts. This is critical as economic empowerment of women reduces their risk of HIV[25], and economic protection is important in mitigating the impact of death on widows and orphans[26]. Here concerted action by civil society has been shown to be effective. In Mozambique, in 2005, after a 10-year effort by a coalition of women's rights organizations, the President signed the new Family Law. This law transforms women's legal status within society, by recognizing their right to work outside the home without the permission of a husband or male relative, and to buy, own, and manage property or other financial assets.

It is also critical that legal and human rights education and monitoring be undertaken to ensure that women are able to claim their economic rights and that such claims are enforced by legal authorities (customary and statutory). Further investment is needed in projects such as the Rwanda Women's Network and the Justice for Widows and Orphans Project in Zambia. Both projects train community paralegals, village chiefs and members of land boards and tribunals about women's property, inheritance and legal rights, as well as helping women navigate the legal process.

Women's lack of economic rights and consequent economic dependency on men can also increase their risk of HIV infection. In Gabarone, Botswana, it was found that women's economic independence was more strongly related to women's negotiating power in their sexual relationships than any other variable explored[27]. Research from South Africa has revealed that poorer women are more likely to have experienced early sexual debut, a non-consensual first sexual encounter and

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[21] *UNAIDS Global Coalition on Women and AIDS. Keeping the promise: an agenda for action on women and AIDS. UNAIDS; Geneva: 2006.*
[22] *Strickland RS. To have and to hold: women's property and inheritance rights in the context of HIV/AIDS in sub-Saharan Africa. International Center for Research on Women; Washington DC: Jun, 2004.*
[23] *Kanyamurwa JM, Ampek GT. Gender differentiation in community responses to AIDS in rural Uganda. AIDS Care. 2007;19(Suppl. 1):S64–S72.*
[24] *Strickland RS. To have and to hold: women's property and inheritance rights in the context of HIV/AIDS in sub-Saharan Africa. International Center for Research on Women; Washington DC: Jun, 2004.*
[25] *Lopman B, Lewis J, Nyamukapa C, Mushati P, Chandiwana S, Gregwon S. HIV incidence and poverty in Manicaland, Zimbabwe: is HIV becoming a disease of the poor? AIDS. 2007;21(Suppl. 7):S57–S66*
[26] *Mendenhall E, Muzizi L, Stephenson R, Chomba E, Ahmed Y, Haworth A, Allen S. Property grabbing and will writing in Lusaka, Zambia: an examination of wills of HIV-infected cohabiting couples. AIDS Care. 2007;19:369–374.*
[27] *Greig FE, Koopman C. Multilevel analysis of women's empowerment and HIV prevention: quantitative survey results from a preliminary study in Botswana. AIDS Behav. 2003;7:195–208*

higher rates of physically forced sex or having exchanged sex for money, goods, or favours – all significant risk factors for HIV. These women also had more sexual partners and were less likely to use condoms[28]. There is some research to suggest that women who have access to, ownership of and control over land and other assets are better able to avoid relationships in which they may be more vulnerable to HIV and the impact of AIDS[29].

A number of initiatives worldwide are using microfinance and skills training to improve women's access to credit and marketable skills in order to help them secure a degree of economic independence. Evidence for the effectiveness of microfinance initiatives in accomplishing this goal remains mixed, and experience suggests that for the very poor, microfinance is simply not enough, and may risk getting people into debt they cannot repay[30]. When such initiatives have been carefully designed and targeted, however, there are some indications that they can play a role in enabling female-headed households to mitigate the impacts of AIDS. World Vision has successfully combined HIV/AIDS education with the provision of microfinance to groups of 20–30 women through its community banking programmes. Evaluations found that the women showed greater economic resilience, higher levels of HIV awareness and prevention behaviours, improved educational attainment among their children, and better nutrition within their families[31].

The Microfinance for AIDS and Gender Equity (IMAGE) study, which was a randomized controlled trial of a microfinance programme combined with a behavioral intervention and community action on gender-based violence in rural South Africa showed a dramatic reduction in exposure to one HIV risk, namely intimate partner violence, which was nearly halved after 2 years[32]. For women's economic empowerment initiatives to have an impact on their vulnerability to HIV and its impacts, they must combine a range of empowerment options (including microfinance, vocational training, legal rights training, income-generating activities) with interventions on gender norms and relations and HIV risk reduction.

RECOMMENDATION 3: Promote initiatives that aim to accord women the same economic rights as men and in so doing improve women's property and inheritance rights.

RECOMMENDATION 4: Expand economic empowerment initiatives targeting women and combine them with interventions on gender norms and relations and HIV risk reduction.

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[28] *Population Council HIV/AIDS unsafe behaviors most common among poor women. Population briefs. Population Council; New York: Jan, 2005. p. 11.*
[29] *ICRW and the Millenium Project Property ownership for women enriches, empowers, and protects. International Center for Research on Women; Washington DC: 2005.*
[30] *Tear Australia [Accessed: June 2008];Target Magazine. Available at: www.tear.org.au/resources/target/054/pdf/microfinance.pdf.*
[31] *World Vision [Accessed: June 2008];Protecting women from HIV/AIDS via Microenterprise Development (MED) Available at: http://www.worldvision.org/worldvision/appeals.nsf/stable/im_med_prod_desc.*
[32] *Pronyk PM, Hargreaves JR, Kim JC, Morison LA, Phetla G, Watts C, et al. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial. Lancet. 2006;368:1973–1983*

Access to quality education

Research in sub-Saharan Africa and Latin America suggests that education lowers women's risk of HIV infection and the prevalence of risky sexual behaviours, and increases their ability to discuss HIV with a partner, ask for condom use, negotiate sex with a spouse or leave abusive relationships. In a recent analysis of eight sub-Saharan countries, women with 8 or more years of schooling were less likely to have sex before the age of 18 years than women with no schooling[33]. A systematic review of educational attainment and infection in serial prevalence studies in developing countries found a lower HIV prevalence among people with more education in Uganda, Zambia and Thailand[34]. Education can play a crucial role in reducing women's vulnerability to gender-based violence[35], with particular protection found among those who have attained some form of post-school qualifications[36].

More generally, education is a cornerstone of gender equity and empowerment of women. Education provides a basis for economic empowerment, access to political power, access to information about HIV, and knowledge and ideas that can be used to change attitudes and make independent life decisions. There is also evidence that the power advantage of women's education is transmitted through generations such that children of more educated mothers are themselves relatively more empowered[37]. In many developing countries, however, the quality of education may be very variable, and life skills and sex education are still often not taught, or inappropriately focus on abstinence at the expense of other HIV risk-reduction approaches. Schools are often a setting in which sexual harassment of female students by teachers and other learners is rife[38]. Here too, political will is needed to ensure the provision of high quality education in a safe school environment.

Evidence points to the importance of life skills education, with a clear focus on gender and sexuality, in reducing young people's vulnerability to HIV. Providing comprehensive sexuality education can both delay sexual debut and increase the practice of safer sex[39]. A study of the effectiveness of a life skills curriculum in KwaZulu-Natal Province in South Africa found that young people exposed to such education were more likely to use condoms than those who were not. The more years they were involved in life skills education, the higher the rate of condom use[40].

Gender education for young men within the school curriculum, through initiatives such as the Better Life Options for Boys, which was implemented across 11 Indian states with over 8000 boys, has shown some promise with regard to changing harmful gender attitudes among young men that are associated with young women's HIV risk[41]. There are, however, also examples of school programmes being constrained in their ability to discuss and demonstrate key HIV prevention approaches, especially condoms[42], which have had potentially important consequences in terms of intervention

[33] Gupta N, Mahy M. Sexual initiation among adolescent girls and boys: trends and differentials in sub-Saharan Africa. Arch Sex Behav. 2003;32:41–53

[34] Hargreaves JR, Glynn JR. Educational attainment and HIV-1 infection in developing countries: a systematic review. Trop Med Intl Health. 2002;7:489–498

[35] Heise L, Pitanguy J, Germaine A. Violence against women: the hidden health burden – discussion paper 225. World Bank; Washington: 1994 & World Bank World development report, 1993: investing in health. Oxford University Press; New York: 1993.

[36] Population Council HIV/AIDS unsafe behaviors most common among poor women. Population briefs. Population Council; New York: Jan, 2005. p. 11.

[37] Viana FJ, Faundes A, de Mello MB, de Sousa MH. Factors associated with safe sex among public school students in Minas Gerais, Brazil. Cad Sauda Publica. 2007;23:43–51

[38] Correia M, Van Bronkhorst B. Ecuador Gender review: issues and recommendations. A World Bank country study. World Bank Group; Washington, DC: 2000. & HumanRightsWatch Scaredatschool:sexual violence against girls in South African schools. Human Rights Watch; New York: 2001

[39] Grunseit A, Kippax S, Aggleton P, Baldo M, Slutkin G. Impact of HIV and sexual health education on the sexual behaviour of young people: a review update. UNAIDS; Geneva: 1997.

[40] Reddy P, James S, McCauley A. Programming for HIV prevention in South African schools. Horizons research summary. Population Council; Washington, DC: 2003

[41] SYNERGY Men and reproductive health programs: influencing gender norms. The Synergy Project; Washington, DC: 2003

[42] Obasi AIN, Cleopas B, Ross DA, Chima KL, Mmassy G, Gavyole A, et al. Rationale and design of an adolescent reproductive health intervention in Mwanza region, Tanzania. AIDS Care. 2006;18:311–322.

effectiveness[43]. Political leadership is required to ensure the roll-out of curricula that comprehensively address sexual and reproductive health and HIV prevention, including aspects of gender and sexuality across all schooling systems. This is especially important given the failure to secure explicit international commitment to sexuality education in schools at the UNGASS +5 meeting in 2006.

Given the acknowledged relationship between violence against women and their vulnerability to HIV, investment in 'safer schools' initiatives, such as the Jango project financed by BP-Angola, is a clear priority. Within such work, building a general climate that is respectful of human rights is crucial and there is need for an explicit focus on gender. This should ensure that male learners and teachers not only do not perpetrate such violence, but that they get involved, as active 'bystanders', in working with young women and young men to stop the violence. Inspiring examples, such as the Safe Dates programme, which was effective in reducing dating violence within US schools, provide a foundation on which such work can be built[44].

RECOMMENDATION 5: Support initiatives to promote higher levels of educational attainment, particularly those targeting girls, and to improve the overall quality of education.

RECOMMENDATION 6: Integrate comprehensive gender and sexuality education into primary and secondary curricula, with adequate training and support for teachers and administrators.

RECOMMENDATION 7: Expand 'safer schools' initiatives with the Jango project financed by BP Angola

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[43] *Ross DA, Changalucha J, Obasi A, Todd J, Plummer ML, Cleopas-Mazige B, et al. Biological and behavioural impact of an adolescent sexual health intervention in Tanzania: a community-randomised trial. AIDS. 2007;21:1943–1955*

[44] *Foshee V, Bauman KE, Ennett ST, Linder GF, Benefield T, Suchindran C. Assessing the long-term effects of the safe dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. Am J Public Health. 2004;94:619–624.*

Suggested Interventions

This literature, combined with our research and direct experience working with men in various parts of Africa, led to the following suggestion as to engage with young men for the promotion of health and gender equity.

Although, theoretically based, SFCG program will aim to positively influence attitudes related to gender, including greater sensitivity to issues of gender-based violence, increased intention to use condoms, improved partner negotiation skills, increased attention to health needs and desire to be more involved as fathers (for those young men who are already fathers).

The program is recommended to focus on helping young men question traditional norms related to manhood. It consists of four components:

1. A validated curriculum that includes a manual series and educational videos for promoting attitude and behaviour change among men;
2. A lifestyle social marketing campaign for promoting changes in community or social norms related to what it means to be a man;
3. A research-action methodology for reducing barriers to young men's use of clinic services; and
4. A culturally relevant validated evaluation model for measuring changes in attitudes and social norms around manhood has been developed to measure outcomes of the initiative.

These components need to be developed based on a baseline research, which need to identify important programmatic implications:

1. The need to offer young men opportunities to interact with gender-equitable role models in their own community setting; and
2. The need to promote more gender-equitable attitudes in small group settings and in the greater community.

Our research will also confirm the need to intervene:
1. At the level of individual attitude and behaviour change; and
2. At the level of social or community norms, including among parents, service providers and others that influence these individual attitudes and behaviours.

It is suggested that SFCG develops a manual series to work in a same-sex group setting, and generally with men as facilitators who can also serve as more gender-equitable role models for the young men. The activities will consist of role plays, brainstorming exercises, discussion sessions and individual reflections about how boys and men are socialized, positive and negative aspects of this socialization, and the benefits of changing certain behaviours. The themes in the manuals need to be selected based on a review of literature on the health and development of boys, and an international survey of programs working with young men.

The activities in the manuals will reinforce each other and make appropriate links between specific activities and themes. The themes of the manuals can be focus one:
1. violence and violence prevention (including gender-based violence prevention);;
2. sexual and reproductive health;
3. reasons and emotions, which focuses on mental health issues and young men, particularly communication skills, dialogue, emotional intelligence and substance use;
4. fatherhood and caregiving, which encourages young men to reconsider their roles in caregiving in the family, including caring for children;
5. HIV/AIDS, including both prevention and caregiving.

It is recommended that the manuals be accompanied by a no-words cartoon video which can the story of a young man from early childhood through adolescence to early adulthood. Scenes can include:

1. the young man witnessing violence in his home, interactions with his male peer group,
2. social pressures to behave in certain ways to be seen as a "real man," his first unprotected sexual experience,
3. having a sexually transmitted infection (STI) and
4. facing an unplanned pregnancy.

The video need to be developed in workshop processes with young men in diverse settings Angola. By being a cartoon video, it quickly engages young men and transfers easily across different contexts. And by having no words, the facilitators can work with young men to create dialogue and to project their personal stories into the video. The video can use a pencil, which erases certain behaviours or thoughts, as a metaphor for gender socialization. Following viewing of the video, young men can discuss how they were socialized or raised to act as men, and ways they can question some negative aspects of that socialization.