Interventions linking gender relations and violence with reproductive health and HIV: rationale, effectiveness and gaps

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abstract

The past decade has witnessed much attention on the interrelationship between accepted gender norms and reproductive health (RH) outcomes in the context of HIV/AIDS. After decades of ignoring men in RH programmes, attention is now focusing on actively involving men in interrogating gender norms underpinning gender-based violence (GBV) in the context of RH and HIV/AIDS prevention, care and support activities. However, there are challenges in addressing gender norms and in male involvement. The purpose of this *article* is to highlight existing evidence-based efforts to challenge gender norms and promote constructive male involvement, with a special focus on South Africa; to present findings on effectiveness of gender and male-focused RH programmes; and to identify knowledge and programme design-related gaps.

This *article* argues that addressing biased gender norms and masculinities in an RH/HIV policy and programme context will contribute to the improvement of the health and rights of women and children, as well as of men. However, achievement of these goals will be limited by a failure to address broader structural factors such as poverty and unemployment that shape gender relations and RH/HIV outcomes. This will require getting RH/HIV interventions 'out of the health box' and into the arena of socio-economic development in collaboration with agencies working in these areas.

Introduction

Feminist-inspired scholarship has shown gender as being not naturally given, but as derived from the society in which individuals live. It involves a society's use of biological differences as the starting point to define what it means to be male and female. In societies characterised by male dominance (patriarchy), gender is an expression of political power that enshrines rigid stratification of gender relations to ensure the political domination by men and the subordination of women. However, all men are not necessarily equally powerful politically and socially, because gender traverses with other social stratifications based on race, class, religion, ethnicity, age and sexuality which determine an individual's social status and political power or the lack thereof (Horrocks, 1994). Numerous studies have shown that social constructions of masculinity and femininity that are stratified in a hierarchical order have many negative implications on relations between men and women and on their sexual and reproductive health (SRH), wellbeing and rights.

The link between gender and negative sexual and reproductive health outcomes

In an era when the world is battling with the scourge of HIV/AIDS, gender inequalities, poverty and economic underdevelopment and mobility have been identified as the major structural factors that facilitate HIV transmission (Zwi, 1993).

Gendered attitudes and behaviours, and gender power inequalities in intimate relationships impact on risky sexual behaviour, which consequently exposes boys and men and their partners to the risk of HIV infection, other sexually transmitted infections (STIs) and to unwanted pregnancies. Gender power inequities exemplified in men's frequent dominance in community and family decisions, impact on SRH (UNAIDS, 1999; Weiss et al, 2000; Gilbert and Walker, 2002; Foreit, 2001).

Although there is a range of quite different and sometimes contradictory masculinity ideologies, social construction of masculinity compromises men's health by encouraging men to equate a range of risky behaviours with manliness and to regard health-seeking behaviours as unmanly (Courtenay, 1998). Masculine ideologies encourage multiple sexual partners and more sexual activity, and promote beliefs that lead to negative condom-use attitudes and inconsistent condom use (Wood and Jewkes, 2001; Varga, 1997). Young men view sexual initiation and fatherhood as a way to prove that they are 'real men', thus affirming their identity as men as well as their concerns about sexual prowess (Marsiglio, 1988; Varga, 2003). This preoccupation at sexual initiation, in some cases, leads to boys having their first sex with sex workers (Jejeebhoy, 1996) or having incestuous relationships where they initiate a sexual encounter with a sister or other close relative in order to learn how to have sex (Njue et al,

2005). Expectations that men are self-reliant, sexually experienced and more knowledgeable than women, inhibit men from seeking treatment, information about sex and protection against infections, and from discussing sexual health problems. Men fear that admitting their lack of knowledge will undermine their manhood (Blanc, 2001; UNAIDS, 1999).

Women are not necessarily victims of male dominance at all times but are 'actors who have opportunities and strategies aimed at maximising their interests within the confines of structural and ideological constraints' (Chege, 1993). However, definitions of femininity that idealise women as passive and sexually ignorant/innocent reinforce existing power imbalances in women's relations with men (Gupta, 2000) and contribute to adolescent pregnancy that has a disproportionate and negative impact on girls (Varga, 2003). The power imbalances are expressed in sexual relationships and confer on men the ability to influence and/or determine women's SRH choices, including utilisation of health care services and use of modern contraceptives including condoms (Obisesan et al, 1998; Wood et al, 1998; Blanc, 2001; MacPhail and Campbell, 2001; Varga, 1997; Horizon's Programme Report, 2001).

Empirical evidence has demonstrated that women's low power coupled with high male control in intimate relationships is generally associated with increased HIV risk behaviours and HIV infection (Dunkle et al, 2004). Some studies have demonstrated that lack of condom use, maintaining multiple sexual partners, early sexual initiation, substance use, violence and delinquency (Courtenay, 1998a) are strongly linked to self-perception of masculinity and gender-related attitudes. Other studies have indicated that women with greater power in sexual relationships are more likely to use condoms, or to use condoms consistently

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(Wingood and DiClemente, 1998; Pulerwitz et al, 2002). Several studies have found that women's household power has effects on general contraceptive use (Gage, 1995; Hindin, 2000; Hogan et al, 1999; Laban and Gwako, 1997) and that forced sexual initiation, physical violence, and unwillingness to confront an unfaithful partner are strongly associated with teenage pregnancy (Jewkes et al, 2001).

GBV, sexual and reproductive health and HIV/AIDS

Patriarchal gender constructions contribute to GBV. Although violence has its roots in political and economic inequality, violence also stems from gender identification in terms of masculinity and femininity: it is an expression of identity and the way in which identity is constructed and reconstructed by society (Simpson and Kraak, 1998; Ulrike, 2003). A study based in South Africa showed that violence is strongly influenced by community norms regarding the use of violence to resolve conflict, women's challenge of traditional gender roles, and sexist attitudes among men (Jewkes, 2002).

GBV has important implications for SRH and sexual behaviour. Studies have identified a strong link between GBV and HIV (Dunkle et al, 2004; Garcia-Moreno and Watts, 2000) and other negative RH outcomes such as maternal mortality, poor outcome of pregnancy and birth (Curry et al, 1998), gynaecological morbidity (Schei and Bakketeig, 1989), non-use of contraceptives and unwanted pregnancies (Jewkes et al, 2001). GBV may contribute to HIV infection directly through transmission of HIV during rape and indirectly through increasing vulnerability to risky sexual behaviour. Women who live in abusive relationships are less likely to be able to

Gender norms contribute to low male involvement in childcare support

negotiate in sexual relationships or suggest condom use (Pulerwitz et al, 2000). Sexual abuse in childhood and intimate partner violence in adulthood may lead to sexual risk-taking (Dunkle et al, 2003; Pulerwitz et al, 2000), and partner violence inhibits women from adopting self-protective practices such as condom use and access to voluntary counselling and testing (VCT) for HIV (Gupta, 2000; Jewkes et al, 2003; Ulrike, 2003). In addition, male perpetration of sexual violence is associated with lower condom use and with higher rates of STIs (Baker and Acosta, 2002).

Gender norms and male involvement in care and support activities

Gender norms contribute to low male involvement in childcare support and care for the sick, orphaned and disabled. In male-dominated societies, dominant social norms present pregnancy and maternity care as women's domain and hold that women will assume the burden of responsibility for taking care of sick family and community members. Lack of male involvement in pregnancy and antenatal care and in prevention of mother-to-child transmission (PMTCT) of HIV programmes have been identified as major bottlenecks to effective programme implementation (Horizons Programme Report, 2002). Involvement of men in AIDS care and support activities is low (Mavimbela et al, 2003).

Gender norms, role definitions and change

The findings on the interplay between gender norms, masculinity and SRH suggest that addressing gender norms and unequal gender relations through altering socialised paradigms has the potential of contributing significantly to the health and wellbeing of women, children and men. However, three questions arise: Firstly, is it possible to change gender norms

that are deep-rooted and intertwined with complex cultural patterns? Secondly, what kind of change in masculinity and unequal gender norms might bring about a subsequent change in risky sexual behaviour and other practices that negatively impinge on SRH/HIV? Thirdly, what are the most effective strategies in different socio-cultural and economic contexts to bring about this change?

Theoretical conceptualisations of gender have different perspectives on the ability to change gender norms and masculinity. The socialisation model of gender identity views masculine and feminine identification as the product of gendered socialisation processes that cannot be reversed (Brittan, 1989). However, both the developmental masculine crisis and the social construction models clearly highlight reasons why gender is not immutable and fixed although there are many individual factors that constrain efforts to change. The developmental masculine identity crisis model views both men's insecurity and dissatisfaction with their identity as a sign of the masculinity crisis that has been brought about by modern social changes and women's challenge of men's power (Horrocks, 1995). In this view, modern changes have forced both men and women to deviate from the 'master gender stereotypes' of their society (Brittan, 1989). According to this view, it is incorrect to view men simply as beneficiaries of patriarchal gender constructions: men are also, to an extent, prisoners and victims of their own gender constructions. In view of the social constructionist model, gender and gender identity is a dynamic concept, there are multiple masculinities, and masculinity is always subject to negotiation. Gender, therefore, is not fixed but constructed, maintained or challenged in social interactions (Brittan, 1989).

Studies that have shown positive changes in gender attitudes and norms amongst young people exposed to interventions challenging prevailing gender norms (Horizons Programme report, April 2004), confirm the fact that gender is amenable to change. The attitudinal and behavioural constellation constituting femininity and masculinity are acquired and perpetuated by evolving socio-cultural and contextual factors which are amenable to manipulation.

Programme interventions and gaps

In the last decade, the realisation of the interplay between gender norms and violence and SRH/HIV outcomes contributed to the formulation of policies aimed at challenging patriarchal gender norms and improving women's lives. This recognition also led to international recognition of violence against women as a violation of their human rights as well as their SRH (United Nations, 1993; Heise et al, 1999). SRH policy makers and programme managers have begun to formulate policies and programmes to address gender norms and GBV. Although for many years, SRH programmes did not address men (Greene and Biddlecom, 2000), spurred by the recognition that men's attitudes and behaviours can either impede or promote SRH of men and women, there is an emerging consensus of the need to incorporate men more adequately in SRH/HIV/AIDS initiatives (United Nations, 1995). However, male involvement does not come without a cost. In the context of scarce resources and the burden of reproductive morbidity and mortality that women bear in many developing countries, some have raised concerns that involving men in SRH/HIV programmes will take away the limited resources available for women's health (Greene and Biddlecom, 2000; Green, 1999).

In spite of the increasing attention to the issue of gender norms and gender relations in the international arena, at country level, there is relatively limited programme experience and

research on how to promote more gender-equitable behaviour among men. Few programmes have documented their experiences and strategies used to reach men. There is a broad range of male involvement offerings in this relatively nascent field, ranging from male involvement in family planning (FP), safe motherhood, involving men in reducing GBV and increasing their participation in HIV/AIDS prevention, care and support activities, providing basic information and counselling services and developing men's parenting skills (White et al, 2003). In addition, there is a range of intervention strategies used to involve men and address, gender norms, including multimedia approaches relying on soap operas, call-in radio talk shows and edutainment, mass media, community mobilisation, male-only workshops, mixed sex workshops, and health facility service delivery (Green, 1999; White et al, 2003; Kunene et al, 2004; Blanc, 2001). However, there has been limited research to evaluate the effectiveness of these interventions (Guedes, 2004). The area of FP has witnessed the greatest number of systematic studies assessing the effect of male involvement. Although these studies have identified better FP outcomes, they have also shown that interventions targeting men, that have focused on achieving RH and HIV/AIDS outcomes only and do not challenge men's gender norms (Kim et al, 1996; Bujra and Baylies, 2000; Blanc, 2001), stand the danger of unintentionally reducing women's autonomy or increasing GBV.

Constructive male involvement, gender norms, and SRH and HIV/AIDS in South Africa

Few programmes in South Africa have attempted to address both GBV and SRH/HIV, with most limiting their scope to either issue in isolation. The majority of the GBV prevention and care programmes are implemented by non-governmental organisations (NGOs) and community-based organisations (CBOs) and they have limited coverage in the country (Ulrike, 2003). A number of programmes which systematically target men and integrate gender and SRH/HIV/AIDS, such as the Mobilizing Young Men to Care Project (MYMTCP) of DramAidE (Drama-in-AIDS Education), Men As Partners (MAP), Stepping Stones, Men in Maternity (MiM), and *Soul City*, have been implemented in South Africa since the 1990s (White et al, 2003; Moletsane et al, 2002; Kunene et al, 2004; Kruger, 2000). Although not strictly focusing on men as the primary target group, the Rural AIDS and Development Action Research (RADAR) is conducting a cluster randomised trial to evaluate the impact of the Intervention with Micro-finance for AIDS and Gender Equity (IMAGE) on GBV, sexual behaviour and incidence of HIV in rural villages of Limpopo province (Kim et al, 2002; Hargreaves et al 2002).

In addition to these programmes, in 2002 the Department of Health set in motion a community-mobilisation and advocacy activity, referred to as the Men's Imbizo, that calls together men's organisations to fight against violence against women and children as well as to combat HIV/AIDS. Both at national and provincial levels, men come together in workshops to deliberate on the issue of addressing gender norms and HIV/AIDS, take stock of what the various stakeholders are

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Mobilizing Young Men to Care Project (MYMC)

Background: Started in 1991 by DramAidE in rural secondary schools in KwaZulu-Natal (KZN).

Target group: Secondary school boys.

Approach: Mixed gender workshops and participatory education theatre.

Soul City

Background: Television and radio programme implemented by the Soul City Institute of Health and Development. First series broadcasted in 1994.

Target group: Primary target groups are students in primary, secondary and tertiary institutions. Secondary target group is the general public.

Approach: Entertaining educational drama broadcasts and distribution of print media.

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doing, and share experiences and lessons learnt in successful strategies.

Our understanding of the effectiveness of these approaches in changing gender norms and increasing positive SRH/HIV behaviour is limited. Few of these male-involvement approaches have been systematically evaluated. Results from available evaluations indicate some positive attitude change among those exposed to the interventions but also some challenges to behaviour change. Findings from an informal qualitative evaluation of the effectiveness of MYMCP indicate that although the project has a focus on male students, the biggest impact was among females. Females exposed to the intervention become more assertive in challenging exploitative and unequal gender relations in intimate relationships (Moletsane et al, 2002; White et al, 2003).

Results of an evaluation of *Soul City*, using quantitative methods, indicate that exposure to *Soul City* increased gender-equitable attitudes and interpersonal communication about domestic violence (White et al, 2003). However, the assessments have not looked at the link between these changes and SRH outcomes.

The findings of the MiM study indicate that there is high support for male involvement, both among pregnant females and their male partners. However, some socio-economic and cultural factors limit the effectiveness of such an intervention: limited health service working hours and existing clinic set-ups were not favourable to men; many partners were not living together; some men, women and service providers still held the view that their culture did not promote male involvement in maternity care; and some men were unable to attend counselling either because they could not obtain permission from their employer or due to the nature of their work. Less than 30% of men in the intervention clinics attended couples counselling sessions. For those men who attended, a third of their female partners reported that they were more helpful and supportive after counselling. The intervention had some limited impact in improving men's support when their partners had a pregnancy-related emergency, and no impact in improving support at delivery, FP use, risky sexual behaviours and condom use (Kunene et al, 2004).

The Medical Research Council (MRC) in South Africa is currently implementing a prospective study to assess the effectiveness of the Stepping Stones Programme. The study seeks to determine the effectiveness of Stepping Stones in reducing the transmission of HIV, changing aspects of gender dynamics in relationships and measuring the impact of this on HIV risk reduction.

The MAP programme in South Africa aims to confront gender norms and attitudes that place the health and safety of men, women, and children at risk, reduce GBV and increase male participation in RH/HIV prevention. EngenderHealth has conducted a number of evaluations using qualitative and quantitative methods to assess the effects of this intervention on male

Men in Maternity (MiM)

Background: An operations research pilot project using a quasi-experimental design. Implemented between 2000 and 2003 in 12 clinics in eThekweni District in KZN by the Population Council, in partnership with the KZN Department of Health and Reproductive Health Research Unit (RHRU).

Target group: Male partners of pregnant mothers accessing antenatal care in public clinics.

Approach: Clinic-based couples counselling addressing male partner involvement and support in maternity, STI and HIV prevention.

Stepping Stones

Background: A life-skills, communication and relationship training programme widely used in sub-Saharan Africa and adopted for South Africa in 1995 by the Medical Research Council (MRC). Pilot project implemented in Umtata in Eastern Cape by MRC and PPASA.

Target group: Male and female youth in the community.

Approach: Single-sex workshops for both male and female youth.

Men as Partners (MAP)

Background: Implemented in 1998 by a number of local NGOs such as Planned Parenthood Association of South Africa (PPASA) and Hope Worldwide with technical support from EngenderHealth. Covers all nine provinces.

Target group: Men in communities and tertiary institutions.

Approach: Male-only and mixed sex educational workshops and peer education.

workshop participants. Results indicate that although there is a sustained positive change in gender roles and relationship attitudes and practices and an increase in HIV/AIDS and STI knowledge among workshop participants, few men can be reached using the workshop approach only (Kruger, 2000; EngenderHealth, 2003; Kruger 2005). Recently, MAP has expanded strategies to include more community mobilisation and networking and male participation to include HIV/AIDS care, support and prevention of mother-to-child (PMTC) transmission of HIV. There has been no systematic study to assess the effectiveness and impact of this model at the community level in achieving both GBV and SRH/HIV goals.

In January 2004, FRONTIERS Program of the Population Council, in collaboration with EngenderHealth and Hope Worldwide, embarked on a three-year intervention study, to test the effectiveness of community-based strategies applied by the Hope Worldwide MAP programme. The study is based on a cluster randomised control design and is implemented in two phases. The first phase of this study, implemented in Soweto in Johannesburg, explored the socio-cultural context of, and factors influencing, the various forms of GBV, sexual abuse of children, definition of masculinity and femininity, and risky SRH behaviour and the effectiveness of the MAP workshop and peer education strategies.

The results of the qualitative interviews with MAP peer educators, coordinators and men who have participated in the workshops, indicate that the programme has been effective in increasing knowledge of HIV/AIDS, changing gender attitudes and norms and reducing risky sexual behaviour. Men who have participated

Structural factors interplay with traditional gender definitions to contribute to high levels of GBV

in the workshops reported that the information and skills provided in the workshops have contributed to an improvement in their communication skills, particularly as it pertains to HIV prevention and sexual health-seeking behaviour; interpersonal relations, particularly with their intimate partners; and has enabled them to challenge the existing gender role definitions and attitudes that support violence against women. However, prevailing cultural and socio-expectations of men in the general population who have not been reached by the programme, inhibits effective behaviour change related to gender norms and roles. Prevailing gender norms that blame women for their male partners' adopting more equitable gender roles and relations, contribute to women's resistance to their partners' attempts to change.

Data from interviews with women and men in the general population not reached by the programme, revealed a prevalence of unequal gender relations, attitudes and behaviours. However, gender attitude change was observed among the younger males and females who support male participation in domestic chores, fathers providing emotional and material support to their children, and who oppose intimate partner violence, modern men being detached from the family, alcohol and drug abuse and the diminishing role of fathers as advisors and positive role models. In addition, the study found that structural factors such as unemployment and poverty interplay with traditional gender definitions to contribute to high levels of GBV. Pressure to provide for the family and the perception that women are doing better than themselves can compromise men's self-esteem, which may lead them to prove their manhood violently.

Summary and conclusions

Preliminary findings suggest gender and HIV/SRH intervention among men can lead to

increases in support for equitable gender norms and improvements in condom use and reported STI symptoms. The findings point to the need for programmes that rely only on workshops, to expand their target to include a broader community reach using existing community-based structures to reach both men and women. To change social norms within the community, a critical mass of individuals who have changed attitudes and behaviours is essential. Thus intervention strategies should be designed to aim at not just individual, but also social change by setting in place strategies that lead to community action and activities that promote and increase the probability of sustained involvement and sustained change.

In addition to limited knowledge of the effectiveness of interventions, there is little programming and research on how to reduce the risk of increased risky behaviour in adolescence and adulthood among child sexual violence survivors. Some studies have indicated that gender roles applicable in heterosexual relations are enacted and enforced in same-sex relations (Ulrike, 2003) and although some work has been done to assess the occurrence of GBV and its implications for HIV risk in male same-sex relationships (Ulrike, 2003), very little is known as yet about violence and about HIV prevalence in female same-sex relationships. In the context of South Africa, although same-sex relationships are common and some research indicates violence in these relationships, there are no interventions focusing on GBV and HIV in such relationships. Further, research findings indicate that in addition to gender, structural factors such as poverty and unemployment impact on both gender relations and SRH/HIV. This calls for SRH/HIV programmes to move 'out of the health box' and broaden their interventions to address these broader developmental issues in collaboration with other developmental agencies.

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