

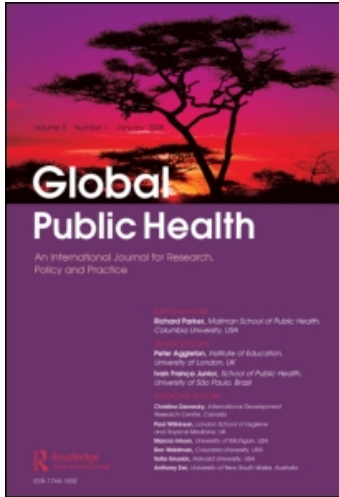
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Questioning gender norms with men to improve health outcomes: Evidence of impact¹

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This article describes a review of 58 evaluation studies of programmes with men and boys in sexual and reproductive health (including HIV prevention, treatment, care and support); father involvement; gender-based violence; maternal, newborn and child health; and gender socialisation more broadly. While few of the programmes go beyond the pilot stage, or a relatively short-term timeframe, they offer compelling evidence that well-designed programmes with men and boys can lead to positive changes in their behaviours and attitudes related to sexual and reproductive health; maternal, newborn and child health; their interaction with their children; their use of violence against women; their questioning of violence with other men; and their health-seeking behaviour. The evidence indicates that programmes that incorporate a gender-transformative approach and promote gender-equitable relationships between men and women are more effective in producing behaviour change than narrowly focused interventions, as are programmes which reach beyond the individual level to the social context.

Keywords: gender; health; masculinity; sexual health; violence; fatherhood

Introduction

Gender norms – social expectations of appropriate roles and behaviours for men and women – and the reproduction of these norms in institutions and practices, are directly related to men's health-related behaviours, with implications for themselves, their partners, their families and their children (Kimmel and Messner 1989, Campbell 1995, Cohen and Burger 2000). Research has shown that men and boys who adhere to rigid views about masculinity (such as believing that men 'need' more sex than women do) are more likely to report having used violence against a partner, to have had a sexually transmitted infection, to have been arrested and to use substances (Courtenay 1998, Pulerwitz and Barker 2008). Other research has found associations between beliefs in inequitable gender norms and rates of HIV/STI transmission, contraceptive use, physical violence (against women and between men), domestic chores, parenting and men's health-seeking behaviours (Marsiglio 1988, Kaufman 1993, Rivers and Aggleton 1998, Barker 2000, Barker and Ricardo 2005). A recent review of 268 qualitative studies (Marston and King 2006) confirmed that gender stereotypes and differential expectations about appropriate sexual

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behaviours for boys and girls are key factors in influencing the sexual behaviours of young people.

Various UN agencies, governments and international organisations affirm the need to engage men and boys in questioning inequitable gender norms, and a number of programmes have begun to do so. The aim of this review was to assess the effectiveness of programmes in changing men's and boy's attitudes and behaviours related to gender inequities in health. Other questions guiding this review are: What types of programmes with men and boys show more evidence of effectiveness? What does it mean to apply a gender perspective in health programmes with men and boys? Does applying a gender perspective to work with men and boys lead to a greater impact on health outcomes?

The review focused on specific health-related areas in which women and men interact in the context of intimate, domestic and/or sexual relationships and, as such, issues of power and gender norms are central. These are (1) sexual and reproductive health, including HIV prevention, treatment, care and support; (2) fatherhood, including programmes that encourage men to participate actively in the care and support of their children; (3) gender-based violence, including campaigns and activities that seek to prevent men's use of violence against women, as well as programmes with men who have previously used violence against women; (4) maternal, newborn and child health, including programmes that engage men in reducing maternal mortality and morbidity to improve birth outcomes and child health; and (5) gender socialisation, including programmes that work across the four health-related areas above (or most of them), and critically address the socialisation of boys and men and the social construction of gender relations.

Working with men and boys in a gender perspective

What does it mean to apply a gender perspective in health programmes with men and boys? Clearly, men and boys have always been included in health policy, promotion and service delivery as patients, beneficiaries of information, providers, policy makers and the like. Even in areas of health that refer specifically to women, including female reproduction, men have been 'present', in policy making, even if not explicitly, affecting the decisions made by women and sometimes constraining their choices and movement.

The limitation, however, is that health programmes often view men mainly as oppressors – self-centred, disinterested or violent – instead of as complex subjects whose behaviours are influenced by gender and social norms. Indeed, thousands of evaluated health promotion and health services-based programmes have included men and boys as a target population but have not fully considered how gender norms affect the health-related behaviours, attitudes and vulnerabilities of men and women.

Most of the 58 studies included in this review either explicitly or implicitly apply a social constructionist approach. This approach suggests that masculinity and gender norms are socially constructed (rather than biologically driven), vary across historical and local contexts, interact with other factors, such as poverty and globalisation, and are created, reinforced and reconstructed by families, communities and social institutions (Connell 1987, Kimmel 2000). Individuals learn and internalise these gender norms but can also question and reject them. For example, boys learn what manhood means by observing their families, where they often see

women and girls providing care giving for children and men working outside. They may also internalise messages about gender from television, mass media, schools and peers. These messages can sometimes encourage risk-taking behaviour, competition and violence, and may ridicule boys who do not meet these social expectations. Gender-role strain theory suggests that ideals of masculinity are never fully attained, so that boys and men are destined to strive towards standards to which they will always fall short. As a result of this inconsistency, between what is socially and culturally expected of boys and men and what is actually feasible in their daily lives and relationships, many experience negative social feedback and internalise negative self-judgements that can result in poor psychological health and risk-taking behaviours (e.g., engaging in violent behaviour with other men as a way to prove one's manhood) (Pleck 1995). Gender norms are also constructed and learned differently in different settings, and it is important to acknowledge this cultural variation as we seek to highlight the overall efficacy of gender interventions with men across different contexts.

It is also important to acknowledge the dynamic and relational nature of how gender is constructed and reproduced. Men's (and women's) behaviours and vulnerabilities related to health and gender are, for example, affected by power relationships between men and women, and by power dynamics between groups of men. Low-income men may be vulnerable for relative lack of access to health care, and by rigid norms that suggest that 'real men do not get sick', with implications for their health and that of their partners. While we emphasise how gender norms and gender dynamics are key issues in the behaviours and vulnerabilities of men and boys, race, ethnicity, religion and social class, among other factors, are also major influences on men's conditions and behaviours. Moreover, while our review is focused on interventions with a gender perspective, we recognise that addressing other factors, particularly socio-economic marginalisation, can also lead to positive and necessary changes in men's and women's vulnerabilities and their health-related behaviours. We argue that these multiple issues – gender norms and dynamics, social exclusion, ethnicity and religion – when possible, should be addressed simultaneously to ensure the most significant and lasting impact.

Determining whether specific health-related programmes lead to lasting and real change on the part of men, let alone in the social constructions of gender, is challenging. Nevertheless, the number of health programmes with men and boys, based on a gender perspective, has been growing in the past 15 years. Three previous literature reviews, two on sexual and reproductive health (Elwy *et al.* 2002, Sternberg and Hubley 2004) and one on interventions with men who use physical violence against women (Rothman *et al.* 2003), have found a mixed but generally encouraging assessment of programmes with men. These reviews affirmed that interventions can lead to changes in men's attitudes, behaviours and knowledge related to sexual and reproductive health, and reduced use of violence against women. Nevertheless, all three reviews noted the relative lack of rigorous evaluation studies of interventions with men and boys. The purpose of this review, in contrast to those three, is to examine a broader range of health-related programmes which engage men and boys, and to analyse the gender approach of these programmes and rank their effectiveness in leading to changes in behaviours and attitudes.

This review also seeks to assess the effectiveness of programmes that adopt an ecological systems approach in working with boys and men. An ecological approach

can be used to map the dynamic interrelationship between individuals, family, peers, structural factors and wider sociocultural norms that shape gender-related behaviours and vulnerabilities (Sallis and Owen 2002). Programmes that are multi-sectoral, and consider the multiple 'systems' and relationships that influence individuals rather than single-issue programmes, may prove more likely to produce lasting effects leading to changes in behaviours and attitudes.

Methods and scope of this review

The online sources consulted for this review included: CSA Social Service Abstracts; Education Resources Information Centre (ERIC); Fatherhood Initiative (USA Department of Health and Human Services); FatherLit Database (National Centre on Fathers and Families, University of Pennsylvania); Google Scholar; Interagency Gender Working Group (USA Agency for International Development); International Journal of Men's Health; Medline; The Men's Bibliography; POPLINE; PsycINFO, SciELO; and Sociological Abstracts (formerly Sociofile). The keywords used were: gender, boys, men, programme, evaluation, violence, family planning, HIV/AIDS, fatherhood, maternal, newborn and child health, and gender-based violence. We also contacted key organisations working nationally and/or internationally, either directly with men from a gender perspective or in research related to men and gender. Finally, we analysed previous literature reviews on the topic of programmes with men.

The criteria for inclusion in the review were: (1) the programme represented an effort to work with men and boys in one of the five selected areas; (2) there was some level of qualitative and/or quantitative data on impact evaluation; and (3) the evaluation data had been published within the past 20 years. Evaluation data were collected from research reports in peer-reviewed journals, online programme descriptions and reports, as well as conferences or meeting presentations.

Programmes were categorised in terms of gender approach and overall effectiveness. The gender approach was categorised according to the following criteria: (1) programmes that distinguish little between the needs of men and women, neither reinforcing nor questioning gender norms, were categorised as having a *gender-neutral approach*; (2) programmes that recognise specific needs and realities of men based on social construction of gender norms were categorised as having a *gender-sensitive approach*; and (3) programmes that seek to transform gender norms and promote more gender-equitable relationships between men and women were categorised as having a *gender-transformative approach* (Gupta *et al.* 2003). The categorisation used is a starting point for more extensive debates and discussions about what a 'gender-based approach' means in engaging men and boys.

The overall effectiveness of the programmes was assessed according to rigour of the evaluation design and level of impact (see Figure 1). Greatest weight was given to quasi-experimental and randomised control trial designs as well as evaluations that sought to triangulate data, including the perspectives or reports of others, such as partners, children or health service providers. In terms of impact, greater weight was given to interventions that confirmed behaviour change on the part of men or boys, followed by change in attitudes and then change in knowledge. A general shortcoming of the programme evaluations was that impact was measured nearly

Criterion 1: evaluation design	Criterion 2: level of impact
<p>Rigorous</p> <p>Quantitative data with: pre/post-testing control group or regression (or time-series data) analysis of statistical significance adequate sample size</p> <p>and/or</p> <p>Systematic qualitative data with clear analytical discussion and indications of validity</p> <p>Moderate</p> <p>Weaker evaluation design (e.g. more descriptive than analytical) Quantitative data lacking one of the elements listed above May include unsystematic qualitative data</p> <p>Limited</p> <p>Limited quantitative data lacking more than one of the elements listed above and/or Qualitative data with description only or process evaluation data only</p> <p>Ongoing</p>	<p>High</p> <p>Self-reported behaviour change (with or without knowledge and attitude change) with some confirmation, triangulation or corroboration by multiple actors or stakeholders consulted (including community leaders, health professionals and women and partners)</p> <p>Medium</p> <p>Self-reported change in attitude (with or without knowledge change) among men (but no behaviour change) May include some consultation with stakeholders or multiple actors</p> <p>Low</p> <p>Change in knowledge only or unclear or confusing results regarding change in attitudes and behaviour</p> <p>Ongoing</p> <p>Overall effectiveness</p> <p><i>Effective</i></p> <p>Rigorous design and high or medium impact Moderate design and high impact</p> <p><i>Promising</i></p> <p>Moderate design and medium or low impact Rigorous design and low impact</p> <p><i>Unclear</i></p> <p>Limited design regardless of impact</p>

Figure 1. Ranking criteria for review

exclusively by changes among individual men and not at the level of broader social norms, including wide-ranging change in power relations.

Limitations

A major limitation of this review is the limited comparability of programmes due to the lack of detailed descriptions about programme methods. For example, group education represents a broad category of programmes, encompassing some that use traditional styles of rote learning, as well as others that are participatory in style. In addition, some group education programmes included here lasted only a few hours, whereas others included up to 16 weekly sessions. Likewise, it is difficult to adequately compare the relative effectiveness of programmes due to variation in outcome indicators, cost data, and the quality and robustness of evaluation methods.

Another limitation is that key variables or differences among men were often omitted in evaluation studies. Grouping men and boys as the unit of analysis may ignore other important variables, such as social class, age or ethnicity. Finally, this

review is limited to available studies published in English, Spanish, Portuguese and French. Since published reports tend to favour the studies that find positive results, those evaluation studies or programmes that showed limited or no impact are underrepresented.

Results

Of the 58 studies included: 17 (29%) were assessed as being effective in changing attitudes or behaviours using the definition previously cited; 22 (38%) were assessed as being promising; and 19 (33%) were assessed as being unclear. Table 1 shows that some programmes are effective in the four types of intervention activities.

Programmes were categorised in terms of types of intervention activities. Twenty-two (38%) of the programmes were comprised of only group educational activities. Group education means programmes that carry out discussion or awareness-raising sessions with men or boys. Some of these may represent traditional kinds of learning, with facilitators or trainers imparting information, whereas others (probably more promising) use more participatory activities, such as role-playing. Eight (14%) of the programmes were exclusively service based. These involved health services for men, or individual counselling based in health or social service settings. These activities generally take place in a health service or social service facility, and may involve one-on-one counselling or imparting of information by a health or social service provider, or the provision of a health service (such as a medical exam or provision of condoms). Seven (12%) of the programmes were exclusively community outreach, mobilisation and mass-media campaigns using theatre, mass or local media, sensitisation of local leaders, or educational and informational materials with messages related to health and gender. This includes public service announcements on television or radio; billboards; distribution of educational materials; local health fairs, rallies, marches and cultural events, including theatre (such as street theatre or community theatre); and training of promoters to reach other men or to organise community activities. Twenty-one (36%) were integrated, meaning they combined at least two of these types of activities.

Geographically, many of the evaluated interventions were from North America (41%), followed by more or less equal numbers from Latin America and the Caribbean, sub-Saharan Africa and Asia, and the Pacific. Europe, the Middle East and North Africa are underrepresented (see Table 2).

Table 1. Overall effectiveness of the 58 programmes by type of intervention.

Types of intervention	<i>n</i>	Effective	Promising	Unclear
Group education	22	2	11	9
Service based	8	2	4	2
Community outreach, mobilisation and mass-media campaigns	7	5	2	0
Integrated (includes more than one of the above)	21	8	5	8
Total	58	17 (29%)	22 (38%)	19 (33%)

Table 2. Geographical location of the 58 programmes by region.

Region	<i>n</i>	Percentage (%)
North America	24	41
Latin America and the Caribbean	9	16
Europe	2	3
Sub-Saharan Africa	9	16
Middle East and North Africa	5	9
Asia and the Pacific	9	16
Total	58	100

Reasonably well-designed programmes with men and boys lead to short-term change in behaviour and attitudes

The evidence presented confirms that men and boys can, and do, change attitudes and behaviours related to: sexual and reproductive behaviour; maternal, newborn and child health; their interaction with children; their use of violence against women; questioning violence with other men and their health-seeking behaviour as a result of relatively short-term programmes (see Figure 2). Short term is emphasised because, as is the case in most of the evaluations reviewed, the results primarily focus on changes in men's behaviours and attitudes immediately after interventions or, in a few cases, with follow-up data collection only a few months after the intervention or programme ended. Among the studies here, for example, none is truly longitudinal.

Programmes assessed as being gender transformative seem to show more evidence of effectiveness in achieving behaviour change among men and boys

The 58 interventions were categorised using the definitions of 'gender neutral', 'gender sensitive' and 'gender transformative', as previously presented.³ Of the 58 programmes, six were considered gender neutral, 25 gender sensitive and 27 gender transformative. Among the 27 programmes categorised as gender transformative,

The following are specific changes in behaviour that have been confirmed in reasonably well-evaluated programmes with men and boys:

- decreased self-reported use of physical, sexual and psychological violence in intimate relationship (Safe Dates Program, United States; Stepping Stones, South Africa; and Soul City, South Africa);
- increased contraceptive use (Together for a Happy Family, Jordan; male motivation campaign, Zimbabwe and Guinea; and involving men in contraceptive use, Ethiopia);
- increased communication with spouse or partner about child health, contraception and reproductive decision making (Men in Maternity, India; Together for a Happy Family, Jordan; male motivation campaign, Guinea; and Soul City, South Africa);
- more equitable treatment of children (Together for a Happy Family, Jordan);
- increased use of sexual and reproductive health services by men (integration of men's reproductive health services in health and family welfare centres, Bangladesh);
- increased condom use (Sexto Sentido, Nicaragua; Program H, Brazil);
- decreased rates of sexually transmitted infections (Program H, Brazil); and
- increased social support of spouse (Soul City, South Africa).

Figure 2. What kinds of changes can be achieved in programmes engaging men and boys?

41% were assessed as being effective versus 29% of the 58 programmes as a whole. This finding is important, as it suggests that engaging men and boys in programmes that include discussions of gender and masculinity with clear efforts to transform such norms may be more effective than programmes that merely acknowledge, or mention, gender norms and roles, and/or focus only on content (such as HIV prevention, treatment, care and support or gender-based violence). At the same time, the fact that there was not a bigger difference in the percentages may suggest that even those programmes that incorporate a gender-transformative approach may not, in and of themselves, be sufficient to lead behaviour change if other social factors, which also influence behaviours and how individuals understand and act upon gender norms, are not also addressed. These other factors include income or social inequalities, broader cultural settings, and the policy–legal context, to name a few.

Relatively few programmes with men and boys go beyond the pilot stage or a short-term time frame

Of the 58 programmes, few go beyond a short-term project cycle, ranging from 16 weekly group educational sessions to one-year campaigns. In general, however, the evaluation reports focus little attention on sustainability, including such factors as social capital, advocacy, fundraising, the management ability of staff to maintain programme efforts and broader political and ideological issues, such as resistance to engaging men (apart from discussions of operational issues and the challenges of engaging men). Further, few, if any, of the evaluation reports describe efforts to scale-up interventions or incorporate them into public policy. Only about 10 of the 58 represent longer term or large-scale efforts to engage men and communities.

Some programmes in each of the five health areas show effective or promising results

Table 3 presents analysis of effectiveness, by health area and by kind of programme. This affirms that some programmes in each of the five areas show effective or promising results. The fatherhood programmes, included here, show fairly low rates of effective or promising results, in part because of the complexity of indicators used, and possibly because of relatively small sample sizes. The indicators used in evaluating fatherhood programmes include employment rates, child development outcomes and amount of time that men spend in providing childcare – all of which are complex and have many causes. This is an area of intervention with men that requires more evaluation and more programme development and testing, particularly in low and middle-income countries.

In contrast to the previous World Health Organisation (WHO) review of batterer intervention programmes (Rothman *et al.* 2003), this review focuses on gender-based violence prevention programmes with men and boys that show fairly promising results in leading to changes in attitudes and behavioural intentions. Gender-based violence prevention programmes showed positive outcomes in terms of changed attitudes towards gender-based violence; reduced self-reported rates of various forms of gender-based violence, including physical violence against female partners and sexual harassment; and increased reported intention to talk to boys about gender-based violence. However, only two studies also included triangulation with female partners, clearly a key issue in assessing the impact of efforts to prevent gender-based

Table 3. Overall effectiveness of the 58 programmes by theme and type of intervention.

Type of programme	<i>n</i>	Effective	Promising	Unclear
Prevention of gender-based violence				
Group education	8	1	6	1
Services	–	–	–	–
Community outreach, mobilisation and mass-media campaigns	3	2	1	–
Integrated (includes more than one of the above types)	4	1	–	3
Total	15	4	7	4
Fatherhood				
Group education	6	–	2	4
Services	1	–	–	1
Community outreach, mobilisation and mass-media campaigns	–	–	–	–
Integrated (includes more than one of the above types)	9	3	2	4
Total	16	3	4	9
Maternal, newborn and child health				
Group education	1	–	–	1
Services	3	1	2	–
Community outreach, mobilisation and mass-media campaigns	1	–	1	–
Integrated (includes more than one of the above types)	2	1	–	1
Total	7	2	3	2

violence. The previous WHO review of batterer intervention programmes (Rothman *et al.* 2003) affirmed, in reviewing 56 studies, that such programmes are somewhat effective in reducing the likelihood of repeat or further abuse or physical violence against women among the men who participate. The study acknowledged that, in many settings, the main shortcomings are high dropout rates, limited coordination or follow-up with law enforcement, or legal systems that mandate men's participation in such programmes.

Integrated programmes, specifically programmes that combine group education with community outreach, mobilisation and mass-media campaigns, are more effective in changing behaviour than group education alone

Among the programmes reviewed, those with community outreach, mobilisation and mass-media campaigns and integrated programmes, seem to be more effective approaches to changing behaviour among men and boys than single-focus interventions. This highlights, but does not affirm definitively, the usefulness of reaching beyond the individual level to the social context – including relationships, social institutions, gatekeepers and community leaders – in which men and boys live, *i.e.*, the ecological model discussed earlier. Mass-media campaigns have shown some level of effectiveness in nearly all health areas, including: sexual and reproductive

health (including HIV prevention, treatment, care and support), gender-based violence, fatherhood and maternal, newborn and child health. Effective campaigns generally go beyond merely providing information to encourage men to talk about specific issues, or act or behave in specific ways, such as talking to their sons about violence against women, or being observant and seeking services in case of a high-risk pregnancy. Some effective campaigns use messages related to gender-equitable lifestyles, in a sense promoting or reinforcing specific types of male identity. Mass-media campaigns on their own seem to produce limited behaviour change, but show significant change in behavioural intentions and self-efficacy, such as self-perceived ability to talk about or act on an issue, or behavioural intentions to talk to other men and boys about violence against women.

Stand-alone group educational activities with men and boys show strong evidence of leading to changes in attitudes and some evidence of leading to change in behaviour

Group educational activities continue to be one of the most common programme approaches with men and boys, and are, by process and qualitative accounts, useful in promoting critical reflections about how gender norms are socially constructed. The evidence included here confirms that such activities can lead to significant changes in attitudes (some of which are correlated with behavioural outcomes) and self-reported behaviours. Although there might be difficulties in recruiting and retaining men to participate in groups, sometimes because they are busy with work or other activities, or because they may initially consider discussion groups to be a 'female' style of interaction, process evaluation has affirmed that if convinced to participate, most men find group education sessions to be personally rewarding and engaging.

There are relatively few data on the impact of public policy aiming to change the behaviour of men and boys in the efforts to achieve gender equality

Apart from historical trend data, and emerging studies on paternity leave policies in Scandinavian countries (which show evidence of increased participation by men in childcare, or at least increased take-up of paid paternity leave), little assessment and few data are available on the impact of legal structures, policies and broader public practices on the behaviours or attitudes of men and boys, particularly in low and medium-income countries. Given the number of new laws and policies related to gender-based violence, paternity establishment, child support and gender equality broadly (such as those embodied in the South Africa's 1994 constitution), the impact of such national-level and policy-level changes on boys and men needs to be understood (Sonke Gender Justice Network 2007). Seeking to identify ways to change gender inequality at a society-wide level requires making the impact of such policy-level changes (and other social trends, such as women's greater participation in employment outside the home) a priority for future research. Although this review did not focus on this, data from western Europe (mostly Nordic countries), where paid paternity leave has been offered for more than 10 years, have confirmed that increasing numbers (and proportions) of fathers are using such leave and spending more time with their young children as a result of these policies, particularly when

paternity leave is paid, and when the time allotted for fathers is not transferable to the mother (Valdimarsdóttir 2006).

Few if any programmes are applying a life-course approach and assessing impact in these terms

As previously affirmed, most of the programmes included here focused on one age group of boys or men during a relatively short project span. One of the few exceptions included Stepping Stones, which works with younger men and women and older men and women, Programme H in Brazil and the Yaari Dosti initiative (an adaptation of Programme H in India), which is engaging younger boys (10–14 years) as well as young men (15–24 years). Nevertheless, few programmes seek to reach men and boys (or women and girls) at different moments of the life course, or integrate their programmes among one age group with other organisations or programmes working with other age groups. Most of the programmes also involve older adolescents and adult men, generally 15 years and older. Only two programmes identified are trying to reach boys younger than 15 years. No study followed men or boys for more than 2 years. As such, the measured impact of programmes represents a limited moment and time in the changing lives of men and boys.

Conclusions and suggestions for future efforts

The studies reviewed confirm that reasonably well-designed programmes with men and boys can produce short-term changes in attitudes and behaviours, and that programmes that show evidence of being gender transformative seem to show more success in changing behaviour among men and boys. This review confirms that there is no ‘magic bullet’ for engaging men and boys in gender equality. Instead, comprehensive, multi-theme programmes, that include specific discussions about social meanings of men and masculinity, seem to show the highest rates and levels of effectiveness. Clearly, caution must be exercised in how much to attribute to the outcomes and indicators reported. On the surface, increasing condom use among men, and increasing men’s use of health services, do not inherently reduce gender inequality – unless they also reduce the burden on women for contraceptive use, or a change in how men view and interact with women. It can also be said, in turn, that increased gender equality may not necessarily lead to improved health behaviours, such as condom use. Yet, the qualitative assessments, taken together with the indicators, suggest that some changes related to gender inequality have resulted from the programmes included here, and that these changes can lead to better health outcomes for men, their partners, their families and children. More evidence is needed, however, on how to achieve large scale and sustained reach necessary to change gender norms and power dynamics, and how to integrate a gender-transformative approach with a social justice approach.

Although many of the programmes reviewed here focused on measuring change among individual men and boys, programme descriptions imply that some are moving towards a more nuanced application of a social constructionist and ecological approach. Programmes generally seem to view the behaviours and attitudes of individual men and boys as emerging from socially and historically

constructed gender inequalities, and, accordingly, target individuals and the broader social setting.

The programmes reviewed suggest, that in the past 10–15 years, there has been a move from single-focus interventions (providing vasectomy or promoting condom use in clinic settings) to programmes working at multiple levels, themes, health areas and with more integrated perspectives. The evidence reviewed suggests that integrated programmes are most effective in changing behaviour, and directly or indirectly adopt an ecological approach combining, for instance, community outreach and mass-media campaigns with group education. This suggests, for instance, that group sessions on safer-sex practices, making condoms available, as well as large-scale mass-media campaigns on the importance of practicing safe sex, may prove more likely to affect changes in sexual behaviours and attitudes as these messages become replicated in multiple contexts of the individual's life.

There is not enough evidence to definitively conclude that multi-issue programmes, using a more nuanced social constructionist and ecological framework, are more effective than single issue and individual-focused interventions. Nevertheless, the conclusion that gender-transformative programmes, as defined here, show more effectiveness than gender-sensitive or gender-neutral programmes, provides weight for this argument. At the same time, some single-focus interventions reviewed here, although not necessarily gender transformative, have demonstrated high levels of effectiveness in leading to short-term changes on a single issue or type of behaviour. It may be more appropriate to affirm that both kinds of approaches have their place and utility depending on the health-related and gender-related objective.

Numerous studies suggest that among interventions with women and girls, reflecting critically about gender norms does not inherently add value to programmes (producing better outcomes) unless accompanied by changes in the opportunity structure, or the ability of women and girls to access resources (Bruce 2006). Although programmes with men and boys to change gender norms must work at the broader societal level, an important step in gender-based programming for men and boys seems to be explicitly acknowledging prevailing gender-inequitable definitions of manhood as part of the problem.

Almost none of the programmes reviewed mentioned, or sought to measure, continued impact of the programmes beyond the period studied or possibilities for continuity, replication and scaling-up. Likewise, there is little discussion of programme quality and integrity, that is, how to maintain programme coherence when models or approaches are scaled-up. For example, what happens when some of the widely used curricula are used beyond their original sites? Scaling-up gender-based health interventions and programmes engaging men and boys requires dealing with these questions as well as which programmes should be scaled-up, where, how and for whom.

Remaining questions and proposed steps forward

Significant number of programmes reaching men and boys with messages or reflections about masculinity were not included here because they did not have evaluation data (or published data that met the criteria used). These unevaluated programme experiences deserve attention in exploring ways to scale-up work with

men and boys to reduce gender inequality. In terms of remaining questions, the following are some that emerge from this review:

- Are some indicators of attitude and behavioural outcomes more important than others in terms of men, boys and gender equality? For example, might there be some key ‘gateway’ behaviours or interventions that create pathways to broader gender transformation among men? Many of the studies reviewed focus on one specific outcome – couple communication on contraceptive or condom use. More longitudinal research is needed that seeks to understand and assess the impact of earlier gender-transformative practices (e.g., men’s involvement as fathers). Might such behaviour create pathways among children that promote gender equality and move men into long-term patterns of greater involvement in childcare and domestic life? More effort needs to be invested in measuring societal attitudes about gender and manhood, given that most of the interventions currently focus on measuring change among a relatively small number of individuals.
- At the interpersonal level, researchers have highlighted that it is through and within relationships that gender norms become personally meaningful and consequential to men and boys, and women and girls (Way 1998). Gender norms are reinforced bi-directionally; boys and men influence and are influenced by the beliefs, attitudes and practices of women and girls. How can programmes take a relational perspective, integrating the engagement of men and boys with efforts to empower women and girls? In which cases is working solely with men and boys (or solely with women and girls) useful, and in which cases is working with men and women together useful and effective?
- What is required for programmes to be able to scale-up and sustain their efforts? What are the common factors, conditions or operating strategies of programmes that have been able to scale-up or sustain themselves? Which programmes should be scaled-up?
- Which factors of ‘good programming’ are common across varied cultural settings, and which are cultural specific?
- What kinds of structural changes and policies could lead to large-scale change in men and masculinity? It could be useful to review, for example, existing policies related to fatherhood (paternal leave, for example), family policy, sexual and reproductive health and laws related to gender-based violence to measure or assess the results of such policies. How do and can such policies take into account other inequalities – particularly income inequality and poverty?
- Similarly, what is known about naturally or spontaneously occurring change or long-term trends in men’s behaviours and attitudes related to sexual and reproductive health, HIV prevention, use of gender-based violence, and participation in child and maternal health and well-being? Reviewing ‘natural experiments’ or naturally occurring differences, such as factors that seem to explain higher rates of men’s use of gender-based violence in one setting versus another, could be useful to understand factors that lead to change. Given the complexity of changing social norms related to gender among men and boys, and the power dimensions behind them, these policy-level and large-scale programme approaches could make a difference.

Finally, what do we know about programmes and policies that take into account gender dynamics and also consider other key issues, such as income equalities, ethnic inequalities and religious and cultural differences?

Notes

1. Portions of this article were previously published by the WHO. The full list of evaluation studies and reports used in this analysis is available at http://www.who.int/entity/gender/documents/Engaging_men_boys.pdf
2. The author is a staff member of WHO. The author alone is responsible for the views expressed in this publication and they do not necessarily represent the decisions or policies of the WHO.
3. At least two of the authors ranked each programme; in the case of divergence, the authors consulted each other, reread the study and arrived at a consensus.

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