research brief |

Young People's Reproductive Sexual Health & Rights

01

Addressing Masculinities as a Strategy to Reduce Sexual Risk Behaviour among Young Men in India

The population of young people between 10-24 years in India is about 314 million, almost a third of the total population of the country. Youth, if rightly addressed, pose for India a potential demographic dividend ,and/or if ignored a challenge of enormous proportions. A well nurtured and equipped youth cohort will lead to larger well being of the country, and on the flip side can make India vulnerable to indeterminable challenges. While sectoral initiatives geared to address socio-economic development will be of the utmost importance to create opportunities for productive employment, income generation, and a healthy workforce, it will be equally important to provide the basic foundation and quality of human resource in terms of the potential participants in the workforce. The size and complexity of the issue requires a multi-pronged approach aimed to address youth as individuals and members of the community and society at various levels.

The investment required for improving the lives of young people will have an impact on achieving several of the Millennium Development Goals[1] (MDGs). While the interdependence of MDGs 3, 4 and 5 is recognized, the role played by men and their relationships with women is appreciated at negligible level. At the same time, vulnerability and associated disease burden is well studied but underlying reasons for vulnerability are often poorly understood.

Over 35 percent of all reported AIDS cases in India occur among young people in the age group of 15-24 years indicating that young people are at high risk of contracting HIV infection. Majority of the young people are infected through unprotected sex.

An understanding of the determinants of sexual health focuses on the socio-demographic variables which have been linked to the sexual behaviour and sexual health of young people is essential. Men's intimate involvement in sex and reproduction cannot be disputed. While there are multiple factors influencing young men's HIV risk in India, an important one that is receiving increasing attention is early socialization about masculinity. Young men in India mature in a male-dominated context, with little contact with female peers and virtually no sex education. As a result some young men are socialised in ways that lead to violence and discrimination against women, violence against other young men, and health risks to them and their communities.

Renewed interest in working with men has been initiated because of the HIV Pandemic which puts emphasis on gender equity and equality in policies and programs. Programmes aimed at "reducing gender differences" and improving partner communication (and thus affecting "masculinity") have focused on both changing gender norms and attitudes and promoting less risky behaviour among men (e.g., Project H: Working with Young Men Series, Instituto PROMUNDO; Stepping Stones, Welbourn; Men as Partners (MAP) Programme, Engender Health).. However few studies have attempted to influence gender norms and measure changes among young men exposed to intervention. In response to this gap, Horizons, CORO and PROMUNDO piloted a participatory group intervention to promote gender equity with young men in Mumbai, an adaptation of a successful program in Brazil.

In the frame of Sexual and Reproductive Health and Rights programme, MAMTA Health Institute for Mother and Child (MAMTA) and Duad Memorial Christian Gramin Vikash Samiti (DAUD) piloted Yari Dosti – a participatory, group education session intervention (2005-07) in rural areas. Group educational sessions initiate and

1 MDGs: i. Eradicate extreme poverty and hunger, ii. Achieve universal primary education, iii. Promote gender equality and empower women, iv. Reduce child mortality, v. Improve maternal health, vi. Combat HIV/AIDS, Malaria and other diseases, vii. Ensure environmental sustainability and viii. Develop a global partnership for development

promote questioning of violent behavioral patterns. The intervention tried to reason with the participants regarding the "necessity" to take risks, hide emotions, and/or exert authority or control in relationships with partners and others at the individual level. In Gorakhpur, the outcome of group education sessions under Yari Dosti programme has been researched for rural population and is showing positive changes in Gender Equitable Male (GEM) Scale.

The objective of this intervention study is to understand masculinities – its constructs and associates – in young men to introduce interventions to comprehend feasibility of such intervention(s), thus contributing in developing a model in Indian context and to validate the GEM scale.

The research addresses following questions

1) Is it possible to change masculinity, unequal gender norms and perceptions – a deep-rooted and intertwined complex cultural pattern?
2) Will change in masculinity, with an emphasis on more equitable gender norms and perceptions, bring about a corresponding change in risky sexual behaviour and practices?
3) Is it possible to validate the GEM scale, which has been successfully employed in Brazil and in Mumbai, for replicability?

METHODOLOGY

A case control design with one intervention site and one non-intervention site for comparison was envisaged. The project was in four phases – formative research, baseline survey, intervention implementation and process and outcome evaluation.

Study population

Gender disparity and inequitable gender relations are accepted norms in eastern part of Uttar Pradesh, a State in Northern India. Population from this region of India constitutes a sizable proportion of the migrant population in major cities and economically prosperous states within India. Gorakhpur is also at the cross roads of international migration between Nepal and India. All these factors already make young people in this area vulnerable to HIV infection.

14 villages each in Pali (intervention) and Bhat Hat (non-intervention) blocks of Gorakhpur district of Uttar Pradesh were the study area. DAUD partnered with MAMTA, as the field implementer.

Young men of 15-24 years in both the intervention as well as in control area villages were the study population. Wives of the married peers attending sessions constituted female group of informants for understanding the effect of intervention. Other groups like adults, community leaders and teachers would act as key informants for formative research.

PLAN FOR INTERVENTION

Peer leaders – young men who speak 'same language' as the target group, were recruited. In each of intervention villages two peer leaders were selected. Realizing that it might be difficult for younger people to deliver modules to older peers, preference was given to peer leaders residing in the intervention villages, educational achievements and age. As caste composition of a village could prove to be detrimental to programme delivery, the caste an individual belongs to, was also given due consideration. Peer leaders in each of the villages formed group of young men and maintained these groups in each intervention villages throughout the intervention period.

Quantitative House listing data collection

Master list of all males of 15-24 years from each of 14 villages of the intervention and non-intervention blocks were compiled to facilitate evaluation baseline, endline and maintain process of intervention through cohort follow up.

Group formation

The six month group formation process was the foundation on which the intervention was build. Peer leaders conducted general meeting to contact villagers, explaining the project and its objectives. Important stakeholder like the village *pradhan*, teachers, doctor if any and prominent villagers were contacted to create an enabling environment in the villages. Separate meetings were arranged with the young men. Gradually, the focus shifted to young men's meetings in which personal rapport was established with youth. The emphasis was on motivating youth to come together.

Peer leaders using qualitative methodologies

Peer leaders, under the guidance of researchers, conducted a total of 125 interviews with young men aged 15 to 24 years from neighboring villages, to avoid contamination in the intervention villages, to learn perception of youth.

Perceptions about masculinity and masculine behaviour, the meaning of 'masculinity' and reason of its expressions, outcome of masculinity as perceived by participants – positive or negative and their impact at individual or personal, family and societal levels were collected. Notions of masculinity among 15-24 years of men, the words that are attached with masculinity to describe these behaviours were discussed. The formative research helped in building the Yari Dosti module used for intervention. The Yari Dosti module contains 29 sessions in total – once a week sessions spread over 6/7 months including eventualities.

Group sessions

Peer leader received extensive residential training for the group education session organized in Gorakhpur in collaboration with Population Council and CORO for Literacy, Mumbai. Peer groups of 40 participants in each village were split into smaller groups of 20 participants each for successfully conducting the session. Peer leaders alternate the role of facilitator and recorder of the session to conduct session with each of the target groups. Peer attendance format, to record attendance details of peers in the sessions according to session number and the part of the session, was maintained.

Evaluation tool: Gender equitable men scale (GEMS)

The evaluation model was grounded in the real life behaviour and attitudes of young men, and not in an idealised or theoretical idea of what 'more gender-equitable behaviour and attitudes' should be. The term gender-equitable was operationalized to refer to young men who:

a) Seek sexual and other relationships with women and men based on equality, respect and intimacy rather than conquest;

b) Would or do seek to be involved fathers, including taking on financial and care-giving responsibilities;

c) Assume some responsibility for reproductive health and disease prevention issues;

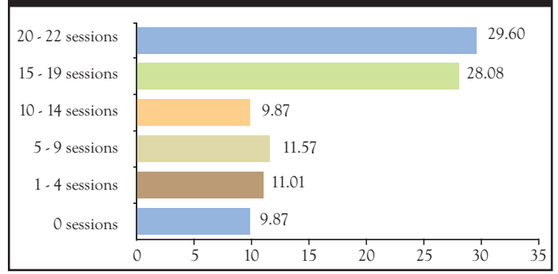
d) Are opposed to violence against women in their intimate relationships.

List of items developed based on work by Barker and colleagues[2] with young men, and Pulerwitz and colleagues[3] on power in sexual relationships. The original GEM scale of 17 items had been modified by addition of seven more items to measure violence, sexuality, domestic life, and reproductive health. To suit Indian context at Mumbai based on the results of formative research, 10 Indian items were added to make the GEMS with 34 items. However, factor analysis of the initial results of Mumbai helped in finally identifying 15 items (11 original and 4 new India-specific) with internal consistency of 0.75 as Indian GEMS. The scale tries to capture a man's perception with regard to the traditional gender norms vis-à-vis egalitarian gender norms.

GROUP SESSION ATTENDANCE

From the session wise monthly attendance record, it was found that the attendance among the peers in sessions varied. More than half of the peers attended more than 15 sessions. Roughly 10 percent of the peers who attended the baseline survey did not attend any of the sessions.

Fig. 1: Percentage distribution of peers in intervention villages attending sessions



EVALUATION :

To avoid implementers' bias in evaluation, all evaluation surveys for this project were conducted by an individual research organization. First endline data was collected from 602 young men (299 in intervention area – those who have attended more than 7 sessions,

2 G. Barker (2000a) 'Gender equitable boys in a gender inequitable world: reflections from qualitative research and programme development in Rio de Janeiro', Sexual and RelationshipTherapy, 15 (3), 263–82.

3 J. Pulerwitz and G. Barker (2004) 'Measuring Equitable Gender Norms for HIV/STI and Violence Prevention with Young Men: Development of the GEM Scale', unpublished mimeo.

and 303 in control area). Process documentation from session reports (from 14 intervention villages) was compiled to record the steps of the sessions, discussion and proceedings. Twenty-four qualitative in depth interviews with wives, as immediate female family members, of males exposed to sessions were conducted to evaluate the changes brought about by the intervention. To measure sustainability of the programme impact, data was collected after a lapse of six months with no interventions in either of the two areas.

KEY FINDINGS

Preliminary analysis of baseline and first endline data indicates changes in the intervention areas when compared to the non intervention area in terms of changes in GEM Scale.

Socio-demographic Profile of young men at Baseline

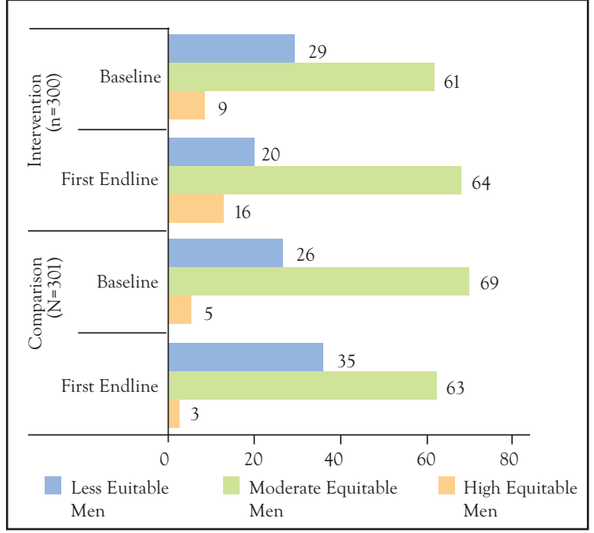
In both the intervention and non-intervention areas the median age of the respondents was 19 years, with median years of schooling as10 years. 69 per cent respondents were un-employed, while 31 percent were gainfully employed. Twenty-six per cent of the cohort was married at the time of survey while rest was unmarried. The reported median age at first sex was 16 years.

The gender equitable men scale (GEMS)

The Gender Equitable Male (GEM) Scale survey was administered to all participants pre- and post-intervention. There was substantial positive change in the intervention arm that was not found in the control arm. In the intervention arm, 9 of 15 items changed in the positive direction, 2 in the negative direction, and 4 items showed no significant change. By comparison, in the control group, 5 items shifted in the negative direction while 10 items showed no significant change in either direction. There were no shifts toward more positive gender attitudes and behaviors in the control group.

In order to easily interpret changes in overall gender equity, each participant's GEM Scale score was categorized as "least equitable", "moderately equitable", or "most equitable." The analysis indicates a significant positive shift ($p<0.05$, Chi Squared test) from the least equitable category to the moderate and high categories (fig2).

Fig 2: Change in GEMS items in between baseline and First Endline surveys



It is interesting to note the perception changes reported at individual level over the period of the intervention. In the intervention group, of the 97 low equity men at the base line, 42.3 per cent remained in the low equity frame while 26.8 per cent changed to moderate equity group. However 30.9 per cent of men with low equity changed to high equity group in the endline. Of the 87 medium equitable young men, 40.2 per cent remained moderately equitable while 16.1 per cent and 43.7 per cent medium equitable became low equitable and high equitable respectively. 63.4 per cent of young men of high equity group comprising of 112 young men (at baseline) remained highly equitable in the endline as well while 13.4 and 23.2 percent high equity men slipped to low and moderate equitable category (Table: 1).

Over all in the first endline in the non intervention area 38.6 per cent men were low equity compared to 23.6 per cent in the intervention areas. Similarly 47 per cent of the intervention area men were highly equitable compared to 29.5 per cent in the non-intervention area. The moderately equitable were 29.4 percent and 32 per cent in the intervention and non-intervention areas respectively.

The mean GEM Scale scores from pre- to post-intervention, for each site was calculated. After the intervention, mean scores on the GEM Scale showed significant changes. The mean scores improved significantly ($p<0.05$) in the rural intervention site in Gorakhpur. Post-intervention, the difference in mean score between the intervention and control sites was also significant (ANOVA test; $p<0.05$) with intervention site having higher scores than control site.

The analysis reveals that during the post-test survey, the young men participating in study interventions showed significant improvement in their attitude toward PLHA. However, comparison group showed significant negative results.

Table 1 : Change in Gender Equitable attitude from baseline to first Endline

Baseline		First End line		
		Low Equity	Moderate Equity	High Equity
Intervention Group				
Low Equity	97	41 (42.3)	26 (26.8)	30 (30.9)
Moderate Equity	87	14 (16.1)	35 (40.2)	38 (43.7)
High Equity	112	15 (13.4)	26 (23.2)	71 (63.4)
Total	296	70 (23.6)	87 (29.4)	139 (47.0)
Non-Intervention Group				
Low Equity	93	52 (55.9)	30 (32.3)	11 (11.8)
Moderate Equity	90	37 (41.1)	26 (28.9)	27 (30.0)
High Equity	115	26 (22.6)	39 (33.9)	50 (43.5)
Total	298	115 (38.6)	95 (32.0)	88 (29.5)

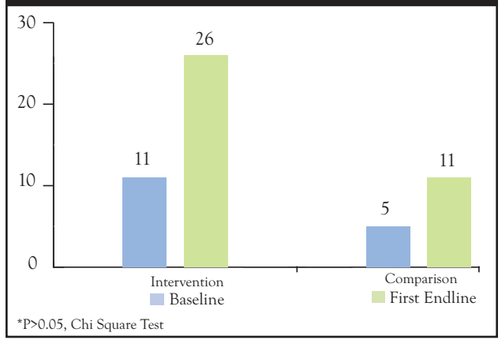
P<.05 chi square test
Figures in parentheses are percentage

Improved communication between partners on condoms, sex, and HIV/STI

The findings indicate that there was significant improvement amongst the intervention participants in discussing key reproductive and sexual health issues with a female partner such as condom use, how to enjoy sex, and sexually transmitted diseases including HIV/AIDS with their partners during the last 6 months ($p<0.05$).

11 per cent of young men in the Pali intervention site discussed condom use, sex, and HIV/STIs with their partners at baseline. This significantly improved to 26 per cent at follow up. The comparison group also showed a significant improvement from 5 percent in the pre-test to 11 percent in follow-up in discussing these issues with their partners.

Fig 3: Change in communication with female partners on Condom, Sex and HIV/STIs during Pre and Post intervention test



*P>0.05, Chi Square Test

Condom use in intervention areas

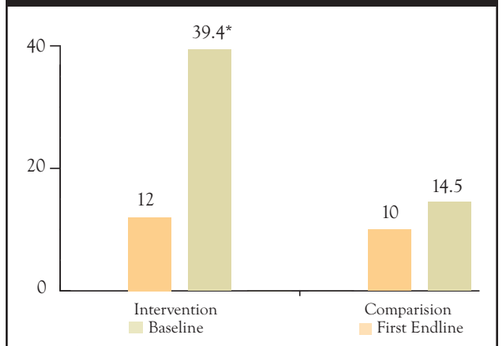
Among the sexually experienced young men, condom use during last sex with any partner increased significantly ($p<0.05$) in rural setting. There was a three-fold increase in the rural intervention sites. In the control sites, there was a slight improvement in condom use.

In the rural intervention site, 12 per cent of young men reported condom use during last sex in the baseline survey. This improved significantly to 39 per cent after the Yari Dosti intervention. In the comparison site, condom use increased slightly from 10 per cent at baseline to 15 per cent during follow up. Condom use was most regular with sex workers, revealing the popular assumption that the sex workers are the major carriers of HIV.

Logistic regression analysis (not shown here) revealed that the likelihood of condom use was 4.5 times higher ($P<.001$) among the young men who discussed condom use, sex and HIV & AIDS with their partners as compared to those

who did not discuss these things with their partners. Also interesting was the fact that the men classified as highly equitable men were 1.9 times more likely to use condom than those that were classified as less equitable men (P<.001). The men exposed to this intervention were 2.8 times more likely to use condoms at last sex than those not exposed to the intervention. These findings indicate that interventions which promote more equitable gender norms can be effective in increasing condom usage.

Fig 4: Change in condom use at last sex with any partner

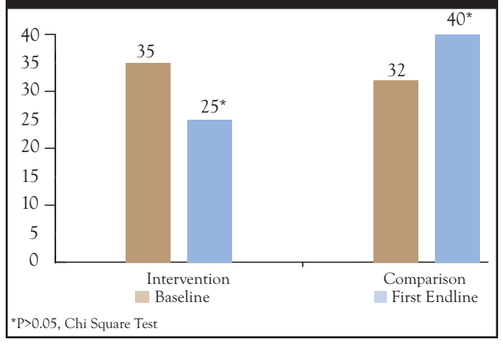


*P>0.05, Chi Square Test

Self-reported violence against partner

Self-reported violence against any partner declined significantly (p<0.05) in intervention area of Pali, reduced from 35 to 25 per cent. The reported violence increased significantly in comparison group.

Fig 5: Change in Violence to the partners by young men



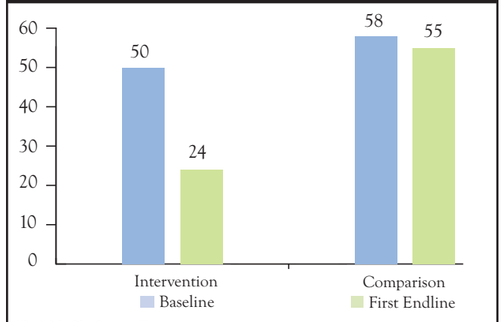
*P>0.05, Chi Square Test

Logistic regression analysis (not shown here) revealed that young men exposed to the intervention were two times less likely to be violent in Gorakhpur (P<.001). Likewise high equitable young men were approximately twice (P<.001) less likely to be violent to their partners. Young men who discussed various issues – HIV, Condom use, how to enjoy sex etc.– with their partners were three times less likely to be violent.

Reported symptoms of STI during the last 3 months in intervention sites

The young men participating in the intervention had a significant decrease in reported symptoms of STI when comparing pre- and post-survey results (p<0.05). In Gorakhpur intervention site – Pali – 50 per cent of young men reported symptoms at baseline while only 24 per cent reported symptoms after the intervention. In the control group in Bhat Hat, 58 per cent of young men reported at least one symptom of STI during the pre-test, decreasing slightly to 55 percent at follow-up.

Fig 6: Change in reported symptoms of STI during Pre and Post intervention test



*P>0.05, Chi Square Test

Exposure to intervention associated with improvement in gender attitude and reduction in HIV/STI risk behaviors

Change in attitude is positively correlated with exposure to intervention. The young men who were exposed to intervention were twice more likely (based on odds ratio) to have a positive change in attitude at endline as compared to young men in the control site (p<.05).

With regards to HIV risk behaviors, young men exposed to intervention were 3.5 times more likely to use condom as compared to young men not exposed to the intervention (p<.001). Also, in intervention sites, young men were significantly less likely to report violence against partner. There was a reduction by 50 per cent (based on odds ratio of 0.52; p<.001).

There was a correlation between positive change in attitude and reduction in HIV risk behaviors. Although, some of the correlations are not statistically significant, they indicate that improvement in gender attitudes can reduce HIV/STI risk practices. For example, young men who had an improvement in the GEM scores at endline were 1.03 times more likely to use condoms. They were also 1.4 times more likely to communicate with their partner. Similarly, young men with positive change in attitudes were less likely to report inflicting violence against any partner after the intervention and prior to the survey. These young men were also less likely to report sex with more than 1 sexual partner in the three months preceding the endline survey. Likelihood of sex with multiple partners in the last 3 months reduced by 24 percent.

DISCUSSION:

The HIV epidemic has sharpened the recognition that existing reproductive health programs have a limited impact in achieving overall reproductive health and development goals.

A participatory, group intervention to promote gender equity, was piloted with young men from rural areas in Gorakhpur, Uttar Pradesh. The gender-focused intervention attempted to promote positive norms such as responsibility, caring attitude, and respect for one's partner and women in general. Compared to baseline, intervention participants showed equitable gender norm perceptions and reported less sexual harassment, higher condom usages and positive attitude to HIV infected. A trend toward less risky behavior.

Study findings indicate that addressing inequitable gender norms, particularly those that define masculinity, is an important element of an HIV prevention strategy for young men. The findings also suggest that group education interventions can successfully influence young men's attitudes toward gender roles and lead to healthier relationships. In addition, the findings provide empirical evidence that a behavior change intervention focused on combating inequitable gender norms is associated with improvement in HIV/STI risk outcomes.

The group education modules were culturally appropriate to implement in the rural setting as is evident from the study outcomes. Significant improvements in gender norms were documented in the intervention site after the intervention while similar improvements did not occur in the control site. The GEM Scale presents a potentially sensitive evaluation instrument for measuring the attitude changes that suggest a movement in the direction of gender equality on the part of young men. The present work suggests that attitude and behaviour changes are possible to achieve through work at the individual level but working at larger environmental level at community and policy levels is required for sustaining changes (Detailed intervention results are forthcoming).

SUSTAINABILITY AND FUTURE DIRECTION

The SRIJAN network constitutes 136 partners in 93 districts spread across seven states of India, with MAMTA functioning as the network secretariat. The effectiveness of the programme thus described is a promising tool to address masculinities in an innovative way. This should address the issue of risk taking behaviour amongst young men by working with them. MAMTA will consider scaling up this initiative through the SRIJAN partners to measure efficacy of the intervention over larger and diverse geo-political areas.

gender roles that dis-empower women and give men a false sense of power are detrimental to our young women and men in their most productive years

RESEARCH TEAM:

Dr. Sunil Mehra
Dr. Subha Sankar Das
Mr. Imtiaz Khan

INTERVENTION TEAM:

Ms. Anita Nura
Mr. Vijay Kumar
Peer leaders' team at Pali, Gorakhpur

PARTNERS

Population Council
Dr. Ravi Verma
Ms. Vaishali Sharma Mahendra
Mr. Ajay Kumar Singh
Mr. Mahender
Mr. Rahul Gaware
Mr. Raju Shinde
Mr. Sandeep Kamble

The programme was jointly supported by

Sida | Population Council

CONTACT DETAILS:

MAMTA- HEALTH INSTITUTE FOR MOTHER AND CHILD

B-5, Greater Kailash Enclave-II, New Delhi 110048 (India)
Tel: + 91- 11- 29220210 / 29220220 / 29220230 Fax: + 91- 11- 29220575
E-mail: mamta@ndf.vsnl.net.in URL: www.mamta-himc.org & www.yrshr.org