Promoting Gender Equity for HIV and Violence Prevention

Results From the PEPFAR Male Norms Initiative Evaluation in Namibia

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Contents

Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
GEM Scale	Gender Equitable Men Scale
GTWG	Gender Technical Working Group (PEPFAR)
HIV	human immunodeficiency virus
MAP	Men as Partners Program (EngenderHealth)
MNI	Male Norms Initiative
NGO	nongovernmental organization
PATH	Program for Appropriate Technology in Health
PEPFAR	US President's Emergency Plan for AIDS Relief
STI	sexually transmitted infection
USAID	US Agency for International Development
WHO	World Health Organization

Executive summary

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

The US President's Emergency Plan for AIDS Relief (PEPFAR) supported interventions to address these issues through the Male Norms Initiative (MNI) in Ethiopia, Namibia, and Tanzania. In Namibia, the initiative involved implementing and evaluating group education activities with male prison guards in six prison sites. In addition, targeted technical assistance and capacity-strengthening activities were provided. This report highlights results from the evaluation of the group education activities and describes lessons learned from the implementation process.

Intervention

Group education activities with adult male personnel from the Namibian prison system aimed to facilitate examination of gender norms and their relation to HIV risk, and to encourage greater support for equitable attitudes and behaviors. LifeLine/ChildLine, a Namibia-based nongovernmental organization (NGO), led program implementation, with technical support from EngenderHealth. As an organization, LifeLine/ChildLine offers HIV-related education, emotional support, and counseling aimed at helping and sustaining behavior change.

The intervention was comprised of 18 sessions that were held for two hours, twice a week, over a nine-week period. Role-plays and guided discussions were used to facilitate examination of gender norms and their relation to HIV risk, and to encourage greater support for equitable attitudes and behaviors. Modules were adapted from EngenderHealth's Men as Partners® (MAP) program and Promundo and partners' Program H. Sessions addressed topics such as "From Violence to Respect in Intimate Relationships" and "Levels of HIV Risk."

Prior to and during implementation of the MNI, LifeLine/ChildLine staff received capacity-strengthening technical assistance from EngenderHealth on integrating gender-related issues into their programmatic activities. The assistance also included specific support for facilitating the MAP and Program H group education workshops aimed at engaging men in exploring the health and other impacts of harmful gender norms and promoting more equitable norms in relationships.

As part of the MNI, a number of other PEPFAR NGO partners received targeted, smaller-scale technical assistance, from both EngenderHealth and LifeLine/ChildLine. The goal was to broaden the number of partners with some exposure to ways to integrate male engagement activities into ongoing programmatic work.

Evaluation design and methods

The evaluation of the MNI was led by PATH and the Namibian research organization Survey Warehouse. Set in six prison sites in Namibia, this quasi-experimental study focused on activities for guards and other staff employed by the Namibian Prison Service. It evaluated the impact of

gender-focused group education activities on attitudes and behaviors related to gender, violence, and HIV/AIDS. Guards from three prisons in an intervention arm received the interactive group education activities. Guards from three prisons in a control arm did not receive intervention activities.

A total of 310 baseline pretest surveys (197 at intervention sites and 113 at control sites) were conducted in the second half of 2008. After significant efforts to track study participants, a total of 172 endline surveys (85 at intervention sites and 86 at control sites) were conducted between May and September 2009, after completion of activities. To maximize comparability, analyses were conducted with the group that completed both baseline and endline surveys.

In-depth qualitative interviews with a randomly selected subsample of 28 intervention participants were also conducted. The interviews were intended to explore attitudes and behaviors related to gender norms, and the effect of the intervention activities, in greater detail. Key interviews were also conducted with representatives of nine in-country PEPFAR NGO partners that received technical assistance, along with LifeLine/ChildLine staff, who reflected on ways their programs were affected, and offered suggestions for improving the intervention.

Study population

- The study population was composed of prison guards and other prison staff. The median age of the study participants was 40, about half were married, and a little less than half lived alone. The majority had received some secondary education.
- The profile of those lost to follow-up was relatively similar to those who responded to both baseline and endline surveys.
- Many guards and staff expressed substantial interest in the program, and participated consistently, and others did not. Based on attendance records, a total of 114 guards participated in the intervention, meaning they attended at least one session. Of those, 85 responded to both the baseline and the endline surveys.
- Despite the challenges related to engaging prison staff, of the 85 respondents from the intervention sites who participated in both the baseline and the endline surveys, each of them attended at least one of the 18 group education sessions. Fifty-nine participants from the intervention sites, or 70%, attended eight or more of the 18 sessions.

Key findings

- *Participants reported substantial HIV risk behaviors at baseline.* Eighty-four percent of respondents had a primary sexual partner in the previous six months, and 20% reported a primary plus at least one secondary partner. Less than two-thirds (60%) reported condom use at last sex with a partner. Twelve percent of respondents reported perpetrating some form of violence toward a primary partner in the previous six months.
- *Almost all who participated in the intervention (90%) stated that they perceived changes due to the group education activities.* Almost all survey respondents agreed with the statement that the intervention had led to change in their lives and behaviors. Based on the responses from an additional, open-ended survey question requesting detail about what had changed,

the most frequently reported changes were minimizing HIV risk (cited by 32%), being a better partner and father (cited by 26%), and minimizing alcohol consumption (cited by 16%).

- *However, survey results were mixed, as limited change was reported via other questions asking for specific changes*. For example, significant positive change was not detected in responses to direct questions on partner violence, condom use, number of partners, and partner communication. This may be due to the reduced sample size, which limited the ability to detect significant change, but may also suggest a disparity between perception of change and actual change. Substantial positive change was found in support for equitable gender norms, as measured by the Gender Equitable Men Scale. However, this positive change was detected in both the intervention and control groups, limiting the ability to conclude that positive change was due to the intervention.
- *Qualitative follow-up interviews with a third of intervention participants (n=28 out of 85) elucidated details about the impact of the intervention, and reinforced indications of positive change.* Among this subsample, positive change was reported in awareness of gender dynamics, support for equitable norms, and related change in HIV risk and other behaviors. These behaviors ranged from increased risk-reduction communication with partners, and a reduction in number of sexual partners, to increased assistance with household chores.

  As one participant stated:

  It taught me to raise a man and woman to an equal level when it comes to sex or anything else. You must not see a woman as being under you, and you as the man are the boss. When it comes to decision-making, you must consider the next person's issues as well.

  And another stated:

  I have learned a lot [from the program]. How to be a responsible parent and bring up kids… I have learned what to be like in a relationship at home with your wife, how to respect, how to have only one partner, how to use condoms.
- *Further, key informant interviews with program staff and staff of other NGOs that received technical assistance indicated positive change in the institutions themselves and in their activities.* According to respondents from PEPFAR partners, for example, strong gender content has been added to existing training curricula and numbers of male volunteers and trainers have increased. However, it is important to note that a number of respondents expressed concern that changes were not sustainable without regular infusions of support, reinforcement of the gender equitable messages, and a critical mass of trained men who can bring these messages back to their communities.

Conclusions and discussion

Improvements in gender dynamics, increased support for gender equitable relationships, and enhanced HIV and violence risk reduction were reported by many participants in the MNI activities. This positive change was perceived by almost all survey participants, and elucidated in detail by a subsample of intervention participants during qualitative interviews. This positive change was reported despite substantial challenges in implementing group education intervention activities with prison staff, and in following up with study participants.

The impact of the program on the prison staff overall is difficult to determine, however, due to the reduced sample size at endline, and the related mixed findings found from the endline survey. Significant loss to follow-up between the baseline and endline meant that analyses were conducted on a limited sample size, resulting in insufficient "power" to analyze certain variables. Therefore, while we can conclude that positive change was perceived and reported by the men who went through the intervention, especially the subsample who engaged in the qualitative interviews, it is not clear how broadly we can generalize these findings. Findings are suggestive of positive potential for these activities if scaled up, however, and to determine the impact on a broader audience, a larger intervention and evaluation would need to be conducted. To permit this type of larger intervention, open and systematic support by key stakeholders at all levels would need to be elicited and expressed.

Positive changes were also noted by NGO partners in the activities offered by the institutions and in the gender dynamics in the institutions themselves, as a result of the technical assistance received. A key recommendation derived from concerns expressed by key informants about maintaining and expanding upon the initial positive progress is that substantial resources for technical assistance need to be committed to broaden the scope of the work and maximize the potential for sustainability.

A critical lesson emerging from the MNI experience in Namibia is the need to more fully engage stakeholders, including decision-makers from the intervention sites (in the case of the current intervention, managers from the prison sites). Recommendations include building in more time for working with key stakeholders and decision-makers in the planning stage, including the process for selection of an appropriate site and time frame for the intervention. Securing buy-in and support is essential for ensuring smooth implementation and logistical planning.

Introduction

HIV risk and related behaviors, such as condom use and partner violence, have been shown to be influenced by gender norms, or social expectations about how men and women should behave due to their sex.[6] There is growing evidence of the importance and success of involving men and explicitly addressing gender dynamics in HIV/AIDS and violence prevention initiatives.[7,8,9] To date, interventions to address common male gender norms and related behaviors that promote risk of negative health outcomes, such as HIV and sexually transmitted infections (STIs), unwanted pregnancies, and intimate partner violence have been small in scale, and few have been evaluated for effectiveness.

The US government, through the US President's Emergency Plan for AIDS Relief (PEPFAR), supported the Male Norms Initiative (MNI) to provide capacity-strengthening to in-country partners, as well as to implement and evaluate gender-focused programs for men and their sexual partners. The MNI has been implemented in Ethiopia[10], Namibia, and Tanzania. This report describes the evaluation in Namibia.

The evaluation was led by PATH and the Namibian research organization Survey Warehouse. Partners EngenderHealth, Promundo, and Namibia-based LifeLine/ChildLine implemented intervention activities. These activities were concentrated on working with adult male prison staff to address gender norms and related behaviors that increase risk of negative health outcomes, especially those related to HIV. The partners also provided targeted capacity-strengthening and technical assistance to local nongovernmental organizations (NGOs) on ways to address gender issues and engage men in HIV/AIDS prevention, care, and support.

The intervention and evaluation strategies used in this project built upon experiences of the international partners in a number of other settings. The intervention activities were adapted from EngenderHealth's Men as Partners® program and Promundo and partners' Program H—two programs focused on reducing health risks by confronting harmful gender norms and exploring how such norms might be changed. They are increasingly recognized as promising programs, because of accumulating evidence of their success within different cultural contexts.[11] Evidence about effectiveness of similar programs remains scarce though, and implementation tends to be on a relatively small scale, reflecting the need for wider-scale implementation and continued evaluations to inform the development of work in this area. PATH has worked with these partners to help refine the intervention strategies and to develop evaluation tools to measure

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[6] Campbell CA. Male gender roles and sexuality: implications for women's AIDS risk and prevention. *Social Science Medicine*. 1995;41(2):197–210.

[7] Mehta M, Peacock D, Bernal L. Lessons learned from engaging men in clinics and communities. In: *Gender Equality and Men: Learning from Practice*. Oxford, UK: Oxfam; 2004.

[8] Verma RK, Pulerwitz J, Mahendra V, et al. Challenging and changing gender attitudes among young men in Mumbai, India. *Reproductive Health Matters.* 2006;14(28):135–143.

[9] Pulerwitz J, Barker G, Segundo M, Nascimento M. *Promoting More Gender-Equitable Norms and Behaviors Among Young Men as an HIV/AIDS Prevention Strategy: Horizons Final Report*. Washington, DC: Population Council; 2006.

[10] See Pulerwitz J, Martin S, Mehta M, Castillo T, Kidanu A, Verani F, Tewolde S. *Promoting Gender Equity for HIV and Violence Prevention: Results From the PEPFAR Male Norms Initiative Evaluation in Ethiopia.* Washington, DC: PATH; 2010. Available at: http://www.path.org/publications/detail.php?i=1834

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

support for (in)equitable gender norms. Issues addressed by the tools include decision-making and communication around condom use, number of sexual partners and sexual relations in general, and violence perpetrated against intimate partners, among others. The Gender Equitable Men (GEM) Scale[12] was developed by PATH and partners, and has been applied to and adapted for communities within a variety of cultural contexts (e.g., Brazil, Ethiopia, India, Kenya, Mexico, and South Africa).

The main objectives of the evaluation were as follows:

- Evaluate the outcomes of activities to increase awareness of gender norms that can encourage HIV risk and violence, increase support for equitable gender norms, and reduce HIV risk behaviors and partner violence.
- Test the comparative impact—among male prison staff of the Namibian Prison Service—of an intervention arm receiving interactive group education activities versus a control arm receiving no activities during the study period.
- Explore in detail how and why such changes may take place, through in-depth interviews with a subsample of male participants.
- Determine programmtic lessons learned via key informant interviews with program staff and partners receiving technical assistance.

Group education intervention

The activities aimed to promote equitable gender norms and to reduce HIV, STI, and violence risk. The intervention's group education activities focused on promoting critical reflection of common gender norms that can increase risk (e.g., encouragement for men to have multiple sexual partners and acceptance of partner violence under certain circumstances) in order for participants to identify the potential negative outcomes or costs of enacting these norms, and the potential positives that may result with more gender equitable behavior.

The group education activities were comprised of 18 modules implemented in a nine-week series of two-hour sessions, conducted twice weekly. Role-plays and guided discussions were used to facilitate examination of gender norms and their relation to HIV risk, and to encourage greater support for equitable attitudes and behaviors.

Specific activities were selected by combining EngenderHealth's and Promundo's activities and experience. In-country staff reviewed and adapted modules from the existing group education manuals to ensure they were appropriate for the Namibian context and met the needs of the prison staff participating in the activities. A number of exercises and topics that were deemed to be the most relevant for this context were selected from the manuals, including: Gender, Act Like a Man, Pleasures/Risk, From Violence to Respect in Intimate Relationships, Sexual Consent, What to Do When I Am Angry, Levels of HIV Risk, Alphabets of Prevention, Getting Tested, New Kinds of Courage, and Making Changes in Our Lives and Communities. The participatory process of the activities included role-plays, group discussions, and personal reflection.

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

Facilitator training

As noted above, the local NGO LifeLine/ChildLine was selected as the intervention partner. Their ongoing community-based work with those affected by HIV/AIDS appeared to be an excellent fit for the intervention, and provided an appropriate framework for integrating a focus on gender. The US Agency for International Development Mission in Namibia had identified a number of potential PEPFAR NGO partners, and LifeLine/ChildLine was selected as the strongest intervention organization from among the group.

LifeLine/ChildLine staff received capacity-strengthening and technical assistance from EngenderHealth on integrating gender-related issues into programmatic activities and facilitating group education workshops aimed at engaging men in transforming harmful gender norms. The training provided an opportunity for participants to reflect on their own attitudes and behaviors around key issues. EngenderHealth staff co-facilitated initial workshops with staff from LifeLine/ChildLine, and provided feedback on subsequent workshops that LifeLine/ChildLine co-facilitated with other organizations. EngenderHealth monitored some sessions directly, and provided ongoing technical assistance on an as-requested basis to identify and address any challenges staff members were facing.

Recruitment of intervention participants

All eligible male staff at the selected prisons were invited to participate in the intervention and/or evaluation activities. The study was promoted at monthly staff meetings and with posters and announcements at all the sites. Participation in the evaluation was voluntary, and supervisors were not informed of which employees participated in the evaluation. Staff who did not meet eligibility criteria or who opted not to participate in the study were allowed to participate in the group education activities. The guards were offered lunch and reimbursed for transportation costs each time they attended a session.

Additional trainings/technical assistance

Other PEPFAR partners were offered, but not mandated to participate in, a subset of technical assistance activities, even though they were not involved with the implementation and evaluation of activities in the prison system. This technical assistance was provided by EngenderHealth, Promundo, and after receiving training themselves, LifeLine/ChildLine. Provided on an as-needed and individually requested basis, technical assistance included the following possible areas: program design, strategic planning, needs assessment, development and review of curricula and informational materials, implementation, monitoring and evaluation, training in group education, community mobilization and service delivery, policy review and assessment, advocacy, and networking. The amount of technical assistance was limited in scope, due to the focus on implementing the intervention at the prison sites.

Methods and study population

Set in six prison sites in Namibia, this quasi-experimental[13] study evaluated the impact of group education activities to bring about positive changes in attitudes and behaviors among adult men employed by the Namibian Prison Service. The decision to focus on prison guards was made by implementation and research partners in consultation with USAID after considering several community-based and larger institutional organizations as options. The Namibian Prison Service was the only group large enough to ensure the sample size needed to measure impact, for which permission from relevant government ministries was also secured. Two groups of guards were followed over time. Guards from three prisons in an intervention arm received interactive group education activities facilitated by LifeLine/ChildLine, a local NGO that offers HIV-related education, emotional support, and counseling services aimed at helping and sustaining behavior change. Guards working in three other prisons, which comprised the control arm, did not receive intervention activities. The two sets of prisons are distant enough from each other to have a low risk for contamination between participants in the two arms. Prior to the start of the study, the protocol was reviewed and approved by the PATH Research Ethics Committee. In addition, the study underwent review by the research ethics committee of the University of Namibia.

Quantitative data collection and analysis

Interviewer-administered baseline surveys were conducted between August and December 2008, and endline surveys were conducted between May and September 2009. The local research partner Survey Warehouse administered a total of 310 surveys at baseline, with as many of the guards as could be reached after multiple visits over two or three months per prison, including 197 in the intervention sites (132 at Windhoek, 45 at Walvis Bay, and 20 at Swakopmund) and 113 in the control sites (37 at Oluno, 19 at Divundu, and 57 at Hardap). This translated into a response rate of 80% at intervention prisons (197/249) and 46% in control prisons (113/246).

At endline, multiple visits over several months led to a total of 172 surveys completed, including 85 at the intervention sites (38 at Windhoek, 35 at Walvis Bay, and 13 at Swakopmund) and 86 at the control sites (24 at Oluno, 12 at Divundu, and 50 at Hardap). This translated into a response rate of 43% in the intervention prisons and 76% in the control prisons. The intervention site of Windhoek, an urban prison with a great deal of transfers and turnover, reported a particularly low response rate. See Table 1 for details. There was a loss to follow-up of 45% for the full sample. Loss to follow-up was due to challenges related to scheduling logistics (e.g., a number of guards had been transferred from the prison and could not be contacted, and others were simply not available because of unpredictable shift rotations or other duties), and a perceived lack of interest from some guards and lack of support from some prison management. Challenges with logistics resulted in the need for the multiple visits noted earlier to reach guards who had not turned up for scheduled interviews.

[13] Quasi-experimental designs are typically used when it is difficult or costly to meet random assignment criteria of true experimental designs, but when researchers want to avoid threats to validity associated with non-experimental designs. Quasi-experimental designs lack random allocation of groups but can be useful in generating results for general trends, especially in social sciences, where pre-selection and randomization can be challenging. Adapted from Fisher A, Foreit J. *Designing HIV/AIDS Intervention Studies: An Operations Research Handbook.* Washington, DC: Population Council; 2002, and from http://www.experiment-resources.com/quasi-experimental-design.html#ixzz0yrdssVu1.

Table 1. Number of study participants.

	Intervention sites			Control sites		
Prison	Windhoek	Walvis Bay	Swakopmund	Oluno	Divundu	Hardap
Baseline	132	45	20	37	19	57
Endline	38	35	13	24	12	50

Prior to the start of data collection, prison management officials agreed to inform male staff about the MNI and invite their voluntary participation in the group education activities and related study. Informed consent was obtained from each guard prior to the baseline. Additional information about study objectives, study design, and need for follow-up interviews was also provided.

The surveys collected quantitative change data on key indicators to assess program impact. These included support for (in)equitable gender norms as measured by the GEM Scale and gender-related behaviors, including those associated with HIV/STI and violence risk or prevention (e.g., condom use, number of sexual partners). Questions were asked about four potential types of sexual partners: primary partner, 'other' primary partner, commercial sex partner, and 'casual' partner. A primary partner was defined as 'someone that you have had a regular romantic and/or sexual relationship with over time, and who you consider to be your main partner (e.g., wife, girlfriend).' 'Other' primary partners were defined as 'persons you regularly have romantic and/or sexual relationships with over time in addition to your main partner that we just spoke about (e.g., second girlfriend, second wife).' Information was also collected about perceptions of changes due to the intervention, and exposure to the intervention (e.g., number of activities attended). Partner communication was measured by the following three questions: (1) How frequently have you spoken to your partner about HIV?; (2) How frequently have you spoken to your partner about using a condom?; and (3) How frequently have you spoken to your partner about your sex life?

The GEM Scale uses a series of statements to understand men's views on the roles and behaviors of men and women. The scale was originally developed by PATH and Promundo for use with Brazilian men aged 14 to 25 years.[7] The original scale included 17 attitudinal statements about inequitable gender roles in the areas of domestic life and childcare, reproductive health and disease prevention, sexuality, and violence. The study team used a version of the GEM Scale that had been previously adapted and tested with men in Ethiopia by PATH and partners (Johns Hopkins University and the Academy for Educational Development).[14] To measure partner violence (both 'any violence' and 'physical violence'), the study team adapted the World Health Organization (WHO) multicountry study tool.[15] The WHO tool has been tested and validated in a variety of cultural settings. Violence was measured by a list of items describing types of violence, which were then added together to form an index for each of the two variables.

Comparing the two groups, the study team examined baseline-endline differences using single items and combinations of single items in indices to measure key indicators (see Tables 2 and 3). For the purposes of examining baseline-endline differences between the groups, statistical analysis was limited to the men from the intervention and control arms who were surveyed at

[13]Middlestadt SE, Pulerwitz J, Nanda G, Acharya K, Lombardo B. *Gender Norms as a Key Factor that Influences SRH Behaviors among Ethiopian Men, and Implications for Behavior Change Programs*. Unpublished final report.
[14] World Health Organization (WHO). *Multi-Country Study on Women's Health and Domestic Violence Against Women*. Geneva: WHO; 2002. Available at: www.who.int/gender/violence/multicountry/en/print.html.

both time points. Guards were offered the opportunity to participate in the intervention, regardless of whether or not they chose to answer the baseline or endline surveys. Respondents were asked about their views toward gender norms regarding a series of topics. Examples of items within each topic are shown below.

Table 2. Illustrative items from the GEM Scale.

Topic	Item
Violence	There are times when a woman deserves to be beaten.
	A woman should tolerate violence to keep her family together.
Sexual relationships	A man should have multiple partners, even if things with his wife are fine.
	Men need sex more than women do.
Sexual/reproductive health	It is a woman's responsibility to avoid getting pregnant.
	A man should be outraged if his partner requests condom use.
Daily life	A man should have the final word on decisions in his home.
	The husband should decide what major household items to buy.

Table 3. Illustrative index on physical violence, combining single items.

Respondents were asked specific questions about perpetration of physical, emotional, and sexual violence. For the physical violence variable, we asked: Have you ever…:
• Slapped your primary partner or thrown something at her that could hurt her? • Pushed her or shoved her or pulled her hair? • Hit her with your fist or with something else that could hurt her? • Kicked your primary partner, dragged her, or beaten her up? • Choked or burnt her on purpose? • Threatened to use or actually used a gun, knife, or other weapon against her? The responses were incorporated into an index on whether participants had engaged in any form of physical violence against a partner.

Study population

To permit comparisons between the same groups at baseline and endline, the analysis included participants from the intervention and control groups who responded to both the baseline and endline surveys (n=172). About half of the 86 respondents (52%) in the intervention group were between 30 and 45 years old. Fifty-seven percent were single, 41% were married, and 2% were divorced or separated. Slightly less than half (45%) lived alone; a much larger percentage of participants from Windhoek lived alone than participants from the other two intervention prisons, because their duty stations brought them to the capital city. The rest were roughly equally divided between living with wives/partners or with their families. A small number reported living with friends. Fifty-seven percent had completed at least some secondary education and 29% had completed some post-secondary education.

Similarly, about half (52%) of the 86 respondents in the control group were married (61%) and between 30 and 45 years old, although a greater percentage in the control site was older than 46 years. Sixty-eight percent had completed at least some secondary education and 17% some post-secondary education. Similar again to the intervention group, slightly less than half in the control group (43%) lived alone, with the rest roughly equally divided between living with their wives/partners or with their families.

Respondents in the intervention and control groups showed roughly similar sociodemographic characteristics, with a few differences. The control group was older and more likely to be married. A larger percentage of the intervention group had completed some post-secondary education. Table 4 presents sociodemographic characteristics of the baseline participants by arm.

Table 4. Percentage of baseline participants with various characteristics, by study arm.

	Intervention site (n=85)	Control site (n=86)
Age		
21–29	(21) 24%	(10) 12%
30–45	(44) 52%	(44) 52%
46+	(21) 24%	(31) 36%
Median age	38	41
Marital status		
Single	(49) 57%	(33) 38%
Married	(36) 42%	(52) 61%
Widowed/divorced	(1) 1%	(1) 1%
Religion		
Protestant	(60) 72%	(72) 85%
Catholic	(23) 27%	(12) 14%
No religion	(1) 1%	(1) 1%
Education		
None	(2) 2%	(2) 2%
Some/completed primary	(10) 12%	(11) 13%
Some/completed secondary	(49) 57%	(58) 68%
At least some post-secondary	(25) 29%	(15) 17%
Living arrangement		
Lives alone	(38) 45%	(37) 43%
With girlfriend/wife	(19) 22%	(21) 24%
With family	(23) 27%	(28) 33%
With friends	(5) 6%	(0) 0%

As indicated above, for the purposes of this analysis, the study population comprised only the 172 participants who responded to both the baseline and endline surveys. However, we also examined whether there might be differences between those who responded at endline and those lost to follow-up, to explore how well the remaining population represented the larger group. No large differences were detected with respect to sociodemographic characteristics for the full 310 original respondents to the baseline compared to the group that responded at both baseline and endline. Forty-four percent of the original group were married and 54% single, 55% had completed at least some secondary school, about one-third (35%) lived alone, one-third (30%) with a partner or spouse, and one-third (31%) with family, and half were between 30 and 45 years old. The 310 respondents also reflected similar risk behavior to the respondents in the smaller sample. Details of key risk measures can be found in the section on baseline results.

Qualitative data collection

In-depth qualitative interviews with a subsample of intervention participants were conducted at endline only. Interviews lasted approximately one hour. The data were used to explore the process of change related to support for (in)equitable gender norms and related HIV risk behaviors, including, for example, how and why such change may have come about, as well as positive and negative reactions to the intervention from the perspective of participants. Twenty-eight participants from the intervention arm were interviewed, which constituted approximately one-third of the full intervention sample at endline. Every young man who participated in the intervention was asked to complete a further in-depth qualitative interview if he had a current regular partner/girlfriend/wife at endline. The first men who agreed were selected, until the needed sample size was reached.

A group interview was also conducted with staff from LifeLine/ChildLine, and additional key informant interviews were conducted with representatives of eight other organizations that received training or technical assistance. Organizations were selected for interviews because of their emphasis on male engagement, their commitment to the principles of male engagement, or their links to other organizations that focus on male engagement activities. Key informants reflected on ways their programs may have been strengthened due to the assistance, and highlighted a number of challenges and offered suggestions for improving the intervention.

Results

Key baseline survey results

Participants reported substantial HIV risk at baseline. Eighty-four percent of respondents had a primary sexual partner in the previous six months. Eleven percent had additional primary partners (e.g., considered a second wife). Another 13% reported a casual partner over the previous six months. Very few participants reported a commercial sex partner or a casual partner over the same period. Overall, 20% reported having multiple sexual partners, meaning a primary and at least one secondary partner, which could include an ‘other primary’ partner, commercial sex worker, or casual sexual partner in the same period.

A little more than half (60%) of respondents reported condom use during their most recent sexual encounter with any partner. Forty-six percent reported condom use specifically during their most recent sexual encounter with their primary partner. Twenty-eight percent responded that they often used a condom, 23% sometimes used a condom, 3% rarely used a condom, and 19% never used a condom with their primary partner. Eighty-nine percent of those responding to the question about whether they used a condom the last time they had sex with a secondary partner (16 respondents out of 18 responding to this question) reported that they had used a condom.

Participants reported moderate levels of violence against primary partners at baseline. At baseline, overall, 12% of respondents reported some form of violence toward a primary partner in the previous six months. Responses indicated that 6% had been physically violent, 7% had been psychologically violent, and 1% had been sexually violent toward a primary partner in the previous six months.

Participants reported high levels of communication with primary partners at baseline. More than three-fourths (77%) of respondents reported that they often or sometimes

communicated with their partner about HIV/AIDS. Sixty-seven percent of respondents reported that they often or sometimes communicated with their partner about condom use, and 62% of respondents reported that they often or sometimes communicated with their partner about their sex lives.

Samples of those who were lost to follow-up and those who remained in the study were similar. As noted earlier, the original 310 respondents to the baseline survey reflected similar measures of risk behavior as the respondents in the sample that completed both the baseline and endline surveys. For example, 11% of baseline respondents reported that they had used 'any form' of violence toward a primary partner in the previous six months and 6% that they had used physical violence toward a primary partner in the previous six months. The great majority (85%) reported having a primary partner, and 13% reported having additional primary partners. More than half (52%) of the 310 original respondents to the baseline reported condom use during their most recent sexual encounter with a primary partner. Thirty-three percent reported that they often used a condom when having sex with a primary partner, 31% sometimes used a condom, 8% rarely used a condom, and 29% never used a condom when having sex with a primary partner.

Post-intervention survey results

All 85 participants from the intervention group who responded to both baseline and endline surveys attended at least one group education session of the 18 offered. Of those, four participants (5%) attended four or fewer sessions, 10 participants (12%) attended between five and seven sessions, and 59 participants (70%) attended eight or more sessions. Twelve participants (14%) did not know or could not remember how many sessions they attended. The most frequently cited reason for missing a session was "due to work." Further analysis did not reveal any statistically significant differences in outcome measures between those with low versus high attendance. However, this could be due to the small sample size.

Almost all who participated in the intervention (90%) stated that they perceived changes due to the group education activities. Based on the responses from an open-ended question requesting detail about what had changed, the most frequently reported changes (based on summarizing and coding the responses) were: minimizing HIV risk (such as reducing the number of concurrent sexual partners), which was stated by 32%; being a better partner and father, which was stated by 26%; and reducing alcohol consumption, which was stated by 16%. Based on responses from another open-ended question, and their subsequent codes, the most important lessons learned by participants during the intervention were: to respect women and their rights, which was stated by 19%; how to reduce risky sexual behavior, which was stated by 17%; family values, which was stated by 17%; and to more clearly understand the importance/role of gender norms and ideas about masculinity, which was stated by 10%.

However, the study team did not detect similar positive change when asking about specific key outcomes, or positive change was seen but was not significant. Some positive change, for example, was seen with a small reduction in the number of respondents in the intervention group who had more than one partner (baseline of 21% and endline of 19%), a change which was not seen in the control group (baseline of 15% and endline of 17%). However, analyses comparing those with more than one partner and those with one or fewer partners showed no significant difference between baseline and endline responses.

Regarding condom use, at baseline, 57% of respondents in the intervention group reported condom use during their most recent sexual encounter. A small, positive increase was seen at endline, when 63% of respondents in the intervention group reported condom use. Similar change was not seen in the control group, in which the percentage of respondents reporting condom use during their most recent sexual encounter actually decreased from baseline to endline, but analyses did not reveal any statistical differences between the groups.

The small sample size affected the study team's ability to measure change with respect to violence over the previous six months. A small proportion reported partner violence over the previous six months at both baseline and endline, and while the percentage of reported violence decreased somewhat in the intervention group and not in the control group, the proportions were too small to detect a significant change.

As noted earlier, respondents reported moderate to high levels of communication with their partners at baseline around condom use, HIV/AIDS, and their sex lives in general. Positive change was seen in the reduction in percentage of respondents in the intervention group who never spoke with their partner about condom use (baseline of 17% and endline of 8%), a change which was not seen in the control group. As with other key outcome measures, however, the small sample size made it difficult to detect a statistically significant change.

Support for inequitable gender norms changed a great deal. Positive change toward more equitable norms was seen in the intervention group for a number of GEM Scale items. Substantial positive change, defined as 10% or greater movement toward more equitable norms, was seen in eight of 24 items. A slightly smaller amount of change was seen in four additional items, for a total of 12 items that "moved" in the intervention group.

Examples of GEM Scale change seen in the intervention group include: 42% of respondents disagreed at baseline with the statement that 'A woman should obey her husband in all things.' At endline, 63% disagreed with the statement, reflecting a 20% decrease in support for an inequitable norm. Seventy-seven percent disagreed at baseline with the statement that 'A man should be outraged if his wife asked him to use a condom.' At endline, 95% disagreed with this statement, reflecting an 18% decrease in support for an inequitable norm.

However, positive change was also seen in the control group for a number of items, with some overlap. In this case, substantial positive change was seen in nine items, and a smaller amount of change in five additional items, for a total of 14 items that "moved" in this group. There was overlap among the two groups in ten items. An example of GEM Scale change seen in the control group: 82% disagreed at baseline with the statement that 'A man should be outraged if his wife asked him to use a condom.' At endline, 92% disagreed with this statement, reflecting a 10% difference in support for a more equitable norm. Therefore, the positive change could not be attributed to the intervention with confidence.

Qualitative interview results with intervention participants (prison guards)

As described above, the study team conducted in-depth qualitative interviews with a subsample of intervention participants (n=28) to explore attitudes and behaviors related to gender norms in greater detail. This subsample constituted about one-third of the intervention participants at endline. Overall, respondents felt that they had learned a great deal from the intervention, and

they perceived changes in attitudes as well as behaviors. Prior to their participation, many of the men were unfamiliar with the topic of gender norms. Group education sessions galvanized awareness of the dynamics of gender norms and masculinities; shifts in thinking around gender inequities, including around violence and a woman's right to refuse sex; and knowledge of condom use. A large number of respondents highlighted their desire to be better husbands, partners, or fathers, and noted the benefits of, for example, taking on responsibility for household chores and childcare, and refraining from excessive drinking and "bad behavior." Respondents reported that the shifts in views translated into an increase in their HIV-protective behaviors as well, such as increased risk-reduction communication with partners, and increased use of HIV testing.

Most men reported positive experiences with the program and recommended that it be expanded to include others. For example, many respondents felt that women would also enjoy the program. Several respondents suggested that the program should be offered in local languages and be expanded within the community.

A number of specific themes emerged from the various interviews, which are highlighted below.

Observations about participants' relationships reinforced reflection on change. The majority of respondents were married (legally or traditionally) or in long-term relationships, and some acknowledged having multiple concurrent sexual partners. Most relationships began casually, growing into long-term relationships over time, and were not the result of forced or arranged marriages. Partners were usually introduced through mutual friends, although some respondents had met their partners at sports events or in *shebeens* (informal bars). Respondents often mentioned that the best part of their relationships was the fact that they did not quarrel with their partners. Many stated that alcohol was the main cause of problems in their relationships, noting in particular that it increased the likelihood of casual sex.

Many highlighted differences between their relationships and their parents' relationships, which they typically described as more traditional. Some respondents mentioned that they did not have good relationships with their fathers and that they were trying to be better fathers to their children.

When asked about the difference between his and his father's relationships, one participant said:

In my parents way of life some men took up to three wives, while I have only one, because of diseases and other things. And in those days, the ladies, like my grandmother, would sit in the back of the car while the man drives up front. Now the women can also sit in the front.

Men perceived shifts in awareness of gender dynamics and views toward inequitable gender norms. Respondents felt that the intervention had affected them a great deal, highlighting in particular greater awareness of the dynamics of gender norms in their lives. Many noted a shift in thinking around masculinities and inequities in relationships, and respect for female partners as equals, especially around negotiation and decision-making.

When asked about changes in his attitudes, one participant commented:

Before I attended the program, I never know about…gender… Things like if you are a man, you must be strong. If you are a man, you must fight. But in real life a lot of people especially men, they have that attitude. I just realized that I have to move these things out of my nature.

Another participant reflected the following:

It taught me to raise a man and woman to an equal level when it comes to sex or anything else. You must not see a woman as being under you, and you as the man are the boss. When it comes to decision-making you must consider the next person's issues as well. For me it was very interesting… I enjoyed being able to speak openly.

When asked what he liked the most about the group education sessions, another participant said:

The point where they talked about gender, and how we must see females having the same rights as males. Just because you are a man doesn't mean you can do what you want and the lady must follow. I think that point on gender and how we share things was important.

Men expressed greater comfort with and responsibility for household chores and childcare. Men appeared to be more supportive of assisting with household chores and childcare. Chores were typically shared between partners, especially when both were employed outside of the home. Some men cared for relatives' children or for their partners' children from previous relationships. Most reported that they also felt greater comfort with and responsibility for household chores and raising children, tasks traditionally considered unacceptable for men.

When asked about how his domestic life had changed, one respondent said:

Since LifeLine/ChildLine came, I started changing my relationship. I inherited my father's life—when I came home the wife must only cook, wash clothes, and look after the baby. But once I took the course it taught me that we have to help each other at home. I can look after my baby and look after the house. But doing it won't make me less of a man and doesn't mean that she is using me. It's a matter of helping each other.

Open communication with partners about HIV risk and prevention, and their relationship in general, seemed relatively common throughout, and also seemed to improve via the intervention. Participants noted the importance of discussing issues around sexual intercourse, HIV testing, and reproductive health in general with their female partners. Respondents also highlighted a high level of comfort discussing prevention with their wives and partners. Many claimed that they engaged in conversations about condom use with their partners, recognizing their effectiveness in preventing HIV/AIDS and other STIs, as well as unwanted pregnancies. Family planning seemed to be influenced by financial concerns. Several respondents highlighted their desire to strengthen family planning, but noted that discussion and action were usually motivated by unplanned pregnancies.

As one participant stated:

Nowadays if we have many children it is very costly. I suggested to my partner that we should better use family planning. Secondly we could also use condoms.

Many respondents indicated that they had told their partners about their participation in the program, and made a point of sharing details of each of the sessions with partners (as well as

friends). Communication and understanding between partners also seemed to improve though exposure to the intervention. The program appears to have led to women having more say on matters regarding sex, for example.

One participant noted the following changes in his relationship since attending the sessions:

I learned that you have to discuss things. Before, if I said I want sex, I had to get sex. But the classes taught me that it's something that you have to talk about with your woman. If she doesn't feel like having sex, you have to understand. I've learned we need to talk to each other if there is a problem, not to just start beating her.

Men's knowledge of HIV/AIDS was already high, but the program may have had a positive influence on condom knowledge and HIV testing. HIV/AIDS knowledge appeared to already be high throughout the intervention period. Most were able to identify the main causes of HIV infection and understood that having multiple, concurrent sexual partners greatly increased a person's HIV risk. At the same time, many respondents mentioned learning about condoms during the sessions.

Several respondents also reported discussing HIV testing with their partners, and some noted that they get tested with their partners regularly. However, the program may have had a positive influence on men who had previously been reluctant to get tested.

One respondent commented:

I am the one who raised the topic and told her: "As we are here now, we need to know our statuses." We went and we are fine. Though if my partner is not here, she reminds us not to forget our commitment. So we go to hospital to check if we are fine.

In general, men expressed opposition to physical and sexual violence against women and support for a woman's right to refuse sex. Most respondents felt that female partners have the right to say no to sex. However, some noted that a partner refusing sex should at least provide a reason, to "avoid trouble." A large number said that they had never beaten their partners and do not condone such violence. Many attributed violence in relationships to alcohol abuse and suggested that partners avoid excessive drinking.

When asked if there are times when women deserve to be beaten, one participant commented:

I think there are never moments when it is needed to beat your wife. If there is a disagreement or something going on which you don't like, just talk about it. I think that is the only solution. You don't have the right to beat someone, and it is even against the law.

Men perceived changes in HIV-related and other behaviors due to participation in the intervention. When asked if his life had changed because of his participation in the group education sessions, a participant said:

To me it's clear that it changed my way life and…[my life] improved a lot in general. I used to be like the old people treating my lady like a slave. But now I'm out of that and starting to help my lady when she does things. And I don't do it thinking I am a slave and that certain things are just meant to be done by ladies. We do it together and it boosts our relationship. She now says, even when I am here and she's in Windhoek: "Oh, if my boyfriend was here he could assist me."

While one participant was asked to talk about what he learned from the group education sessions, he commented:

I have learned a lot [from the program]. How to be a responsible parent and bring up kids… I have learned what to be like in a relationship at home with your wife, how to respect, how to have only one partner, how to use condoms…

Another participant described what he learned during the group education sessions as follows:

I learnt quite a lot of things that even changed my life totally. I learnt that it is not good to have multiple partners…it is not good to always take risks or knock off your duties. When you are just at the bars drinking you will end up abusing alcohol and picking up people that you don't know. It taught me how to be patient with many things—like not to hurry sex but to plan for it. You must give the lady a chance to decide whether she feels like doing it or not.

When asked about how the sessions had influenced his life, one participant commented:

I was someone who drank alcohol. So after this program we have learnt a lot about the consequences of drinking and the bad behavior that can come with it. So I reduced drinking. I also learnt that if it happens that you have maybe friends who are not true friends, you should stay away from these kinds of friends because they can influence your behaviors.

He went on to talk about the discussions he had had with his girlfriend about the session:

…I have told her that I had gone through LifeLine/ChildLine training. And my feeling is that I am growing up and I have also changed inside myself and my feelings are telling me to go into the right direction of life. So I have told her that what helped me a lot was the training.

Lessons learned during implementation

The Male Norms Initiative included capacity-strengthening and technical assistance activities—provided to LifeLine/ChildLine, the main implementing partner, and other national and international NGO PEPFAR partners—on integrating male engagement activities into ongoing programmatic work. Several lessons emerged from the implementation of the intervention and the broader technical assistance and capacity-building activities, from the perspective of PEPFAR partners that received technical assistance.

Positive changes in both activities offered and the institutions themselves were perceived as a result of the technical assistance received. According to respondents from the PEPFAR partners, there seemed to be greater gender sensitivity, and less miscommunication and misunderstanding among staff and the male-dominated management as a result of their involvement in the MNI. Strong gender content has been added to existing training curricula, and numbers of male volunteers and trainers have increased. In the key informant interviews, representatives of NGO partners reflected that:

Although it is a program that is intended for community use, within the organization also, there was a certain sense of gender sensitivity.

Traditionally [we] would say, we're going to be training some new volunteers and…23 women and two men would show up, and at the next session both men had left. That's changing, and there are now more men involved, going out in the community, doing community mobilization,

talking about prevention [and] services.

I think it was more my viewpoint of how I looked at men. I felt that it's very difficult to work with men and have them change their norms…but what I experienced was that these guys would go back and [have] discussions at the shebeens. It showed that if you create a platform where men can sit and discuss these issues, changes will eventually start happening.

Representatives from LifeLine/ChildLine further highlighted that:

I can say that this program works and it made me believe in this curriculum…I think another success is if you look at LifeLine/ChildLine as an NGO…where gender is something that is integrated into absolutely everywhere and everything…it is not a separate conversation, it is a part of conversation.

Through our work with prisons and other NGOs, we have become the 'go to' people when you talk about gender and male engagement. I can say without a doubt our facilitators know what they are talking about, our director knows what she is talking about, and people we have trained and have really engaged in this process know what they are talking about.

Working in the prison system included special challenges. LifeLine/ChildLine staff noted in key informant interviews that the implementation of the intervention would have been strengthened through securing the full support and buy-in of key stakeholders at all levels from the inception of the program. Top officials in the prison system had provided approval for the intervention, and support for working in the prisons; however, it was sometimes challenging to engage the prison community on the level of the individual prisons, due to competing priorities related to the daily work of the prisons. This support would have facilitated LifeLine/ChildLine's ability to reach out to participants, conduct the activities, and guide the discussions in the consistent manner envisioned—with each session building on the previous one. Windhoek, as a large urban site, where many staff transfer from one place to another, was perceived as particularly difficult by LifeLine/ChildLine staff.

Reaching men in appropriate settings and with appropriate messages and role models was key, but it was still often a "battle" to engage men and influence gender norms. Some respondents felt that men feel uncomfortable attending and talking in front of women at outreach events and meetings. They suggested that organizations should engage men where they naturally congregate, for example, in *shebeens*. At the same time, many noted the need to engage more women in the intervention, noting how challenging it is to continue engaging men in these processes, and how critical it is to foster supportive, equitable relational dynamics and communication with partners. Others highlighted the potential role of influential people in attracting men to the program:

It's a battle to bring men onboard. We try and look for influential people like media practitioners, to say men should come onboard…

Respondents highlighted deeply ingrained masculine norms and practices as a challenge when working with men. Some feared that addressing male norms could lead to the impression that organizations were trying to impose 'western' culture on 'traditional' beliefs. One respondent noted:

People will challenge you by saying, "well, it's my culture, and it's my religion," and it is really challenging to try to explain to people that those things need to be challenged. I always

emphasize to them that we don't want to change their culture or their religion, but to adapt it. That is really the most challenging issue, the culture and the religion.

Resources and time need to be committed for consistent, continued technical assistance and follow-up to the intervention. Within the context of the challenge noted above, respondents highlighted the need for consistent, constant follow-up and support, and for building a "critical mass of trained men who can take these messages back to their communities." The timing of funding and lack of resources for implementing activities after receiving assistance was a challenge. One person reflected that:

Trainings are good. They're very, very important—they're like the start of a journey for a human being. But if they aren't followed up, then it flows away into the air after 4 to 6 months. Certain things will stay in, but it's really hard to remember new things if you don't have some follow through.

LifeLine/ChildLine representatives reflected on the potential engagement of other local NGOs in the following way:

I think the main challenge is relying on organizations taking it on and implementing it. Our success is dependent on what a partner commits to implementing, while telling us they don't have funding for it and having a whole lot of things like their own capacities and so forth.

They see this as a problem, as an extra work load on a group of people who are low on capacity, struggling to make the best with the funding they have. Now here we come with this whole gender thing... NGOs view it as a separate process they need to implement, instead of a program that they need to dovetail into what they are already doing.

Overall, partners involved in the MNI in Namibia felt positively about the program, noting in particular the *potential* for galvanizing change in deeply held gender norms and masculinities. Many noted the seeds of transformation reflected in greater gender sensitivity among staff and management—but highlighted that to be sustainable, such transformation needs to be nurtured over time, with the commitment of sufficient resources, training, support, and follow-up.

Conclusions, lessons learned, and recommendations

Findings from the evaluation of the Male Norms Initiative activities in Namibia indicate that there was a strong perception by group education participants of positive influence and change related to awareness of gender dynamics, a reduction in support for inequitable norms (including around violence and HIV risk), and a related change in behaviors. These findings emerged in the surveys and interviews with Namibian prison system staff participating in the intervention. In the endline survey, almost all who participated in the intervention (90%) stated that they perceived changes due to the group education activities, and the most frequently reported change was a reduction in HIV risk (about a third reported this). In the qualitative interviews, men described in detail various examples of how the intervention had influenced their lives and relationships. These changes ranged from more harmonious daily interactions and more equitable distribution of labor in the family, to specific outcomes related to HIV prevention, such as a reduction in forced sex and increased comfort with condom use and HIV testing. Both of these findings indicate that important goals of the intervention—to promote gender equitable norms and to reduce HIV, STI, and violence risk—were achieved, and support the strategy of approaching HIV risk reduction through a focus on gender relations and norms.

The quantitative findings from the surveys were mixed, however. Positive change was not detected in the responses to direct questions related to key outcomes, including partner violence, condom use, number of partners, and communication. This is partly due to the limited sample size, but may also suggest that significant change did not take place, despite a perception of change by the participants. Literature on 'perceived' behavior change, while limited, indicates that the perception of change is an important correlate of other reported behavior change. While perceptions of change do not always mean that behavior change has taken place (or can be objectively measured), perceptions—and related constructs, such as the 'intention' to engage in a behavior—are important components of the behavior change continuum.[16]

Further, while substantial positive change was seen in responses to the GEM Scale, positive change was also detected among the control group, inhibiting the ability to conclude that positive change was due to the intervention. The GEM Scale was not developed for the Namibian population, and a specific adaptation for this population did not take place, so that would be useful for future work focused on gender dynamics. And, as the qualitative interviews were conducted with a subsample of the intervention participants (about a third), their strongly positive responses may not reflect the full sample.

Another limitation of the study was the loss to follow-up between the baseline and endline, despite repeated attempts to find potential interviewees at endline. Loss to follow-up between the baseline and endline resulted in a small final sample size and insufficient "power" to analyze many variables meaningfully. For example, the researchers were unable to analyze whether statistically significant differences in outcomes of interest between participants with low attendance versus those with high attendance could be seen.

Therefore, while we can conclude that positive change was perceived and reported by the men who went through the intervention, especially the subsample who engaged in the qualitative interviews, it is not clear how broadly we can generalize these findings. On the positive side, the profile of those who participated in the baseline survey but not the endline survey was similar to those who participated in both, and the subsample may therefore relatively accurately reflect the full group. It is important to note that these results may well reflect the full prison staff as well, but this was not a population-based sample, and results cannot be generalized to the larger male Namibia population.

A related difficulty was experienced by the intervention partners, who had trouble successfully implementing regular group education activities with a group of men who returned in a consistent manner to participate. LifeLine/ChildLine indicated they had difficulty engaging the interest and participation of the target population, guards in the Namibian prison system, in the

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[16] See for example:
Barker G, Ricardo C, Nascimento M, Olukoya A, Santos C. Questioning gender norms with men to improve health outcomes: evidence of impact. Global Public Health. 2010;5(5):539–553.
Rimal R, Böse K, Brown J, Mkandawire G, Folda L. Extending the purview of the risk perception attitude framework: findings from HIV/AIDS prevention research in Malawi. *Health Communication*. 2009;24(3):210.
McCoy SI, Kangwende RA, Padian NS. Behavior change interventions to prevent HIV infection among women living in low and middle income countries: a systematic review. *AIDS and Behavior*. 2010;14(3):469–482.
Shepherd J, Kavanagh J, Picot J, et al. The effectiveness and cost-effectiveness of behavioural interventions for the prevention of sexually transmitted infections in young people aged 13–19: a systematic review and economic evaluation. *Health Technology Assessment*. 2010;14(7):1–206, iii-iv.

full intervention. The interviews conducted as part of the MNI in Namibia, with participants as well as representatives of NGOs, offered a very rich, detailed glimpse into people's perceptions of the intervention, positive and negative, that would have been difficult to get from the quantitative surveys alone.

In summary, findings are suggestive of positive potential for these activities if scaled up, and to determine the impact on a broader audience, a larger intervention and evaluation would need to be conducted. To permit this type of larger intervention, open and systematic support by key stakeholders at all levels would need to be elicited and expressed. As noted earlier, LifeLine/ChildLine emphasized that significant buy-in and logistical support on the part of prison system staff and other key stakeholders would have greatly strengthened implementation of the intervention and their ability to reach out to participants in the consistent manner intended.

Interviews with local intervention partners supported the fact that positive change was seen in the institutions themselves with regard to more gender-sensitive activities and staff. Partners also felt that the activities they implemented among their communities were more gender sensitive and more effective. However, they were concerned that changes are not sustainable without regular infusions of support and reinforcement of the gender equitable messages. When strategizing about implementing similar interventions, donors, potential implementation partners and all key stakeholders need to reflect on sustaining momentum beyond a one-time program, via additional workshops, follow-up and scaled-up activities, and ongoing, visible, public endorsement at high levels of the gender equity messages being promoted.

Related to this issue, many respondents emphasized the need to intentionally engage women in the intervention. While it is critical to provide safe, single-sex spaces for men to feel comfortable discussing sensitive topics, sharing fears and seeking advice, true movement towards gender equity can ultimately only happen when women and men are able to hear from and understand each other. In India and Brazil, interventions targeting men based on the Program H model have been adapted for women and girls and evaluations of different combinations of activities for women, men and both together are ongoing. Emerging evidence suggests that integrating both women and men as active partners in interventions addressing gender equity is likely to be a useful strategy for improving communication, collaboration and mutual respect.[17]

In conclusion, improvements in gender dynamics and HIV risk were reported by many participants, and these positive changes were notable, and suggestive of the potential of these activities. The impact of the program on the group overall is difficult to determine, however, due to mixed results found in the surveys and qualitative interviews, and the limited scope of the intervention itself. Findings suggest that additional resources would be needed to reinforce positive change both for the group education participants and the institutions receiving technical assistance to implement gender-sensitive programming.

Certain recommendations emerged based on the findings of, and experiences with, the Male Norms Initiative in Namibia. They include:

- Engage and secure support and buy-in from key stakeholders at all levels in all aspects of program implementation, including the selection of the intervention population group.

[17] Pulerwitz J, Michaelis A, Verma R, Weiss E. Addressing Gender Dynamics and Engaging Men in HIV Programs: Lessons Learned from Horizons Research. *Public Health Reports*. March-April 2010:125:282-292.

- Identify a target group that is engaged, excited, and committed to participating in this process.
- Consider intentionally engaging women during the intervention activities as a way of fostering improved communication, understanding and true equity.
- Work closely with the implementing partner in planning the intervention activities, taking into consideration local context and potential challenges that may come up. Ensure a realistic time frame for planning and meaningful implementation.
- Consider the timing of funding, realistic expectations around the amount of time allocated for implementation, and potential ramifications for implementation partners vis-à-vis work plans and ongoing activities.
- Commit adequate resources and time for consistent, continued technical assistance and follow-up to the intervention.
- Identify a partner or partners on the ground that have experience with similar community-based group mobilization efforts and existing relationships with other organizations and individuals in the community that can be harnessed and leveraged for the intervention.