

The 'One Man Can' Model: Community Mobilisation as an Approach to Promote Gender Equality and Reduce HIV Vulnerability in South Africa

EMERGE Case Study 6

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Engendering Men
Evidence on Routes to Gender Equality

Cover photograph: One Man Can Community Mobilisers role playing in a training session in Bushbuckridge, Mpumalanga, South Africa.

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Abbreviations

AIDS	Acquired immuno-deficiency syndrome
CAT(s)	Community action teams
GBV	Gender-based violence
HIV	Human immuno-deficiency virus
NGO	Non government organisation
OMC	One Man Can

Abstract

One of the main contextual factors driving the HIV epidemic in Sub-Saharan Africa is shared social norms reinforcing restrictive masculine and feminine roles and inequitable gender relationships, which limit women's ability to protect themselves from HIV while simultaneously putting social pressure on men to take on a range of sexual and health risks. A growing body of scholarship and programme development focuses on the impacts of engaging men and boys in reducing women's and girls' HIV vulnerability as well as improving men's health and well being. To further understand the benefits of engaging men and boys for gender equality and HIV prevention, this study explores the impacts of the South African non government organisation, Sonke Gender Justice's 'One Man Can' (OMC) community mobilisation approach in a multi level HIV prevention intervention to address the community level factors that contribute to women and girls' increased HIV vulnerability and men's HIV risk taking behaviour.

This case study examines qualitative data collected as part of a gender equality and HIV prevention intervention implemented in rural South Africa that engaged men 18 to 35 years old to increase their support for girls' and women's rights and to decrease men's unsafe sexual practices, especially those that increase girls' and young women's vulnerability to HIV infection. Our findings indicate significant attitudinal and some behavioural changes around gender and HIV risk amongst OMC community mobilisers, community action team (CAT) members, and community members exposed to the intervention. At the interpersonal level, adoption of gender equitable beliefs and values had positive effects of improved interpersonal communication and a more balanced division of labour in the home. At the community level, participation in collective activities and increased social awareness of men's and women's unique HIV vulnerabilities produced changes in community members' lives and relationships and created new pathways for collective action for social change. Key lessons learned and potential policy implications are offered.

1 Introduction

Over the past two decades, gender inequality has been identified as a key determinant for women's and girls' HIV vulnerability. In Sub-Saharan Africa, the evidence shows that women's HIV transmission risk is heightened because of a host of contextual factors, which include inadequate access to sexual and reproductive health information and services, women's and girls' low personal agency, lack of access to quality education, gender inequalities, and experiencing various forms of gender-based violence (UNAIDS 2015). These contextual factors build upon shared community norms reinforcing restrictive gender roles and inequitable gender relationships, which limit women's ability to protect themselves from HIV while simultaneously putting social pressure on men to take a range of sexual and health risks.

One of the key responses to the HIV/AIDS epidemic globally is targeted social and behavioural policies and programming aimed at addressing both contextual drivers and individual behaviours that put people at increased risk. Addressing gender inequalities is central to this approach, with a primary focus on interventions to empower young women and adolescent girls who account for 74 per cent of new infections among youth and young adults 15 to 24 years old in Africa (UNAIDS 2013). A more recent area of HIV prevention programming and research focuses on the impacts of engaging men and boys in reducing women's and girls' HIV vulnerability. Much of this work has sought to address men's sexual risk behaviour and harmful expressions of masculinity such as multiple concurrent sexual relationships, a lack of consistent condom use, and engaging in sexually coercive practices. Other programmes have worked with men to change their health seeking behaviour in general and specifically increasing men's use of HIV services including testing, treatment and care (Abramsky *et al.* 2014; Colvin *et al.* 2009; Hossain *et al.* 2014; IDS *et al.* 2015; Jewkes *et al.* 2010; Pulerwitz *et al.* 2004; Welsh 2001). Evaluations of these programmes and this research suggest that individual and interpersonal behaviour change approaches can be effective. Yet, few interventions have shown a sustained impact in shifting community level norms and broader structures (political economic and cultural systems) that interact with and influence gendered beliefs and practices (Connell 1987) and are important determinants of gendered HIV vulnerability (Baral *et al.* 2013; Latkin and Knowlton 2005).

Over the past few years, there has been an uptake of HIV prevention strategies that seek to address structural factors, with a sustained focus on gender inequality as a key determinant of HIV risk. Several studies and interventions have shown that community mobilisation is an intervention that has the potential to change inequitable gender norms, reduce women's and girls' intimate partner violence risk, and improve HIV outcomes (Abramsky *et al.* 2014; IDS *et al.* 2015; Wagman *et al.* 2015). To further understand the benefits of engaging men and boys to transform harmful gender norms and improve women's and men's HIV outcomes, this study explores the impacts of a multi level HIV prevention intervention to address the community level factors that contribute to women's and girls' increased HIV vulnerability and men's HIV risk taking behaviour. This case study examines qualitative data collected as part of a community mobilisation intervention implemented in rural South Africa that engaged men aged 18–35 to increase their support for girls' and women's rights and decrease men's unsafe sexual practices, especially those that increase girls' and young women's vulnerability to HIV infection. Section two of this report provides an overview of the HIV/AIDS epidemic in South Africa, summarises the community mobilisation intervention approach and implementation, and outlines the methodological framework for this case study report. Section three presents the key determinants of women's and men's HIV vulnerability on which the intervention intervened, highlights multiple levels of changes, while also exploring how these changes came about, the role of the project, external factors, resistance, and challenges faced, and ends by drawing some lessons from the work. Section four offers concluding thoughts on the policy implications of these findings for programming on mobilising men and boys towards promoting gender equality and addressing HIV risk.

2 Background

2.1 The HIV epidemic and response in South Africa

South Africa has among the highest HIV prevalence rates in the world (estimated at 18.9 per cent in 2014) and the largest population of people living with HIV (6.8 million persons) globally. A recent South African population survey supports numerous studies that show higher estimated new HIV infections among women than men, and that the HIV incidence rate among young women aged 15 to 24 was over four times higher than the incidence rate among their male counterparts (2.5 per cent vs. 0.6 per cent). Young women also account for a quarter of all new HIV infections in the population (Shisana *et al.* 2014).

A sizeable body of evidence has documented myriad determinants driving South Africa's HIV epidemic and specifically the risk factors and conditions that put adolescent girls and young women at increased risk. Dominant gender ideals – especially those that equate manhood with dominance over women, sexual conquest, multiple sexual partners, alcohol use, and risk taking – and those that limit women's agency in negotiating safer sexual practices with their male partners, are a primary predictor of women's and girls' HIV risk in South Africa (Dageid *et al.* 2012; Greene *et al.* 2004; Greig *et al.* 2008; Hawkes and Buse 2013; Pettifor *et al.* 2012; UNAIDS 2012). The social reproduction of inequitable gender norms is a mechanism through which the patriarchal order of male dominance is maintained. This acute driver of South Africa's HIV epidemic and of women's and girls' vulnerability has spurred a groundswell of government initiatives, civil society led programmes, and research interventions to empower young women and girls educationally, economically, and in their ability to negotiate safer sexual practices in their intimate relationships. Gender transformative interventions – those that seek to shift narrow gender roles and foster more egalitarian interpersonal relationships (Gupta 2001) – offer a parallel HIV prevention approach to women's empowerment programmes and primarily work with men and boys to alter their inequitable gender attitudes and behaviours (Berton *et al.* 2011; Flood *et al.* 2010; Jewkes *et al.* 2010; Pulerwitz *et al.* 2004; Ricardo and Barker 2008; Scharer 2013; Welsh 2001; WHO 2007).

2.2 A community mobilisation approach to promote gender equality and reduce women and men's HIV vulnerability: intervention design and study implementation

This case study examines a community based intervention designed to assess whether community mobilisation activities targeting young men aged 18 to 35 years could change gender norms and improve HIV outcomes in Bushbuckridge (BBR), a rural area of Mpumalanga, South Africa. Young adult men were specifically targeted because they are the primary sexual partners for most young women and adolescent girls. This is also the age group with a high incidence of HIV infection in South Africa and among whom change of gender norms and HIV behaviours may be most feasible and effective (MacPhail *et al.* 2007; PEPFAR 2014; Pettifor *et al.* 2005; Stern *et al.* 2015).

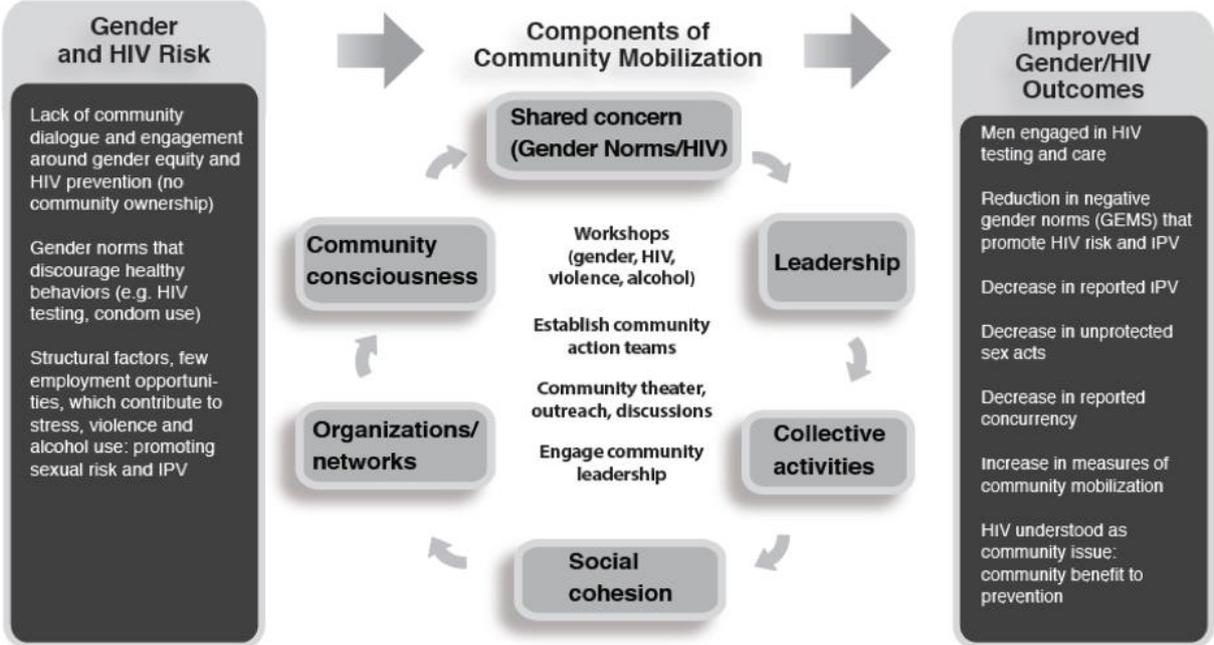
The study was designed, conceptualised, and implemented as a part of an academic and non governmental organisation (NGO) research partnership among the University of North Carolina Chapel Hill, the University of California San Francisco, Wits University Rural Public Health and Health Transitions Research Unit, Wits Reproductive Health and HIV Institute, and Sonke Gender Justice (Lippman *et al.* 2013; Pettifor *et al.* 2015). The intervention sought to engage young men through a variety of community mobilisation approaches to increase their support for girls' and women's rights and decrease men's unsafe sexual practices, especially those that increase girls' and young women's vulnerability to HIV infection. A parallel study was conducted, in the same area, to provide conditional cash transfers to girls and their families to keep girls in school and to see if there was an additional protective effect for girls receiving cash transfers in villages receiving the community mobilisation intervention.

Our research partners at the University of North Carolina Chapel Hill took the lead in analysing data from the conditional cash transfer study and will publish these findings separately.

The community mobilisation intervention was adapted from Sonke Gender Justice’s ‘One Man Can’ (OMC) model. Sonke Gender Justice (Sonke) originally developed OMC in 2006 as a rights-based education and outreach programme engaging men through a series of workshops to challenge harmful gender norms and educate men about gender-based violence and HIV risks (Peacock 2013; Van den Berg *et al.* 2013). The OMC model has been implemented in several South African provinces and in other African countries through the MenEngage Africa Network. Previous studies evaluating OMC activities have shown positive effects on men’s reconfiguration of harmful masculinities as well as a reduction in HIV risk behaviour (Colvin *et al.* 2009; Dworkin *et al.* 2013). The intervention under study was designed to unpack the community mobilisation domains of the OMC model and implement a variety of activities specifically targeted to young men to increase awareness about the relationship between gender inequities and HIV and encourage community action to address negative gender norms and HIV risk (Lippman *et al.* 2013; Pettifor *et al.* 2015).

Figure 1 illustrates the conceptual framework for the OMC community mobilisation intervention, highlighting the theory of change. The conceptual framework is comprised of six targeted community mobilisation components which include the development of a shared community concern around HIV and gender norms, engaging community leadership, engaging communities in collective activities, building social cohesion, establishing and leveraging community organisations and groups, and building critical consciousness. Addressing these domains of community mobilisation around gender norms and HIV risk was intended to improve several gender and HIV outcomes including reducing harmful gender norms that contribute to both women’s and men’s HIV risk, and increasing communities collective action in preventing HIV.

Figure 1 Conceptual framework for community mobilisation (Lippman *et al.* 2013)



Prior to the intervention, local men and women were hired and trained to serve as ‘community mobilisers’ to implement OMC intervention activities. Mobilisers were selected based on their previous experience conducting community development work either formally through NGOs or through informal community networks. Additionally, some mobilisers had

training in and basic knowledge of gender-based violence and HIV prevention strategies. In addition to implementing intervention activities and engaging fellow community members towards collective action in promoting gender equality and reducing HIV risk, one of the primary functions of community mobilisers was to serve as positive role models in attitude and behaviour change. Mobilisers conducted manualised workshops with men and women in the intervention communities on seven content areas including gender, power, health, and community activism. The mobilisers also conducted outreach activities through door to door campaigns, street soccer tournaments, painting community murals, street theatre performances, mini workshops in *shebeens* (unlicensed bars) and taverns, and through digital stories and photo voice projects documenting men's and women's personal stories of change. Mobilisers identified and recruited research participants through their personal social networks, referrals from local social institutions, and recommendations offered by formal and informal community leaders.

As a central component of the OMC model, mobilisers were also responsible for establishing and supporting community action teams (CATs) who serve as community volunteers.¹ CATs, comprised of intervention research participants (with greater representation from women participants than men), play a key role in disseminating knowledge gained about gender and HIV throughout their communities, raising awareness about the causes and consequences of harmful gender norms and HIV risks, and advocating for the effective implementation of policies that support community level efforts to promote gender equality and improve HIV outcomes. Establishing CATs as part of the OMC model has been found to enable autonomous local groups of women and men to develop action plans and engage in political advocacy against gender-based violence at the local level (Wright 2014). CAT members were trained by community mobilisers to carry out OMC activities and workshops and were encouraged to join local government structures as another avenue of community activism.

2.3 Rationale for the case study

A key priority raised in both the sexual health and rights and the sexual and gender-based violence chapters of the EMERGE Evidence Review (Edström *et al.* 2015) was the need to better understand how to motivate and sustain men's involvement as agents of change in gender equality initiatives, which is explored in the findings section of this case study. We also assess how men were successfully engaged as community mobilisers and CAT members, and barriers to engaging men at the community level. The EMERGE Evidence Review noted several difficulties for engaging men as advocates of change in sexual and reproductive health and gender-based violence. This may be partly attributable to some men's self reported support for gender equality, which may be related to social desirability and exposure to gender equality discourse, yet these same men may in practice not be willing to relinquish the patriarchal privilege afforded to them (Ratele 2014). Developing improved measures to support and evaluate men as advocates of change is relevant to programmatic sustainability, particularly given men's roles as gatekeepers to women's sexual and reproductive health, their critical role in maintaining norms condoning gender equality, and that men may need continuous support to maintain changed behaviours and attitudes in support of gender equality (Dworkin *et al.* 2013).

The case study sought to answer the following questions:

- What are the processes of change among men involved in the OMC community mobilisation activities?
- What are the key drivers and barriers to men's engagement as mobilisers and CAT members? Which men engage in advocacy around reducing HIV risk and why? Where do men's interests lie in advocating to prevent and address women's and girls' HIV vulnerability both personally and politically?

¹ The following url links to a description of the community action team approach www.genderjustice.org.za/community-education-mobilisation/community-action-teams

- How does men's involvement in HIV prevention relate to wider processes of change towards gender equality and renegotiations of power? What are the personal and political roles of men and women in these processes?
- What strategies and factors are the most effective at promoting men's engagement as advocates of change in gender equality and HIV prevention? How can such changes and impacts be sustained?
- What are typical attitudes in the community around civic participation and community advocacy, including social and psychological propensity for this, and how is this linked to men's engagement as advocates of change?

2.4 Case study methodology

The OMC community mobilisation intervention research design was a cluster-randomised controlled trial implemented in the Agincourt area of Bushbuckridge in Mpumalanga, South Africa between 2012 and 2014. OMC activities were implemented in 11 intervention villages and another 11 comparison villages were followed so as to measure the effectiveness and impact of the intervention. Both quantitative and qualitative data was collected to measure the effectiveness and impact of the intervention. Two cross-sectional, population-based surveys were conducted, a baseline survey in 2012 before intervention activities were implemented and an endline survey followed in 2014. Approximately 1,200 men and women ages 18–35 years took part in each survey. Surveys were used to assess the gender inequities that increase HIV vulnerability among women and men. Sonke's research partners at the University of California San Francisco took the lead in analysing quantitative data from the community mobilisation intervention and will publish these findings separately. In addition, 11 focus group discussions were conducted with CAT members, and 42 individual in depth interviews were conducted with community mobilisers and community members exposed to the intervention. Qualitative data collection took place at two to three time points during the intervention and was conducted to understand how the local social, economic, cultural, and political context in the intervention villages contributes to gendered inequities and HIV risk among women and men.

This case study draws from qualitative data collected at the last time point during the intervention in 11 intervention villages. The data under review includes 13 interviews with community mobilisers (six men and seven women), 14 interviews with community members exposed to the intervention (eight men and six women), and 11 focus group discussions with community action teams (men and women). Please refer to the topic guides used for data collection in Annex 1–3 and a description of case study participants in Annex 4. Informed consent was obtained from all research participants and the identities of respondents are protected and not linked to any statements or responses that can violate their privacy. The research was conducted in English and Shangaan (a local language).

Utilising these sources of data, this case study explores the dynamics of change among men and women who were involved in the community mobilisation intervention. This is warranted given the gap identified in the EMERGE Evidence Review (Edström *et al.* 2015) that programmes engaging men and boys often do not indicate men's processes of change and women's evaluation of the extent of change in community level gender norms and the changes in the attitudes and behaviours of men in their lives.

2.5 Study limitations

The complexity of the multi component research design built into the OMC community mobilisation intervention allows for a rigorous analysis of the data for both intended and unexpected outcomes, however there are a few study limitations to note.

The first study limitation concerns the adaptation of Sonke's One Man Can model for the randomised controlled trial intervention design. Several changes were made to the original OMC model to avoid potential exposure to intervention activities in the control communities.

Sonke's original model includes: (1) engaging in peer outreach and education on GBV and HIV prevention (included in the intervention) and (2) supporting and holding government accountable for the implementation of existing laws and national plans on GBV and HIV (excluded from the intervention). For this second set of community activities, Sonke supports CAT members to join local government structures such as community policing forums, school governing bodies, clinic committees, and local AIDS councils as a strategy to monitor local government's delivery of constitutional obligations and to devise strategies for holding officials and social institutions to account. Almost always, when CATs are involved in this type of local activism they and Sonke engage local and national media to draw attention to HIV and GBV issues and to exert pressure on duty bearers to resolve community demands. Many of these activities are directed at local government institutions, which in the community mobilisation intervention had the potential to affect both intervention and control communities. To avoid potential contamination, accountability and media focused activist strategies were removed from the OMC community mobilisation intervention, which could have diminished some of the potential intervention effects of the full OMC model.

The second study limitation is that the OMC intervention is designed to address gender inequality and prevent HIV within a heterosexual gender binary and does not address the sexual diversity that likely exists within the communities in which the research took place. While noting this limitation, a body of evidence suggests that the HIV epidemic in South Africa, and throughout the continent, is driven through heterosexual transmission of the disease. Although the intervention focuses on gender and HIV risks through heterosexual transmission, sexual diversity and discrimination are a part of the manualised OMC curriculum and these issues were discussed during various intervention activities.

A third study limitation is the restricted scope of data analysis for this case study. As mentioned in the methodology section, longitudinal quantitative and qualitative data were collected for the OMC community mobilisation intervention. The co-investigators of the intervention are in the process of analysing and publishing the main research findings. The analysis for this case study is limited to qualitative data collected at the last time point during the intervention in 11 intervention villages.

The last study limitation concerns Sonke's involvement in producing this case study report. Sonke was an implementing partner in the OMC community mobilisation intervention and is also the organisation producing this case study report. To reduce the potential for publication bias, an independent consultant (TM) was hired to conduct the initial data analysis and produce a draft report. Another independent consultant (ES) and Sonke staff member (AA) contributed to revising the report. Five internal and external experts in the field of gender equality and health programming reviewed a full draft report, which was revised further, incorporating much of the useful feedback received. The funder approved the final case study prior to publication.

3 Findings

3.1 How is the problem being addressed?

3.1.1 Mobilising communities to address harmful gender norms and HIV risks

The OMC community mobilisation intervention was found to effectively mobilise men and women in 11 intervention communities to address harmful gender norms and HIV risks. Community mobilisers and CAT members were trained and supported to deconstruct masculine ideals that contribute to HIV risk behaviours through a variety of activities. Several mobilisers and CAT members expressed that workshops, training sessions, and door to door campaigns created safe spaces for them to talk to both men and women about how harmful

gender norms negatively affect (1) their personal lives (2) social interactions within intimate relationships and families, and (3) their communities more broadly. In several villages, mobilisers and CATS members shared that in the past HIV/AIDS prevention programmes lacked a focus on gender equality, and in comparison intervention activities improved the community's 'shared concerns' (a domain of community mobilisation in the intervention's conceptual framework) with regard to shifting harmful gender norms and decreasing women's and men's HIV risks.

Some mobilisers and CAT members felt that they are now viewed as role models by other men in their communities and offer an alternative and positive version of masculinity. Intervention team members reported that they were frequently approached by their fellow community members who sought advice on disclosing one's HIV status, experiences of gender-based violence, and requests for mobilisers and CAT members to support problem solving in family matters. Several of the intervention activities allowed men and women to reflect on how role models influence gender norms. As mentioned in the background section of this report, developing positive local role models was one of many intended outcomes in the intervention's theory of change. As a community mobiliser reported during an interview:

I started to be involved in OMC and I was not thinking that I can be a role model in this community but the knowledge that OMC has given me it has helped me to find myself... my skills on communication or mobilisation generally has helped me ... so since I have joined OMC in short I started to think how to bring the change in the community.

(Community mobiliser, male, village 18)

Men involved in implementing the intervention also indicated that they feel more engaged in their communities as critical allies to women in preventing HIV/AIDS and promoting gender equality. A key aspect of the intervention approach is working with men to understand that inequitable gender norms can have negative effects on the lives of both women and men. For some men, implementers and participants alike, taking part in intervention activities was the first time they had an opportunity to discuss gender socialisation, masculine and feminine roles, and gender power dynamics critically with women in their communities. Through this process, men and women developed shared concerns about the effects of harmful gender norms in their lives and how these norms contribute to women's and men's HIV vulnerability. These findings highlight the importance of working with men as allies for women's empowerment to help them recognise how harmful gender norms can have deleterious effects for women in their lives, as well as for their own health and well being (Dworkin *et al.* 2012).

In the community mobilisation workshops and trainings, community mobilisers and CATs were also able to build critical consciousness by raising awareness and sensitising community members about the links between gender inequality and HIV risk. One of the most effective approaches was to involve men in OMC soccer tournaments, which allowed mobilisers to engage male soccer players and coaches. All-women and mixed-sex soccer teams were also formed. In order for men to take part in the soccer tournaments, they had to participate in a two-hour workshop, which included topics on gender power dynamics, HIV sexual risks, and community activism. These workshops were delivered before each game during the two-month soccer tournaments. Men and women had an opportunity to discuss the workshop topics in depth and to pose questions and dialogue among themselves about the consequences of upholding harmful gender norms.

3.1.2 Linking unsafe sexual behaviours and harmful gender beliefs

Unsafe sexual risk behaviours expose men and women to HIV and render them vulnerable to infection. The promotion of consistent condom use as a masculine ideal to prevent HIV infection was central in the community mobilisation intervention. Several research participants reported that learning about the appropriate use of condoms, and the benefits of

men using them consistently, positively influenced their decision to initiate condom use with their partners. As one mobiliser shared:

In terms of condom use, there is a change in my household. There was a time where we were not using them ... because of [gender] norms, but since we got OMC messages my partner [and I] are using condoms, because even if you have one partner you can get infected ... so it is better to use condoms, and it is easier because I always have it.

(Community mobiliser, male, village 16)

Community mobilisers often experienced challenges in convincing their friends and family to shift their gender beliefs and used digital stories created during the intervention as a tool to share other community members' processes of change. Digital stories and other visual media platforms have been central to the OMC approach. Moreover, they are widely used in community based participatory research to allow people to reflect on how their lives are shaped by social conditions and to create a sense of social cohesion through shared experience among community members who produce stories and those who view these stories digitally (Gubrium 2009; Hull and Gatz 2006). A community mobiliser reported on the use of this strategy:

When it comes to condom use, while busy with our work in the community and even in my family we enter and try to educate... It has took me a long time to start the discussion like this in the family, so lucky enough we have the digital stories so I start to play it then we start to watch it. So from there we start to discuss, then it was easy for me in that way. So every time when I'm with them I come with the topic then we discuss it then I put in positive input that will start to help them as family.

(Community mobiliser, male, village 18)

Community mobilisation workshops and trainings covered the drawbacks of men adopting masculine ideals that encourage unsafe sexual behaviours and sought to encourage men to challenge these versions of masculinity. Participants were supported in making conscious decisions about their sexual practices and the impacts of these practices on their health and the health of their female partners. Men were taught through OMC activities the importance of creating space for open communication about sexual protection during all sexual acts and that choosing not to discuss condom use with their partners increases their HIV risk. Mobilisers and community members perceived that the OMC intervention increased men's awareness of adopting masculinities that promote health and wellbeing for themselves and their female partners.

Several community mobilisers and CAT members reported that harmful masculine practices, including high rates of alcohol consumption and violence, were common in their communities. They conducted outreach, to mostly men but also women, in *shebeens* and taverns to discuss the harmful effects of excessive alcohol use on sexual decision making including negotiating condom use and engaging in sexually coercive practices. A community mobiliser shared his experience of changing masculine ideals of excessive alcohol consumption:

Okay it's just the issue of the gender norms that as a man you have to always drink alcohol, having multiple partners, so I have realized that because I was drinking heavily. But since OMC has played a role in my life I have transformed myself and find myself drinking with care or moderation.

(Community mobiliser, male, village 4)

As mentioned in the methodology section, young men aged 18 to 35 years were the primary targets for the community mobilisation intervention along with their female counterparts. Young men and women in this age group are more likely to engage in sexual risk behaviours

compared to younger adolescents and older adults (Charnigo *et al.* 2013; Homma *et al.* 2012). Both young men and women in this age group were the primary participants in intervention activities. A consistent finding in the literature is that older adolescents and young adults are the most important target audience for HIV social behavioural interventions because they are more open to changing their perspectives around gender norms and their sexual attitudes and behaviours as they transition to adulthood (MacPhail *et al.* 2007; Pettifor *et al.* 2005; Stern *et al.* 2015). Moreover, information about harmful gender beliefs and HIV risk can be disseminated to and shared among young adults through a wide variety of strategies including social media platforms given their widespread adoption and utilisation of this particular medium. The majority of young adults in the intervention acknowledged the effectiveness of media and art-related intervention strategies such as creating community murals, and taking part in digital story and photo voice projects to document their experiences throughout the intervention. These were said to be innovative and engaging approaches to sharing gender and HIV information and raising awareness about gender inequitable norms.

The intervention specifically targeted young men and evidence shows that the majority who were exposed to the intervention appreciated what they learned and some participants tried to incorporate new knowledge on reducing their HIV risk behaviours, working towards gender equality in their interpersonal relationships, and taking action to increase awareness and shift community norms on gender and HIV. As mentioned in the background section of this report, this age group was specifically targeted due their high HIV risk. However, in a focus group discussion a CAT member suggested that interventions to prevent HIV and transform widely held community beliefs about gender should also include activities for younger youth.

Especially nowadays young people are the ones who involve themselves in sex... I suggest that we must also engage young children from 9–17 years old in our activities.
(CAT member, village 16)

3.2 What has changed?

An analysis of focus group discussions with CAT members and individual interviews with mobilisers and community members revealed many notable changes in the intended outcomes of the research that can be attributed in part to the intervention. These changes in relation to HIV and gender equality were observed on three levels: (1) individual attitudinal and behaviour changes, (2) interpersonal relationship changes, and (3) through community institutions.

3.2.1 Impacts on individual attitude and behaviour change

Although the primary target population for the OMC community mobilisation intervention was young men, attitude and behaviour change was also expected among community mobilisers and CAT members given their more extensive exposure to intervention activities. Our analysis indicates that the intervention contributed to building the personal capacities of CAT members and community mobilisers. A CAT member shared how the intervention training impacted upon their ability to disseminate the information learned:

There is a change with me because I'm now facilitating. If we recruit people some of them ask about One Man Can and I can be able to tell [them] everything and that it is where we share and advise each other.
(CAT member, village 4)

Many mobilisers and CAT members reported having internalised the OMC messages and content, specifically a clear understanding of the benefits of gender equality and working collectively with women professionally and in their personal lives. They also reported that the intervention has helped them to transition to more gender equitable decision making in their intimate relationships. CAT members and mobilisers indicated that they were often regarded

as community role models and mentors, especially around the difficult issue of increasing men's utilisation of HIV testing services. The majority of mobilisers and CAT members openly shared with community members that they have been tested for HIV. This led to a notable increase in understanding and willingness to test for HIV and other sexually transmitted infections among community members. The qualitative data analysed for the case study indicates that more men are visiting health facilities to receive HIV tests. These findings are supported by survey data from the study showing that community mobilisation was associated with higher HIV testing uptake in intervention communities and this association did not hold in control communities. Following are testimonials from men interviewed in intervention villages about shifts in their HIV testing behaviour.

OMC has made the awareness campaign for us to not be afraid to go to the clinic and do HIV test so that we can know our status.

(Community member, male, village 4)

I can say everyone has learned about HIV, OMC teaches us that we must always go to the clinic for an HIV test and that's where you will make decisions of how are you going to live life... They are talking, especially men when we are in the soccer field, most of them were afraid to go to the clinic to do HIV test. But OMC encouraged them they are now free to do HIV test.

(Community member, male, village 20)

In addition to the positive impacts on men's health, these changes were expected to improve the health and livelihoods of women as well. When men are knowledgeable about the importance of condom use, HIV testing and treatment, and then enrol in treatment and care and have reduced viral loads, it reduces women's risk of acquiring the virus from their male partners. Central to the OMC curriculum is encouraging both men and women to be knowledgeable and actively involved in their sexual and reproductive health. Following are reflections from two intervention team members on their observations of behaviour change in response to the community mobilisation intervention.

People are communicating with their partners about the use of condoms. If they want to make love they start with negotiating, they don't just do it.

(CAT member, village 4)

I can say I have gained lots of things, the issue of healthy relationships and your partner it's what I have gained, I don't think I can escort her to the clinic if I'm without this knowledge or to do a HIV test for us to know our HIV status.

(Community mobiliser, male, village 4)

Intervention staff, volunteers, and participants stated that the community mobilisation activities provided opportunities for men to talk about gender socialisation and negative impacts of restrictive gender roles on their health and well being. Moreover, men gained life and communication skills that help them communicate more effectively with their female partners and refrain from violence when settling relationship disputes. A CAT member describes their work in addressing intimate partner violence:

Gender and violence, this activity has helped me a lot. On the side where I stay there's another man who likes to beat his wife, one day his wife came to me and said send people to my house to come and teach about violence in his presence. Then I sent my colleagues to teach him from that time until today he is no longer doing that and his wife came to me and said 'thanks, it's been two months without him beating me'. So I like this activity, I also like to teach about it everywhere because women are being abused in the household.

(CAT member, village 18)

Participating in the OMC community mobilisation intervention was a catalyst for men to serve as male role models for children in their communities, which was an important way to disseminate OMC messages and contribute to boys' and girls' gender socialisation. Active involvement as community change agents further strengthened their contribution to the communities they worked with, which is a key aspect of the intervention's theory of change. Community mobilisers also discussed how serving as community change agents inspired them to reduce sexual risk behaviours such as alcohol abuse and having unprotected sex. Being held accountable by their communities made them feel responsible for ensuring that their behaviours were in line with OMC messaging on gender equality and reducing HIV risks.²

3.2.2 Transforming gender norms in interpersonal relationships

An analysis of focus group discussions and interviews uncovered positive changes in establishing more gender equitable practices between intimate partners as well as more meaningful relationships between men and their children as a result of exposure to OMC activities. Both men and women reported better relationships with their children in response to what they learned through the intervention. This is consistent with findings from the implementation of the OMC model in other areas in South Africa (Van den Berg *et al.* 2013).

Several men indicated that their participation in the community mobilisation intervention has improved their parenting skills and they are now playing a more active role in raising their children. In the following quote a community member describes the positive parenting practices he has adopted based on what he learned during the intervention:

It is important to take care of the kids, especially when it comes to child abuse, is one of the biggest [forms of] violence that we come across. So OMC has taught us that if a child does mistakes there are certain punishments that you can use than beating her. Violence does not promote family, but it destroys the family, because if you beat a child [they] will grow up knowing that if you do mistakes you must be beaten. And will do the same to their children.

(Community member, male, village 11)

Men are often changing their parenting practices against a backdrop of very narrowly defined gender norms of appropriate masculine and feminine roles. Parenting gender roles for men typically involve financial provision and protection for children, while women are responsible for instrumental daily caretaking. A community mobiliser shared his story of taking up more active parenting practices and the resistance he received from family members:

I have a wife but we are not staying together. When she visits, she visits with our child, so I cook food for them on Sunday. I cook Sunday 'kos' [family lunchtime meal]. Like when my child wants to go to the toilet, I take him to the toilet and after he's finished I take a toilet paper and wipe him. So it becomes a problem to my family. 'Why you do this? What people are going to say when they see you doing this?'. I asked them what's wrong, if I do such things like that for my blood. That's where they started to understand.

(Community mobiliser, male, village 11)

In intimate relationships, men and women who were mobilisers reported being in a better position to openly communicate with their partners. Mobilisers shared that they were increasingly able to have open discussions with their partners around gender roles and responsibilities in the household. Another area of change among cohabiting couples was a marked increase in establishing a more balanced division of labour in the home. Several men in intervention villages said that as a result of trainings on gender equality they have begun

² The following url links to one male community mobiliser's story of change in this area www.genderjustice.org.za/video/one-man-can-in-bushbuckridge-king.

to challenge norms on the types of domestic tasks associated with 'real' men and women. Two community members from intervention villages shared their views on the benefits of gender equality in the household:

Gender equality I can say is to make men and women equal and I think it's good... they say 'everything has to be done by a man because he has to show himself that he's a man', sometimes it's where I see that there is a little mistake ... on the issue of money it has to be used equally not to say this is for my husband and then he has to buy all household items... gender equality on its own, I don't see a problem about it because it helps.

(Community member, male, village 20)

There were roles that were done by women like to clean, sweep the yard and taking care of children... but since OMC came to do their workshops all the roles now people do together. As you can see today that I am also taking care of the child... back then we knew that children were women's roles to take care of them but nowadays it's all our roles... I can say OMC did bring impact.

(Community member, male, village 4)

The vast majority of focus group discussions with CAT members and individual interviews with community mobilisers and research participants revealed the pervasiveness of harmful gender norms that contribute to inequitable power dynamics in relationships and can increase both men's and women's HIV vulnerability. Mobilisers, CATs, and community members generally felt that in their communities, as is the case in most places globally, men and women are relegated to restrictive gender roles and responsibilities. Many indicated that prior to the OMC community mobilisation intervention, the majority of men in their communities served as primary decision makers when it came to how money was spent in their relationships, wanted some control over their female partner's freedom of movement, and chose the extent to which unsafe sexual practices were a part of their relationships with little to no input from their female partners. Following are two reflections by community members on how harmful gender norms are changing in their communities as a result of the community mobilisation intervention:

So in terms of decision making, some years back a word of a man was final, but nowadays a man must work together with a woman in everything, they must consult each other and they make a final decision together.

(Community member, male, village 11)

Some years back, men were marrying many women: one man was marrying five wives. And it was easy for them to get infected because if one of them is infected all of them will get infected. OMC taught that it's not good to have multiple partners because it is easy to get infected.

(Community member, female, village 20)

These positive changes in men's interpersonal relationships towards more gender equality are promising. However, the evidence shows only minimal change in men's attitudes around shared decision making in relationships. Male mobilisers, and CAT and community members views indicated that they were open to taking women's opinions into consideration when making important decisions about the household, but making final decisions is the role and responsibility of men. As one female mobilisers stated, 'in terms of decision making, it is rare for the women to make decisions, because men still have norms that they are the head of the families' (Community member, female, village 20). In addition, most men in the intervention did not support the notion that women should serve as independent decision makers in the domestic context. The following quote illustrates contradictions in men's support for joint decision making in intimate relationships:

Males and females work together when it comes to decision making. Because it is not good for a woman to make a decision without consulting a male because it will favour her. So I think it's good to tell a male and then they work together and take a decision together. The Bible says a man is the head of the family. So even if a woman is working, and her husband is not working, she must always be humble to her husband.
(Community member, male, village 11)

There were also concerns among other participants about a lack of community support for changes in gender norms. For instance, a community mobiliser explained some of the barriers to sustaining gender equality in interpersonal relationships:

When we meet them in the workshop, what is difficult for people, it's the gender roles. When you have been raised as [a] woman you must do this and that, and a man you have to do this, so sometimes when people want to practice gender equality it's difficult for them because they think about how the community will take them. But when we meet in the workshop people are sharing that they do this but they do this only inside the house, I'm referring to men. Sometimes they are saying that they cook or wash dishes but they only do it inside the house. Sometimes women are being selected to be part of the committee [leadership] but they are afraid to perform their skills in the community to show that they are thinking like men because they have been raised under the gender roles that women have to do this and men this. So this puts them to be under pressure.
(Community mobiliser, male, village 10)

3.2.3 Problematising harmful gender norms: work with social institutions and community leaders

Mobilisers, CAT, and community members all report improvements in several domains of community mobilisation identified in the intervention's theory of change. The impact of mobilisers and CAT outreach in implementing intervention activities has resulted in increased interest among the community to raise awareness and work collectively to reduce gender inequality and HIV risk. Community leaders and institutions including the *induna* (village chief), traditional, religious, and local political leaders, the community development forum (CDF), schools, and community clinics have all worked with the OMC intervention in some capacity. In many communities, OMC intervention team members have received support in conducting workshops, trainings, and short health talks in community facilities and for the most part intervention implementers reported that community leaders felt that the intervention was positively impacting their communities. In addition, there is some evidence that institutions are becoming more gender equitable, as a community member noted, 'on gender norms I see now on the CDF structure there are also women. That shows that it's changing a little' (Community member, male, village 11).

Despite these positive reflections, mobilisers and CAT members' experiences in working with local organisations and community leaders was mixed. In some local institutions – schools, *stokvels* (community savings and investment groups) and clinics – mobilisers and CAT members were allowed by leaders to conduct workshops and trainings on HIV/AIDS and gender and the intervention's focus on promoting gender equitable norms and practices was enthusiastically supported. However, some intervention team members mentioned that a lack of active involvement by some local leaders in interventions undermined the overall impact of community mobilisation activities. Their lack of involvement in this important area of social change can negatively affect the sustainability of the gains in intervention villages. The engagement of community leaders in supporting and promoting more gender equitable norms is an important aspect of many gender transformation interventions to ensure the sustainability of positive shifts in individual level attitudes and practices, interpersonal interactions, and community level social change (Doyle *et al.* 2014; Kyegombe *et al.* 2014; Viitanen and Colvin 2015; Withers *et al.* 2015).

In general, local councillors and faith and traditional leaders were willing to support and identify community members and groups to participate in intervention activities, but were reluctant to play an active role in intervention implementation. In some cases, local leaders, and specifically elders, were critical of the intervention's promotion of condom use, discussions on alcohol abuse, and approach to transform gender norms. A community mobiliser discusses his frustration with the lack of engagement by religious leaders in his village:

We do mobilisation in the community, I found that religion is against what OMC is talking about, the way people are living when it comes to sex, the issue of using the condom, it seems as if it's prohibited in some of the churches. I remember we once conducted a workshop in a certain church around the community and we entered inside in the church with the condoms. From there the elders of the church chased us because the OMC workshop is encouraging people to use the condom. The church elders were no longer happy saying that we also talking about alcohol, we don't want you to run the workshop or any activities in this church.
(Community mobiliser, male, village 10)

Only a few community members mentioned receiving strong support from their traditional, religious, and local political leaders. One CAT member offered the following recommendation for engaging local leaders for meaningful change:

I can say if we can sit down with the churches, traditional leaders as the custodians of our culture and discuss this message and there is something, which is taboo in our culture, maybe this can open a bigger platform than the one that we are having now. We can be able to cover lots of people. When it comes to our traditional leaders, they are having a problem when it comes to the issues of gender and in religion they are having a problem when we talk about condoms because their only way to deal with this is to abstain, whereas even when we push abstinence and to condomise that can help HIV/AIDS reduce, I think now they can understand. That is why if we can target the church leaders and traditional leaders and we sit down and discuss our views maybe they will assist us to carry this message and use the church and the traditional platforms when they gather.
(CAT member, village 4)

3.3 What can we learn?

Community mobilisation as a model for transforming inequitable gender relations and norms, and decreasing men's and women's HIV vulnerability provides meaningful and relevant lessons across different levels of change. At the individual level, there was attitudinal and some behavioural changes around gender and HIV risk among mobilisers, CAT members, and people exposed to the intervention. At the interpersonal level, adoption of gender equitable beliefs and values had positive effects on interpersonal communication and a more gender balanced division of labour in the home. At the community level, there is some evidence that intervention activities that increased participants' social awareness of men's and women's unique HIV vulnerabilities led to moderate changes in social norms, as well as created new pathways for collective action for social change. Throughout all three levels, mobilisers, CATs, and community members testified to both positive changes resulting from the intervention and challenges to successful implementation.

Key lessons learned about the OMC community mobilisation intervention approach:

- **Young men are open to changing their attitudes and behaviours towards gender equality and reducing their own vulnerability to HIV and the HIV risks of women in their lives.** As illustrated in the EMERGE Evidence Review, attitudinal and behaviour changes towards supporting certain aspects of gender equality are evident

particularly amongst younger men (Edström *et al.* 2015). Working with young men and women can have sustained impact on long term change in social norms as young adults' transformed attitudes and practices overtime have the potential to shift communal beliefs and values.

- **Engaging men in gender equality and HIV programming promotes more gender equitable norms among couples.** The men who took part in the OMC community mobilisation intervention often changed their attitudes towards gender roles and responsibilities with their partners as far as sharing household chores and participating in more positive parenting practices.
- **Creating safe spaces for men to dialogue has significant impacts on challenging and deconstructing social norms.** This study supports other findings that men are sometimes more comfortable talking about gender equality, HIV/AIDS, unsafe sexual behaviours, and masculinity in single-sex spaces (Jewkes and Morrell 2010). These spaces can create an initial platform for men to begin discussions about gender inequality and masculine socialisation, which prepares them to critically discuss ways to transform harmful gender practices with women in mixed-sex spaces.
- Identifying men and women within communities to serve as change agents (community mobilisers and CAT members in this particular intervention) is a strategy to **create new role models advocating for gender equality and presenting alternative masculine ideals** (Aikman and Unterhalter 2005; Barker 2006; Dworkin *et al.* 2011; International HIV/AIDS Alliance 2006; Morrell and Jewkes *et al.* 2014). When men, and women, become change agents for gender equality they not only have the capacity to disseminate new knowledge and values throughout their communities, but are also held accountable by their communities to consistently put into practice the gender equitable values and beliefs they uphold.
- **Community mobilisation is a powerful tool to promote more equitable gender norms and build critical consciousness and action around reducing HIV vulnerability for both women and men.** When men are mobilised to recognise how harmful gender norms negatively impact their lives, the changes they make towards improving their own health and well being can have added benefits for the women and girls in their lives.

Identified areas for improvement:

- Community interventions tailored to engage men and boys to promote gender equality and reduce women's and girls' HIV vulnerability should **invest in building strong working relationships with local institutions such as schools, workplaces, and health care facilities to build a network of support for shifts in gender norms.**
- **Engaging community leaders (local religious, traditional, political, and informal leaders) is important to sustaining changes in gender norms.** Several intervention staff mentioned experiencing resistance from religious and traditional leaders in training community members on gender equality, condom use, abortion rights, and homosexuality. HIV prevention interventions that incorporate a community mobilisation and a human rights approach should explore avenues to actively and effectively engage local leadership in supporting shifts in social norms around these issues. Some proven strategies for engaging religious and traditional leaders include conducting trainings with leaders to illustrate how gender equality is compatible with faith and cultural belief systems, addressing harmful gender norms from a theological perspective by unpacking scriptural texts that are often used to justify gender inequalities, and continuously engaging with opinion leaders as authoritative voices within communities who can serve as agents of change (Palitza 2009; Tearfund 2014; Tomkins *et al.* 2015).
- While young adults were the target population for the OMC intervention, **there are benefits in incorporating older adults in community mobilisation activities to reduce barriers to resistance in changing norms towards gender equality and**

acknowledge that elderly men and women may have specific HIV vulnerabilities. Additionally, programming for younger youth is important especially in contexts where early sexual debut is prevalent. Moreover, **targeting younger youth can ensure that messaging on gender equality is a part of on going gender socialisation.**

Area of further investigation:

- Shifts toward more equitable gender norms are a process not a destination. Throughout the process, change agents and community members may accept some aspects of gender equality while challenging others due to religious and cultural beliefs and values. **Exploring ways to incorporate non-harmful aspects of culture and tradition into gender equality activism and HIV programming** could be useful in addressing resistance to change and encouraging further adoption of gender equality at multiple (community, interpersonal, and individual) levels.

4 Conclusion

In this case study, we examined the One Man Can community mobilisation intervention as a strategy to engage young men in promoting more equitable gender norms and reducing gendered HIV vulnerabilities in a rural area of South Africa. Perspectives shared by the intervention implementers and community members suggest that community mobilisation is perceived as an effective approach to build critical consciousness and collective action towards gender equality and to decrease men's unsafe sexual practices. In addition, we learned that the intervention likely contributed to shifting some harmful gender norms, which is critical to ensuring sustained impact of changes in gender equitable attitudes and practices. One of the challenges to this approach was building strong working relationships with community leaders to support gender transformation at the community level and encourage men to support joint decision making in interpersonal relationships. As mentioned in section three of this report, gender transformative HIV interventions that incorporate community mobilisation and human rights approaches should explore avenues to actively and effectively engage local leadership and social institutions to strengthen shifts in gender norms and decrease gendered HIV vulnerabilities.

These findings shed light on the processes of change, how, and why outcomes are changing, at multiple levels, including through community institutions, within interpersonal relationships, and in individual attitudes and behaviours, as well as the role of community mobilisation in these change processes. An understanding of these processes of change is directly relevant as the OMC community mobilisation research team is currently implementing a follow up study in other villages in Mpumalanga, South Africa to extend the OMC community mobilisation intervention model to mobilise men and women to use HIV treatment as a way of preventing HIV infection. More broadly, the significance of the OMC intervention is that it contributes to a growing body of evidence highlighting best practices in engaging men and boys to transform harmful gender norms that contribute to women's HIV vulnerabilities and to men's HIV risk taking behaviours. Moreover it provides additional support for new developments among global and regional policymakers to more thoroughly engage men in the HIV response to promote gender equality and scale up gender transformative health policies and programmes. Actively facilitating the dissemination of these research findings to global and national policymakers, HIV and gender programme implementers, and gender justice activists is critical to enhancing the impact of the OMC community mobilisation intervention model.

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Annex 1 Interview topic guide – Community Mobilisers

Effect of Community Mobilisation on HIV prevention for young South African women

Background

1. Tell me a little bit about yourself
 - Family, interests, involvement in One Man Can (OMC), role etc.
2. Why were you interested in getting involved in OMC as a mobiliser?
3. What did you think about gender equality before you were trained as an OMC mobiliser?
4. How did your family shape your views of gender and gender equity?

Community Engagement

1. How well do you think community members are engaging in the “One Man Can” activities since we last spoke?
2. Which topics/activities are the easiest to get people to engage with? Why?
3. Which topics/activities are the most difficult to get people to engage with? Why?
4. What are currently the main barriers to engagement?
 - Different or the same across all villages?
5. Who are currently the main people engaging with the activities?
 - **Probe:** age, gender, formal structure membership
 - Is this changing?
6. What is it that makes some people engage with the activities and others not? Any strongly emerging patterns?
 - Individual characteristics or village characteristics?
7. How has engagement changed [*since we last spoke*]?
 - Number of people
 - Type of people
 - Level of participation
 - Same or different across villages? Give examples
8. Why do you think that the level of engagement is changing?
9. What are the things that have most facilitated community engagement with the activities recently?
 - Different or the same across all villages?
10. How engaged has the Community Action Team in [*insert name of village*] been since we last spoke?
 - Reasons for level of engagement?
 - Better or worse than other communities?

Perceived effect of Intervention

1. What impact do you feel the “One Man Can” activities have had in communities [*since we last spoke*]?
 - Evidence for this?
2. Can you tell me about changes that have occurred in your community since we last spoke that can be attributed to OMC? (**Probe:** changes in terms of gender equity; violence against children; engagement in HIV issues). Who are the main perpetrators of violence against children? Has this changed?
 - If no evidence of change: Why do you think there has been no change? (**Probe:** intensity, participation, format, content, leadership support)
3. Can you give me some specific examples of how OMC activities have influenced change?
4. What do you think can be done or changed/improved to make a larger impact?

Personal Change

1. How have your views on the role of women and men in our communities changed since we last spoke?
 - **Probe:** men washing dishes and childcare, women working, gender violence, violence against children, HIV, etc.
 - **Probe:** are you more involved in working with the community on problems outside of OMC’s focus? Is this a change or how it always was? Why do people choose to get involved or not?
2. What do like most/least about being a community mobiliser?
3. Of the OMC messages you teach community members, which do you agree with the most? Disagree with or are unsure about? [*Remind mobilisers this is anonymous and has no bearing on employment status.*]
4. Which OMC messages have been difficult to communicate to men? Women?
5. Tell me about friends, family members, or community members who may not support your participation in OMC? Are there individuals who are especially supportive? Please describe.
6. In your own family life, or relationships, tell me about how you have made changes based on what you’ve learned from OMC, since we last spoke?
 - **Probe:** household chores, treatment of female family members, violence, condom use or other HIV prevention behaviors
 - Have these changes been easy or difficult? What has it been like for you?
 - What has been the easiest change? Hardest?
7. Can you describe a time in the past few months when you realized you acted in a way that was counter to the OMC ideas about gender equality?
 - How do you reconcile this with your involvement in OMC? What do you think that the community would think about this?
8. Tell me about anything else that has changed in your knowledge; viewpoints; attitudes since we last spoke?
9. From your point of view, what was this experience like for OMC participants? What praise/criticism have you heard about OMC since we last spoke?

Annex 2 Interview topic guide – Community Members

Effect of Community Mobilisation on HIV prevention for young South African women

Background information

1. To start our discussion for the first time, can you tell me a little about yourself?
 - Age, profession, employment
 - Family structure
 - Which village you live in
 - Origins and time living in this community
2. What community structures are you involved in? (**Probe:** political, church, volunteer, sports, school, cultural, wo/man's, savings)
 - Explain what each group does
 - What impact does each group have on the community
3. What other groups or community organizations do you have in this community? What do they do?
4. Is this community a good or a bad place to live? Can you explain why you think that?
5. Tell me about the leaders in this community.
 - What makes them leaders?
 - Effectiveness
 - Trust

HIV prevention in communities

1. Are people concerned with HIV in your community? Why or why not?
 - What is the community concerned about that is related to HIV/AIDS?
2. How has the community tried to deal with HIV/AIDS or its impact? What has the community response been? (**Probe:** programs/social services/community support.)
3. Tell me about HIV prevention programmes in this community. How did you learn about these programmes? (If none: How do people in this community learn about HIV?)
4. What is the impact of HIV prevention programmes in this community?

Genders issues in communities

1. What are the roles of women in your community? What are the roles of men? (In terms of family, work, decision making). Have these roles changed further since we last spoke?
2. What are your views about gender equality?
3. Is gender-based violence occurring now and if yes, why? (**Probe:** is it justifiable?)
4. Is gender-based violence (or violence against women) a concern in your community? Why or why not?
5. What about other forms of violence, like violence against children? (**Probe:** who are the perpetrators? How much of a concern is this for the community?)
6. Tell me about the gender equality organisations or campaigns in your community. (**Probe:** organisation against gender violence)
 - What is the impact of these organisations in promoting gender equality in this community?
 - Any changes since we last spoke?
7. What are neighbours and the community expected to do in this community when they know about a problem (for example: gender violence)?
 - Do people get involved or do they choose not to? Why do they make this choice?
8. What do you think is a relationship between HIV and gender roles or norms?

“One Man Can” campaign knowledge

1. How well known is the “One Man Can” campaign in this village? (**Probe:** approx. % who know of campaign)
 - More known since we last spoke? The same? Profile declining?
2. What are people in your community currently saying about “One Man Can”?
 - Mostly positive or mostly negative?
 - Who is talking about it?
 - When and how did you first hear about it?
3. [*follow up only*] Have you learned something new about “One Man Can” since the last time we talked?

“One Man Can” participation and evaluation

1. Have you personally been involved in any of the “One Man Can” activities since we last spoke? What?
2. Tell me about your experience of participation (one-to-one; workshop; outreach [*type*])
Ask probe questions of all activities that participant reports
 - Describe the level of participation in this activity (number of participants but also degree of engagement with the activity)
 - Who were the people that were involved in the activity (gender, age, status in community, formal structures or informal grouping)
 - What was the goal of the activity? Do you think that this was achieved?
3. Has your experience of “One Man Can” been enjoyable? Why or why not?
4. Who is getting involved? Who isn't? (**Probe:** men, women, youth) Why is this the case?
5. [*follow up only*] Since we last spoke, do you think that there has been any meaningful change in terms of community discussion or action around gender norms and HIV?
 - What has changed? How is this change related to OMC?
 - If no – why? What are the barriers to changing gender norms or community interest in HIV?
 - Do you think that OMC has made an impact on violence against children?
6. [*follow up only*] Since we last spoke, what has changed for you? Has it changed the way you interact w/your community? Has it changed the way your community interact with one another? If yes, how? why?
 - Have you been involved with community organizing for change? Is your community open to change? Why/why not?
7. Has it changed the way you behave? If yes, how? Why? (**Probe:** in romantic relationships? At home with family? With kids (esp violence)? Clinic attendance? HIV testing?)
 - Are there any choices you've made about the way you live that were affected by your participation?

Annex 3 Focus group discussion topic guide – Community Action Teams

Effect of Community Mobilisation on HIV prevention for young South African women

Motivation to and Experience of CAT

1. How could OMC workshops be improved in the future?
 - Content, duration, focus, balance of skills vs activity training, location, timing
2. Tell me about your experience of running OMC activities
 - Balance of activities – which do they do most?; Activity preference
 - Barriers and facilitators
 - Monitoring; Feeling of competence; Additional training needs
3. How appropriate do you feel the OMC messages are for this community? Why?

Community Engagement

1. How well do you think community members are engaging in the “One Man Can” activities?
2. Which activities are the easiest to get people to engage with? Why?
3. Which activities are the most difficult to get people to engage with? Why?
4. What are the main barriers to engagement?
5. What are the things that have most facilitated community engagement with the activities?
6. Who are the main people engaging with the activities?
 - **Probe:** age, gender, formal structure membership
 - Is this changing?
7. What is it that makes some people engage with the activities and others not? Any strongly emerging patterns? Individual characteristics or village characteristics?
8. How has engagement changed [*since we last spoke*]?
 - Number of people
 - Type of people (age, gender, formal structure membership)
 - Level of participation
9. Why do you think that the level of engagement is changing?
10. How is your CAT finding working with leadership? (**Probe:** particular challenges)

Perceived effect of Intervention

1. What impact do you feel the “One Man Can” activities have had in communities [*since we last spoke*]?
 - Evidence for this?
2. In which focus area of the intervention has the impact occurred? [*HIV or gender*]
 - Why this one?; Why not the others?
 - Has there been any change in violence against children?
 - Have there been changes in people working together to solve problems outside of OMC focus on HIV and gender?
3. If no evidence of change: Why do you think there has been no change?
 - Intensity, participation, format, content, leadership support
4. Can you give me some specific examples of how OMC activities have influenced change?

CAT level change

1. How has the CAT evolved since the last time you spoke with us?
 - Membership; Attitudes, commitment; Methods

Annex 4 Description of case study participants

Community mobilisers no. = 13

	Male	Female	18–35
No. of individuals	6	7	10

Community action teams focus group discussions no. = 11

	Mean	Min.	Max.
No. of individuals	6	3	10

Community Members no. = 14

	Male	Female	18–35
No. of individuals	8	6	10

Engendering Men: Evidence on Routes to Gender Equality' (EMERGE) is a two-year project to build an openly accessible basis of evidence, lessons and guidance for working with boys and men to promote gender equality, by early 2016. Supported by the UK Department for International Development (DFID) Leadership for Change Programme, a consortium of the Institute of Development Studies (IDS), Promundo-US and Sonke Gender Justice Network collaborates in reviewing and analysing existing evidence, in documenting lessons from the field and in developing guidance for improved learning, policy and practice.

Institute of Development Studies: www.ids.ac.uk/, Promundo-US: <http://promundoglobal.org/>,
Sonke Gender Justice: www.genderjustice.org.za/

Learn more about EMERGE, our work, our findings and our free resources on: <http://menandboys.ids.ac.uk/>



This publication is available on the Men, Boys and Gender Equality website at:
<http://menandboys.ids.ac.uk/evidence>