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When Sex is Power: Gender Roles in Sex and their Consequences

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"Everything in the world is about sex except sex. Sex is about power."
-Oscar Wilde

Sexual acts and sexual relationships serve myriad purposes, a great many of them positive. Sex can be an expression of love, intimacy, or lust. It can provide pleasure, an outlet for expression of identity and desires, and enable reproduction. In some cultures, it can be viewed as beautiful and exciting and delicious and intriguing; in other cultures, it is viewed as a social obligation.

Sex can also be used as a negative expression of power. For some, power during sex is desirable and sexy, creating an arrangement of dominance and submissiveness, a moment for letting go or taking control. But when that power is exercised outside of a consensual arrangement, or the decision-making process around when and what type of sex to have is held by one partner, it can result in several negative consequences. We have known about the potential negative consequences of the intersection between gender, sexual power, and risks to one's health and well-being for some time (Amaro, 1995); however, relationships between these variables and poor outcomes continue to be identified across multiple cultures and contexts. For instance, in a study of relationship control among women in Boston, USA, those with higher levels of relationship power were five times as likely as women with lower levels to report consistent condom use,

even after controlling for socio-demographic and psychosocial variables (Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002). In addition, one study of Nepali women's sexual experiences found that sex is a male domain and a form of male power—women's roles were described as passive, with sex being a duty required to fulfill their husbands' needs (Menger, Kaufman, Harman, Tsang, & Shrestha, 2015). Nepali men, on the other hand, can initiate sex whenever they want and have the freedom to pursue different types of sex as they wish, both within and outside of marriage.

When sex is power it can mean the use of a condom or lack thereof. This means the protection of both partners' sexual health and reduction of risk from sexually transmitted infections and HIV can lie in the hands of one partner. For women in South Africa, men are often the decision makers regarding condom use, leaving women at risk of unprotected sex if they are not able to negotiate use (Ackermann & de Klerk, 2002; Harrison, O'Sullivan, Hoffman, Dolezal, & Morrell, 2006). In a study of adolescent clients at a clinic in San Francisco, those who had more power than their partners in the domain of emotional intimacy were more likely to get their way regarding condom use than were adolescents who had less power in this domain, with young men reporting greater emotional intimacy power than women (Tschann, Adler, Millstein, Gurvey, & Ellen, 2002).

When sex is power it can mean violence (or the threat of violence). For instance, in a study that assessed African American women's experiences of communicating with their male intimate partners before and after an unwanted sex incident, the women reported that male partners pressured them in a way ranging

from pestering and blunt requests to verbal bullying and violence (Gutzmer, Ludwig-Barron, Wyatt, Hamilton, & Stockman, 2016). Over half the women in the study reported that their partners applied force and violence (from being sat on, held down, pushed, slapped, and choked) to achieve unwanted sex.

When sex is power it can result in unwanted pregnancies. A study of married women in Timore-Leste found that rural women who experienced domestic violence were more likely than other rural women to have an unplanned pregnancy (Meiksin, Meekers, Thompson, Hagopian, & Mercer, 2015). Furthermore, those women who experienced violence were more likely to have fewer than the four recommended antenatal care visits during pregnancy and were more likely to have a baby born smaller than average (Meiksin et al., 2015).

These negative consequences of sexual power, while often discussed in the context of male/female genders in heterosexual relationships, can arise in same sex relationships as well. Gender and power can be further complicated for transgender individuals who sometimes give up power in order to be accepted enough by a partner to have sex in the first place (Sevelius, 2009).

This chapter focuses on the negative consequences when sex is power. Here we will discuss how we understand the relationship between gender and power, how that manifests itself in sexual relationships, how we can measure power in sexual contexts, and actions we can take to balance gendered sexual power so as to protect the health and well being of sexual partners. This goal of a more balanced distribution of sexual power between genders is important from the perspectives of maintaining health, human rights, and psychological well being.

Defining Gender and Power

In order to discuss these constructs in more detail, it is important to define what we mean when we refer to gender and power. *Gender role* is a term often used by developmental psychologists to describe the behaviors, attitudes, and traits that a society or culture classifies as either feminine or masculine and then often assigns a value to those characteristics (Ruble & Martin, 1998). While this definition implies gender roles are entirely socially constructed, researchers often disagree as to how much gender roles are a product of the social environment versus evolutionary or biological influences (Zucker, 2001).

Gender norms, on the other hand, refer to a society's expectations for genders in regards to tasks, professions, roles, and responsibilities. These are a set of rules, so to speak, about the ways in which women and men should look, behave, and think. Gender norms can vary by culture. For instance, in agricultural societies, women do a large part of the hard labor of farming. Gender is not always considered binary (masculine and feminine), but traditionally gender norms are referred to in this way, with other genders viewed as "gender non-conforming".

The Theory of Gender and Power (Connell, 1987) states that gender-based inequalities are the result of three social mechanisms—the structure of labor, the structure of power, and cathexis. These mechanisms determine how much control women have over resources, whether they are permitted to pursue economic opportunities, and what is expected of them as women. In the context of sex, this theory suggests that when women do not have control over resources (financial, educational, etc.), they often cannot be financially independent, and therefore those

who are in power—primarily men—often control what is expected of them. In a sexual relationship, this may mean that a woman does not have the ability to request condom use if it means risking her partner leaving and taking away financial stability. For a woman engaged in sex work, this may mean succumbing to condomless sex because it produces a greater amount of money. This power, or lack thereof, can place women into positions where their health, safety, financial security, or children's wellbeing are put into jeopardy.

The Theory of Gender and Power is an example of the social constructionist perspective of gender identity, which suggests that gender roles are created by societies rather than being a product of evolutionary design, biology, or hormones. This creation of gendered identities starts early, as even babies are referred to in gendered language and gender stereotyped (Brown, 2014). Popular onesies for baby boys read "Daddy's Little Slugger" or "Mommy's Little All-Star," emphasizing the link between males and sports. Little pink bows are commonly wrapped around a baby girl's hairless head so there is no mistaking her for a boy. These gendered identities are reinforced and perpetuated by both men and women. And while in some Western contexts women seem to have a larger range in which to express their gender than do men (for instance, women are now pursuing stereotypically male professions but not necessarily vice versa), men still have more power overall. This discrepancy is evident at the state or structural level in the number of men holding positions of power in large businesses and policy-making bodies (Medland, 2016). It is also evident all the way down to the household level through the ways in which women bear the brunt of household work, often despite having their own careers

(Horne, Johnson, Galambos, & Krahn, 2017). In the U.S., women and men receive lots of conflicting messages about gender at the same time—some women are leaders and some are not—which suggests that women have this wider range of options. However, those women who do pursue work or roles outside of the stereotypically feminine are often met with resistance and stereotyping in other ways, such as critiques of their leadership styles, appearance, body shape, or their level of devotion to their families.

In some other parts of the world, gendered identities are still constructed in ways that align with traditional gender stereotypes. For instance, in rural Ethiopia, decisions regarding family planning often fall to the man as the head of the household (Bogale, Wondafrash, Tilahun, & Girma, 2011), which is not unlike many other African cultures (Do & Kurimoto, 2012). One study found women's decision-making power regarding family planning increased if she had more education and was employed outside of the home (Belay, Mengesha, Woldegebriel, & Gelaw, 2016). In a qualitative study of the roles and responsibilities in newborn care in Nigeria, Tanzania, and Ethiopia (Iganus et al., 2015), taking care of a new baby was considered a woman's domain. Fathers had little physical contact with their newborns, but instead played a major role in financing newborn care and being the ultimate decision-maker in the family. These traditional gendered identities can translate into a lack of power for women in sexual relationships as well, whereby norms dictate that women should be faithful to one partner, submissive, be primarily concerned with pleasing their partner, and sacrificing their own needs, even if this means putting their health and well being at risk.

If the social constructionist perspective is correct in that these gendered identities—and the meanings attached to them—are created and perpetuated by cultures and societies, we should be able to change them. This is quite a task, however, when these gender binaries are so engrained in everyday life. Think about how many times gender is relevant as you go about your day, from the moment you get up and pick out clothes, to possibly the work you do, to the extent to which you feel safe walking down the street alone after dark. But this idea of gender transformation is not an impossible task, and working with both men and women to change gender roles and their meanings is possible. We reflect more on that in a bit.

Measuring Power in Sexual Relationships

In order to address gendered power imbalances, we must first be able to measure them so as to identify benchmarks for improvement. While measuring power and inequality in other settings can be quite straightforward—wage gaps, university enrollments, gender distribution in governments, for example—measuring power in sexual contexts can be tricky. Two well-established scales, the *Sexual Relationship Power Scale* and the *GEM Scale,* have attempted to do so. These measures are quite different—the former addresses dynamics within a relationship or couple (the interpersonal level of the socio-ecological model (Dahlberg & Krug, 2002)), and the latter addresses views towards men and women based on societal messages or norms (the society level in the socio-ecological model).

The Sexual Relationship Power Scale

The Sexual Relationship Power Scale (SRPS) was developed by Pulerwitz, Gortmaker and DeJong (2000) to address the lack of reliable and valid measures of

relationship power in social, behavioral, and medical research. Designed to measure women's perceptions of relationship power, the SRPS has 23 items comprising two subscales measuring the constructs of relationship control (15 items) and decision-making dominance (8 items). Since its development, the SRPS has been used extensively in the field of HIV prevention and sexual risk behavior, and there exists a substantial literature reporting the psychometric properties and subsequent modifications of the scale. Early on, the SRPS was viewed as a useful tool (Blanc, 2001), and at this point, it is the most widely used tool to measure relationship power in the HIV/STI prevention literature (McMahon, Volpe, Klostermann, Trabold, & Xue, 2015). Reflecting its extensive use, McMahon et al. published a systematic review of the scale's psychometric properties in 2015. The review included a total of 54 published articles; the SRPS was found to exhibit very sound psychometric properties across multiple study populations and research settings and was associated with a number of key variables, including sexual and physical violence, HIV incidence, condom use, and higher education levels (McMahon et al., 2015). Providing further evidence for its usefulness, the scale has been translated into over a dozen languages and used with a wide variety of difficult cultural settings and sub-populations (e.g., adolescents, youth, and adults; girls/women and boys/men). Evidence suggests the core concepts measured within the scale appear to apply globally.

Characteristics of the scale. This multi-item scale includes specific elements of relationship power that are lacking in more global measures, and both subscales (relationship control and decision-making dominance) can be combined into one

overall SRPS, or each subscale can be used on its own. Items were designed to incorporate events common to both dating and married couples.

The two subscales have distinct response sets. The relationship control subscale employs a 4-point Likert scale to measure level of agreement on item statements (strongly agree; agree; disagree; strongly disagree). See Table 1 for sample items. The decision-making dominance subscale was constructed to measure the balance of decision-making power (1=your partner has more power; 2=both of you have equal power; 3=you have more power) on each of the eight items, with higher scores indicating higher relationship power for the respondent. SRPS responses are typically summed and then normalized to a range of 1-4 to maintain the original range of answer choices, with standardized scoring to enable cross-sample comparison (Pulerwitz et al., 2000). Alternatively, scale scores are split into three separate and equal categories—'low', `medium' and `high' power—for ease of interpretability. The 2015 systematic review noted that in subsequent studies, response sets were sometimes modified from the original, such as expanding the Likert scale to include a neutral response or more responses, dichotomizing responses, or reflecting the Likert scores (McMahon et al., 2015).

Adaptations and uses. The SRPS has been successfully adapted and used in a number of countries and settings and with a variety of sub-populations. Use of the scale is reported in a wide range of scientific and reports. The SRPS scale was developed in both English and Spanish, but has also been translated into numerous other languages, including multiple African languages (i.e., Sotho, Zulu, Tswana, Xhosa, Pedi, Venda, Tsonga, Afrikaans, Setswana, siSwati, and Runyankole), Native

Creole, Chinese, French, Hindi, Urdu, and Tamil. Other translations are currently ongoing (e.g., Persian). Most translations involved the use of back translations, pilot testing, and expert evaluation of cultural content validity.

Psychometric properties. In general, the entire SRPS and relationship control subscale have exhibited very sound psychometric properties (e.g., Cronbach's alphas >= .75) across multiple study populations and research settings. By contrast, the decision-making dominance subscale—when used alone—has been found to have weaker psychometric properties. Of note, although the SRPS was designed to measure women's perceptions of relationship power, a fair number have now been applied to men (including 10 studies in the 2015 systematic review.) While none of the studies reported conducting formative work to evaluate the appropriateness of administering the SRPS to men, they were shown to be a useful measure among men, given adequate internal reliability and significant associations with key outcomes.

Associations with key variables. The SRPS has been associated with a range of health and development outcomes: sexual and physical violence, dating violence, HIV incidence, HIV positive status, condom use, frequency of unprotected sex, contraceptive use, unwanted pregnancy, fewer untreated STIs, likelihood of engaging in transactional sex, condom use self-efficacy, perceived HIV risk, satisfaction with the primary relationship, social support, and higher education. While not every study that applied the scale found significant associations with key outcomes, a number of well-designed and rigorous studies have, and this

information has been applied towards appropriate health programming (e.g., HIV and violence prevention programming.)

An example of a key finding emerged from a cluster-randomized controlled trial undertaken in the Eastern Cape province of South Africa from 2002–2006 (Jewkes, Dunkle, Nduna, & Shai, 2010). A sample of 1,099 women aged 15–26 years who were HIV negative at baseline were followed over two years, and women with low relationship power were more likely to acquire HIV than those with higher power. In another study of the sexual dysfunction of young rural Chinese couples, (Lau et al., 2006) researchers applied a Chinese language translation of the SRPS. Lower relationship control scores were significantly associated with a wife's report of lower sexual satisfaction. Additionally, men whose wives scored lower on the relationship control scale were more likely to have a sexual dysfunction.

The systematic analysis (McMahon et al., 2015) examined the association between SRPS (or subscale) scores and measures of condom use. Of the 32 analyses reporting condom use outcomes, 19 (59%) found that higher relationship power for females predicted greater condom use at the 0.05 significance level. Fourteen studies reported results that examined the association between SRPS or subscale scores and measures of intimate partner violence (IPV). Of these, 12 (86%) were found to be statistically significant at the 0.05 significance level, with higher relationship power for women predicting less IPV. The two reports of no association with IPV both used the decision-making dominance subscale alone.

Recommendations for successful scale use. With few exceptions, the full SRPS—and the relationship control subscale, when used on its own—show good

psychometric properties across numerous populations and research settings, including with both girls and boys, and women and men. Consistently strong associations with key health and development outcomes provide evidence the scale is 'tapping into' something important. It is recommended to pre-test the scale carefully for a given study, and explore whether any modifications should be made. However, it is relevant to note that studies using the original versions display acceptable reliability and validity across numerous populations and settings, and modifications to the original scale items or response sets tend to have a negative impact on scale reliability (McMahon et al., 2015). Thus, unless researchers have a substantive reason for revising scale content, there appears little justification for modifying items or response sets when using the scale.

The GEM Scale

The Gender-Equitable Men (GEM) Scale was developed by Pulerwitz and Barker (2008) to measure support for certain gender norms by boys and men. It is a 24-item scale consisting of two subscales (Inequitable Norms—17 items, and Equitable Norms—7 items), which can be used combined or alone. The items measure views towards gender norms related to sexual and reproductive health, sexual relations, violence, domestic work, and homophobia (see Table 1 for sample items). Since its development, the scale has been used extensively in the fields of HIV, violence prevention, and sexual risk behavior, and there exists a substantial literature reporting findings with the scale. The scale has been translated into over a dozen languages and used across a number of countries and with a wide variety of sub-populations (e.g., adolescents, youth, and adults; boys/men and girls/women).

Evidence suggests the core concepts measured within the scale appear to apply globally, and various adaptations have been successful in identifying an important construct. The scale has demonstrated that gender norms are significantly associated with a variety of key variables, including sexual and physical violence, condom use, contraceptive use, and higher education levels. Per a 2016 study in South Africa, "among the many available measures of gender norms/ideology…the GEM Scale has become the most common measure used in HIV and violence prevention research and program evaluations in developing country settings" (Gottert et al., 2016, p. 1786).

The scale was originally informed by qualitative research with young men in Brazil (Barker, 2000), which led to the term 'gender-equitable young man' operationalized as a man who 1) seeks relationships with women based on equality and respect rather than sexual conquest; 2) seeks to participate in household chores and childcare; 3) assumes some responsibility for STI prevention and reproductive health in their relationships; 4) is opposed to violence against women under all circumstances; and 5) is opposed to homophobia/violence against homosexuals (as men often included "nonhomosexual" in their definition of what it was to be a "real" man.)

Characteristics of the scale. Answer choices for each item include: agree, partially agree, and do not agree. Typically, each item is scored such that one point is given for the least equitable response, two points for the moderately equitable response, and three points for the most equitable response. Responses to each item are then summed. Continuous GEM Scale scores can be used in analyses as is, or the

responses can be coded into different formats, such as trichotomized into ‘‘high,’’ ‘‘moderate,’’ and ‘‘low’’ support for equitable gender norms by splitting the scale into three equal parts (Pulerwitz & Barker, 2008).

Adaptations and uses. The GEM Scale has been successfully adapted and used in a number of countries and settings and with a variety of subpopulations. It was developed in both English and Portuguese originally and has since been translated into many other languages, including Spanish, Hindi, Amharic, Thai, Chinese, and several African languages (e.g., KiSwahili, Luganda). It has been tested with age ranges including the very young (10 – 14 year olds), youth aged 15 – 24, and adults (up to 60 years old).

Psychometric properties. The original study testing the measure found the full GEM Scale and both of the subscales to be internally consistent (reflected in adequate/high Cronbach's alphas), and factor analyses confirmed that the items held together well. Some researchers have chosen to use only one of the two sub-scales (usually the Inequitable Norms subscale) due to space constraints and/or perceptions of the most appropriate items for a given setting. Further psychometric testing of the scale and subscales has demonstrated that the full GEM Scale and the Inequitable Norm subscale consistently demonstrate high internal consistency, while internal consistency varies for the Equitable Norm subscale. Thus, if one subscale is chosen, scale developers recommend the Inequitable Norms subscale (Pulerwitz et al., 2010).

Of note, while the scale was developed for males, it has now been used several times with girls and women, without any changes to the items related to this

shift. While limited at this point, available psychometric data indicate it is appropriate for females as well, given high internal consistency and significant associations with key health and development factors (Levtov, Barker, Contreras-Urbina, Heilman, & Verma, 2013). The authors now generally use the term 'GEM' Scale (as opposed to spelling out Gender Equitable Men) to indicate that the scale can be used for both men and women.

Associations with key variables. The GEM Scale has been associated with a range of health and development outcomes, in the expected direction (i.e., the more gender equitable one's beliefs, the more positive the outcome), including: IPV, dating violence, condom use, contraceptive use, greater number of sex partners, greater number of concurrent partners, early sexual debut, STI symptoms, sexual satisfaction, sexual dysfunction, more participation in domestic life, and higher education. The scale has consistently shown associations with key outcomes via cross-sectional studies, as well as with intervention studies intending to measure change in views toward gender norms (and outcomes hypothesized to be related) over time.

Research with the scale has found statistically significant associations with physical violence, contraceptive use, higher education level (Pulerwitz & Barker, 2008), reduced STI symptoms, and increased condom use (Pulerwitz, Barker, & Verma, 2012), in expected directions. In rural Gorakhpur and urban Mumbai, India, the GEM Scale was associated with condom use, IPV, and the reporting of sexual dysfunction (Pulerwitz et al., 2010). One study examining results from a survey conducted in eight different countries found that having less support for gender

equity as measured by the GEM was associated with a higher likelihood of ever perpetrating physical IPV (Fleming et al., 2015). And, in most of the studied countries, greater scores on the scale were found to be associated with daily care of children and domestic duties, reduced use of violence, and higher sexual satisfaction (Levtov et al., 2013). In Ghana and Tanzania, the scale was associated with greater numbers of sex partners over the past year, more concurrent partners, and greater frequency of paid sex among men (Shattuck et al., 2013). In California, USA, athletes with less equitable views were more likely to perpetrate abuse against their female dating partners (McCauley et al., 2013).

Certain notable findings have been highlighted when using the GEM among different sub-populations. For example, in a study with youth representing a range of ages in Uganda, while all participants reported high levels of support for inequitable gender norms, 10-14 year olds were consistently less gender equitable than their older counterparts (15-24 year olds; Vu et al., 2017). Comparing responses from males and females indicated similar support for gender inequity. Further, responses were significantly associated with early sexual debut and greater partner violence.

Recommendations for successful scale use. With few exceptions, the full GEM Scale—and the Inequitable Norms subscale, when used on its own—shows good psychometric properties across a number of populations and research settings. The consistently strong associations with key health and development outcomes, and usefulness in intervention evaluations, provide evidence the scale is identifying an important construct when considering gender and power.

Of note, the few items related to homosexuality have often been removed from the scale, especially in African settings. This change is due to reactions during pre-tests, where questions have been raised around the relevance of these items. Initial research demonstrated that views towards homosexuality is an integral component of the definition of manhood, but in circumstances where negative reactions to the questions arise, certain researchers have determined it would be best to remove them (Shattuck et al., 2013).

Balancing Power: Effective Interventions

Now that we have described methods for measuring power inequity in sexual relationships and at the societal level, how do we actually go about bringing that power into better balance? One way researchers and practitioners have been attempting to do so is through *gender transformative* interventions. These programs seek to transform gender norms and relations in a way that promotes equity as a means to reach desired health outcomes and eliminate gendered health disparities (Dworkin, Treves-Kagan, & Lippman, 2013; MenEngage & UNFPA, 2014). We say health outcomes and disparities because that is where gender transformative interventions have been used most to date—to address gender inequities in sexual risk behavior, family planning behaviors, and violence.

Figure 1 shows the spectrum of gender (in)equity as it applies to programs and interventions. A *gender blind* intervention ignores gender norms completely. Examples of this might be intervention programs that simply teach males and females it is important to use a condom at every sexual encounter to protect oneself from STIs and HIV. However, this approach ignores the fact that the male wears the

condom (generally speaking), and that there are gender dynamics often making it impossible or even dangerous for the female partner to ask for protection. A *gender sensitive intervention* acknowledges the genders but does not address the inequalities between them. An example of this would be an HIV intervention that has sessions for males and females separately where they can talk about their experiences with sexual risk among those of the same gender. However, this set up does not necessarily allow for discussion of how having a partner who does not have gender equitable beliefs can result in a power imbalance. A *gender specific* intervention acknowledges gender norms and considers men and women's needs, but it is often tailored for one gender in particular. An example of this would be a program that acknowledges women may not have power in their sexual relationships but gives them options to try to work around this, such as making condom application a sexy game. Finally, a *gender transformative* intervention addresses the causes of gender-based power imbalances and works to transform harmful gender roles, norms, and relations to achieve a more equal balance.

Dworkin and colleagues conducted a review of gender transformative interventions for men and found that the most effective ones have several elements in common (Dworkin et al., 2013). First, they consider a socio-ecological approach—gendered power imbalances occur not just between male and female relationship partners, but in families, communities, the society at large and are often reflected in local, state, or national policies and laws. Second, gender transformative interventions focus on critical reflection of gender norms. The program facilitator might ask participants to think about how being male puts one at an advantage in

day-to-day life, or how being female puts someone at a disadvantage. Third, gender transformative interventions tend to integrate multiple components. For instance, they might include group education, social and behavioral change communication campaigns, or community mobilization activities. Fourth, the most effective gender transformative interventions include the participation of the target audience in the design of the program. For instance, if a program seeks to target heterosexual couples where the female partner is pregnant, then pregnant woman and their partners would be consulted regarding the program content. And finally, the best gender transformative interventions have well trained facilitators. This element is key to any successful intervention, but when trying to change deeply socially engrained practices such as patriarchal gender norms, the facilitator must be very talented in the way she/he helps participants examine their deeply ingrained beliefs.

How do these gender transformative interventions actually work in practice? While this approach in general is fairly novel and new, several model programs have come to the forefront that show significant effects in decreasing endorsement of gender inequality, reducing violence against women, and increasing healthy behaviors.

Stepping Stones

The Stepping Stones program (Welbourn & Rohr-Rouendaal, 1995) is one of the first and most well known gender transformative interventions. It was originally developed and implemented in Uganda as a program to address HIV prevention in a way that also takes into account harmful gender norms in the country. The program

is a life skills training that focuses on improving sexual health by developing strong, more equitable relationships between partners, addressing gender-based violence, increasing communication about HIV, and improving relationship skills and assertiveness in sexual relationships. The program utilizes participatory learning approaches, including critical reflection and role-playing. It is facilitated by a person of the same gender and slightly older in age than the participants so that he/she is relatable. The sessions are held over several weeks in a group setting.

The Stepping Stones program has been evaluated in multiple countries, but among the most rigorous studies was a randomized controlled trial in the Eastern Cape of South Africa (Jewkes et al., 2006; Jewkes et al., 2008). The evaluation showed that male participants experienced a statistically significant reduction in perpetration of violence and exploitative behavior two years after participating in the program. The program was also associated with a reduction of Herpes Simplex Virus-2 incidence by about 33% for men. For female participants, they showed fewer experiences of IPV, rape, and transactional sex two years after the program as compared to baseline. Additional smaller-scale evaluations have shown similar effects for long-term outcomes. The authors speculate the program worked better for men than it did for women because women remain disempowered economically. Researchers are currently assessing the effect of adding an economic component to the program for women (see Gibbs et al., 2017).

SASA!

Another more recent example of a gender transformative intervention that operates at the community level is the SASA! Study in Uganda (Abramsky et al.,

2014; Michau, 2008). SASA! is a community mobilization intervention focused on changing community attitudes, norms, and behaviors that result in gender inequality, violence, and increased HIV risk for women. The program trains community activists (men and women) who are interested in issues of violence, power, and rights along with staff from community institutions such as the police, health care system, etc. The activists then introduce concepts of power and encourage their communities to analyze the imbalance of power through four strategies: local activism, media and advocacy, communication materials, and training. The activists conduct informal activities with their own social networks and, with each activity, increase the number of individuals and groups involved in order to build the critical mass needed to enacted social norm change.

In a pair-matched cluster randomized controlled trial of eight communities (four intervention, four control) in Kampala, Uganda (Abramsky et al., 2014), the SASA! intervention was found to be associated with significantly lower acceptance of IPV among women and men (though only marginally significant among men). They also showed significantly greater acceptance (by both genders) that a woman can refuse sex and lower levels of past year experience with sexual IPV. Women who did experience violence in intervention communities were more likely to receive supportive community responses. They also found that men in the intervention communities were significantly less likely to have concurrent sexual partners than were men in the control communities. Since this large-scale evaluation, the intervention is has been being replicated in more than a dozen countries.

Men as Partners

Some gender transformative interventions focus on transforming norms and attitudes of just one gender at a time (commonly men). The Men As Partners (MAP) program created by Engender Health (Engender Health & Planned Parenthood Association of South Africa, 1999) is a leading example of this. Established in 1996, MAP works with men to play a role in promoting gender equity and health in their families and broader communities. The MAP program includes workshops that confront harmful stereotypes about what it means to be a man, works with health care facilities to ensure they are male-friendly, uses public art, street theater, and mass media to explore the theme of partnership rather than power, and works to build national and international gender equality advocacy networks.

An example of a MAP adaptation is a program in Ethiopia called the Male Norms Initiative (Pulerwitz et al., 2015). The two main intervention components are interactive group education for men and community mobilization and engagement activities that focus on raising awareness and encouraging community dialogue. In sum, the interventions focus on promoting critical reflection regarding common gender norms in Ethiopia that might increase one's risk of violence or HIV and other STIs. Through this reflection, the participants are able to identify potential negative outcomes of enacting these norms and the potential positive aspects of more gender-equitable behavior. Using the GEM Scale to assess outcomes, researchers found significant positive shifts in GEM Scale scores over time, and high-equity GEM Scale scores were associated with a 34% reduction in the odds of any type of violence (p = .08).

Program H

Program H in Brazil is an example of a gender transformative intervention working with one gender only (again males). Program H focuses on helping young men to critically assess traditional gender norms and to discuss and reflect on the costs of inequitable gender-related views and the benefits of more gender-equitable norms and behaviors (Pulerwitz et al., 2012; Pulerwitz, Michaelis, Verma, & Weiss, 2010; Ricardo, Nascimento, Fonseca, & Segundo, 2010).

In an evaluation of the program (Pulerwitz, Barker, & Segundo, 2004), young men ages 15-24 were assigned to one of three groups: 1) interactive group education sessions with a community-based "lifestyle" social marketing campaign, 2) interactive group education sessions only, or 3) a comparison group that received the intervention later. Pre- and post-intervention surveys were conducted. In both intervention arms, young men were significantly less likely to support inequitable gender norms (as measured by the GEM Scale) at both the 6- and 12-month follow up surveys. There was no change in norms for the comparison group participants. Furthermore, men who decreased their support for inequitable norms were significantly less likely to report STI symptoms and more likely to report condom use with their primary partners over time, even after controlling for demographic variables such as age, family income, and education level. In sum, Program H was effective at both changing harmful gender norms and improving sexual health behaviors. A subsequent evaluation of an HIV and violence prevention program adapted from Program H for young men aged 16 – 26 years in India (called Yari Dosti) similarly found that views towards gender norms became more equitable in

the intervention but not in the comparison group, and more condom use and less IPV was reported (Pulerwitz et al., 2012; Pulerwitz et al., 2010).

A sister program for young women ages 15-24 in Brazil and India is Program M (Ricardo, Nascimento, Fonseca, & Segundo, 2010). It has a similar format to Program H—group education combined with youth-led community campaigns to promote gender-equitable attitudes and improve young women's agency in their interpersonal relationships. Evaluation studies from the two countries found that women who participated in the program showed increased communication with their partners regarding sexual health, increased self-efficacy in their interpersonal relationships, decreased substance use, and increased condom use by partners.

BALIKA

Finally, an example of a gender-transformative program for girls only is the Bangladeshi Association for Life Skills, Income, and Knowledge for Adolescents (BALIKA) program (Amin, Ahmed, Saha, Hossain, & Haque, 2016). This program aimed to empower girls in rural Bangladesh and prevent child marriage—an institutionalized form of gendered-power that by its very nature creates power imbalance in sexual relationships. BALIKA provided mentored safe spaces for about 9,000 girls ages 12-18 to increase their skills, and engaged the community in the program. A four-arm cluster randomized controlled trial compared: 1) an education intervention, 2) gender-rights awareness training, 3) livelihood skills training, and 4) control villages (no interventions). Results of the trial showed a 30% reduction in child marriage in all intervention groups relative to the comparison villages. All arms also reduced school dropout rates by about 20%.

Where Do We Go from Here?

By now it is probably evident that power in sexual relationships that is tied to gender and gender roles can be a real liability, especially for a woman's sexual health. Gender transformative interventions are providing evidence that change can happen—we can balance power in sexual relationships in a way that benefits both partners. This is the first step towards larger societal shifts in the direction of gender equity. We also need to focus on balancing power at multiple levels of the socio-ecological framework, such as in one's family, community, or in the form of policies and laws at the national or international level. The PEPFAR DREAMS Initiative is one recent example of intervening at multiple levels to change gender dynamics (PEPFAR, 2017). Programs under the partnership are attempting to reduce HIV risk and incidence among adolescent girls and young women in sub-Saharan Africa by combining individual health services with programs to create healthy interpersonal dynamics (such as with parents, peers), education, and economic support such as cash transfer programs (Population Council, 2016). These holistic, multi-level interventions may be the best way to create real societal change that results in more equal distributions of power and less risk to women's health. While this work of tackling power imbalance is not easy, especially when it is complicated by sexual relationships, it is only by continuing to change harmful gender norms—for both males and females—that we will see larger scale benefits of more equal power.

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Figure 1. Spectrum of gender (in)equality as applied to programs and interventions

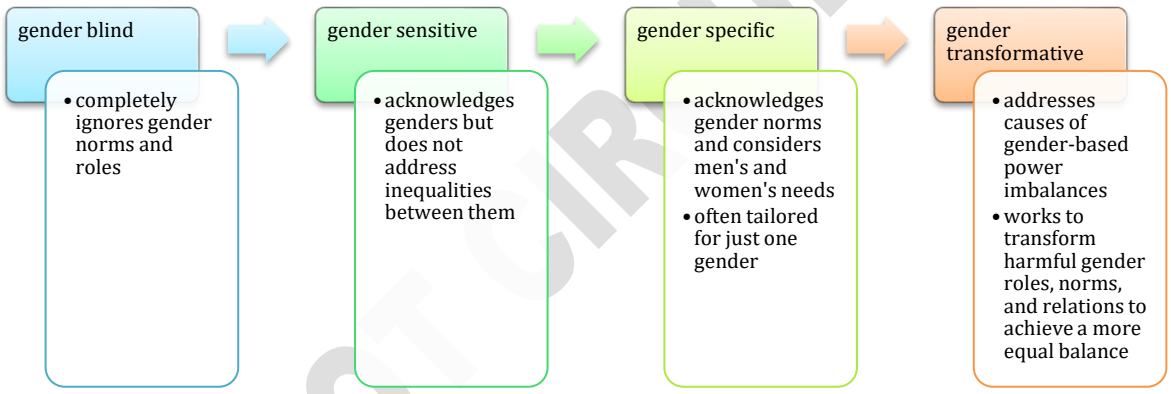

Table 1. Selected items from Sexual Relationship Power Scale and Gender-Equitable Men Scale

Sexual Relationship Power Scale
Relationship Control sub-scale
· If I asked my partner to use a condom, he would get angry.
· My partner has more say than I do about important decisions that affect us.
· My partner tells me who I can spend time with.
Decision-Making Dominance sub-scale
· Who usually has more say about whether you have sex?
· Who usually has more say about what you do together?
· Who usually has more say about whether you use condoms?
GEM Scale
Equitable Norms sub-scale
· It is important that a father is present in the lives of his children, even if he is no longer with the mother.
· A man and a woman should decide together what type of contraceptive to use.
· A man should know what his partner likes during sex.
Inequitable Norms sub-scale
· A woman should tolerate violence in order to keep her family together.
· A man should have the final word about decisions in his home.
· It is a woman's responsibility to avoid getting pregnant.
· A real man produces a male child. (Adaptation from India)
· A woman who has sex before she marries does not deserve respect. (Adaptation from Ethiopia)
· It disgusts me when I see a man acting like a woman. (Adaptation from Ethiopia)