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Engaging Men As Partners® in Health: *Promoting Equitable Gender Norms through Male Engagement in Tanzania*

KEY POINTS

Male partners often wield decision-making power when it comes to sexual relations and health—including when to have children, whether to seek health care, and whether to use family planning.

Between 2009 and 2014, the CHAMPION Project implemented Men As Partners® (MAP®) educational workshops to engage men in playing a constructive role in promoting gender equality and health in their families and communities.

Results demonstrate a positive change in knowledge about and attitudes toward gender equality, gender-based violence (GBV), sexual and reproductive health, HIV prevention, and support for HIV testing.

INDIVIDUAL INTERVENTION

BACKGROUND

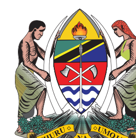
Gender Inequality's Toll on Health

While the steady decline in Tanzania's national HIV prevalence rate—from 5.7% in 2008 to 5.1% in 2012—indicates a positive trend in combating the epidemic, it masks significant epidemiological disparities (TACAIDS et al., 2013). Globally, women are disproportionately vulnerable to HIV infection (Jewkes et al., 2010). This is true in Tanzania as well, where HIV infection rates are higher among women than among men (6% vs. 4%) (TACAIDS et al., 2013). Rates of HIV testing are also low in the country, particularly among men, with 62% of women and 47% of men aged 15–49 having ever been tested for HIV and received their test results (TACAIDS et al., 2013). Despite these disparities, women bear the primary burden for ensuring sexual and reproductive health (SRH); however, unequal gender dynamics often render them powerless to make decisions that impact their and their family's health.

It is increasingly recognized, in Tanzania and elsewhere, that gender norms—societal expectations of men's and women's behaviors—are among the strongest factors fueling HIV transmission worldwide. Traditional male gender norms encourage men to equate a range of risky behaviors—using violence, abusing substances, pursuing multiple sexual partners, and dominating women—with affirming their manhood (Barker & Ricardo, 2006). Traditional female gender norms encourage women to accept such behaviors and, in some cases, support or perpetuate the power imbalances that exist between men and women (Greene & Levack, 2010). In populations where gender equity is low, women often lack the social, educational, and economic opportunities that can help to protect them from HIV (Greene & Levack, 2010).

How MAP® Works

The process of undergoing a personal reflection to increase understanding of how existing gender norms negatively affect one's own life, one's partner, and one's family has been shown to engender sustained behavior change (Population Council, 2004; Peacock & Levack, 2004; Rivers & Aggleton, 1999). EngenderHealth's MAP® group education workshops were designed using an experiential learning model that encourages men to question and analyze how unequal power in relationships makes both men and women more vulnerable to HIV and to poor RH. Key to MAP®'s transformative aim, workshop activi-



MAP® Guiding Principles

Inequitable gender roles and stereotypes:

- Compromise SRH by encouraging men to equate risky behaviors with masculinity.
- Encourage men to view health-seeking behavior as weakness.
- Give men the ability to influence and/or determine women's RH choices.

However:

- Men have a personal investment in challenging inequitable gender norms and can serve as allies in improving their own health and the health of women and children.
- Women welcome men's participation in promoting gender equity.

ties ask men to consider how to make the positive changes in their lives necessary for sustained behavior change. Individual sessions seek to reduce men's high-risk behaviors, promote fidelity and reduce their number of sexual partners, eliminate GBV, and increase men's participation in health services.

As part of the MAP® group education workshops in Tanzania, CHAMPION engaged key stakeholders in a rigorous adaptation to the country context of a 30-session global MAP® manual (ACQUIRE Project & Promundo, 2008). The manual was further adapted for use with mixed groups of men and women (rather than men only), based on the hypothesis that social transformation requires the exposure of both sexes to more gender-equitable attitudes. The finalized manual was then translated into Kiswahili.

CHAMPION selected nine nongovernmental organizations as local implementing partners and trained a cadre of 60 field facilitators (42 men and 18 women) to lead community MAP® workshops. Workshops were conducted twice a week for 2–3 months with mixed groups of no more than 25 male and female community members.[1]

Implementing MAP® in Communities

Facilitators implemented MAP® in 14 districts through a total of 231 community workshops. In all, 5,495 individuals (2,927 men and 2,568 women) completed a MAP® workshop. Throughout implementation, CHAMPION conducted MAP® refresher courses for facilitators to address previous workshop gaps and emerging issues. While MAP® was being implemented at the community level, CHAMPION held MAP® curriculum sensitization orientations with influential district, ward, and other community and religious leaders to foster an enabling environment for MAP® work.

SUMMARY OF FINDINGS

Support for Gender Equality

The workshop participants' beliefs regarding gender norms were assessed before and after the intervention using the Gender Equitable Men (GEM) Scale,[2] a 24-item scale measuring individual attitudes toward gender norms (Pulerwitz & Barker, 2008). CHAMPION supplemented the assessment with additional questions about HIV knowledge and attitudes. Comparisons of GEM scale responses from before and after the intervention showed that the workshops were successful in shifting individuals' attitudes toward gender norms in intimate relationships. An analysis of more than 200 questionnaires completed by adult male and female MAP® participants in Kinondoni District found that the proportion of participants reporting "high" support for gender equity increased by 15 percentage points, to more than seven in 10 participants (73%) (Table 1).

Qualitative data collected from 12 postintervention interviews support these findings. A number of participants felt that MAP® helped them better understand gender dynamics and inequities, prompting them to change their behavior. Many also reported feeling compelled to share MAP® messages with their peers and initiate further dialogue within their communities.

> *"Since the MAP® workshop, my relationship with my wife has improved. My understanding of being a man or a woman has changed. We now have a more equal division of roles, budget our money together, and use health services together. I can also now speak openly to my children, in-laws, and even religious leaders about HIV preventive measures such as condom use, which was not the case before. I can also now speak to university students who are more educated than me, but they pay attention when it comes to our dialogues on gender-based violence and healthy relationships."*
>
> —Emmanuel Jackson Mwailubi, Iringa Municipality

Pastor Sekelagha Lugano Kyamba, a MAP® graduate from Mbeya Urban District, expressed his appreciation that MAP® was different from other community-level interventions, motivating him to share MAP®'s messages with his congregation:

> *"Other HIV interventions just teach about causes and prevention, but MAP® addresses the root cause of the problem. If we deal with the patriarchal system, then we are sure to reduce HIV infection. I have already used my MAP® knowledge to counsel married members of my church and those about to get married. I have also organized a one-week MAP® workshop in my church, which was facilitated by a CHAMPION MAP® facilitator."*

Shifts in attitudes resulting from the MAP® workshop were most prominent relating to violence, household duties, and decision making. The number of participants who agreed with several

Table 1. Percentage distribution of respondents by support for gender-equitable norms, pre- and postintervention, Kinondoni District, Tanzania

GEM Scale Category	Preintervention (%)			Postintervention (%)		
	All (n=196)	Men (n=102)	Women (n=94)	All (n=196)	Men (n=102)	Women (n=94)
Low (24–39)	4	2	6	3	1	4
Moderate (40–55)	38	31	46	24	22	26
High (56–72)	58	67	48	73	77	70

Table 2. Percentage-point decrease in harmful gender norm attitudes among MAP® participants in Kinondoni District, postintervention	
Statement	Postintervention percentage-point decrease
A woman should tolerate violence in order to keep her family together.	14
If a woman cheats on a man, it is okay for him to hit her.	16
Giving the kids a bath and feeding them are the mother's responsibility.	19
A woman's most important role is to take care of her home and cook for her family.	19
A man should have the final word on decisions in his home.	20
It is a woman's responsibility to avoid getting pregnant.	22

inequitable gender attitudes measured using the GEM Scale decreased by 14–22 percentage points (Table 2). However, the percentage of participants reporting "low" support for gender equality preintervention remained relatively unchanged afterward. Women tended to agree more with gender-inequitable statements in the GEM Scale than did men both before and after the intervention, but women participants also showed more positive change in their GEM scores than male participants.

Gender Equity and HIV Knowledge

Chi-squared tests performed postintervention showed a statistically significant association between support for gender equity, knowledge of HIV transmission, and support for HIV testing ($p<.05$), confirming CHAMPION's premise that gender-equitable attitudes are positively associated with improved knowledge and attitudes concerning HIV.

Postintervention, 89% of men accurately reported that mosquitos could not transmit HIV, an increase of eight percentage points; 78% correctly reported that HIV infection could not result from witchcraft, up from 71% preintervention (Table 3). Following the intervention, 84% of the participants correctly identified that HIV infection could be prevented by being faithful to just one uninfected sex partner who has no other partners, up from 79% before the workshop.

Misconceptions about people with AIDS were high and remained largely unchanged. After the intervention, 64% of the participants believed that it is possible for a healthy-looking person to have AIDS, a slight decrease from 65% preintervention. This was also 16 percentage-points lower than the proportion of respondents in the most recent Tanzania HIV/AIDS and Malaria Indicator Survey 2011–12 (TACAIDS et al., 2013). Some attitudes related to HIV risk behavior were not so easily changed, including the belief that "women who carry condoms on them are easy" and "a man needs other women, even if things with his wife are fine." As a result, more attention could be given to sexuality in future interventions.

A CHAMPION-trained field facilitator leads a MAP® group education workshop in Mwanza Region.

RECOMMENDATIONS

Positive Reinforcement, Sustainable Change

Family, friends (especially other men), and perceived community norms heavily influence and reinforce men's attitudes and behaviors. To ensure that positive behavior change resulting from MAP® workshops is sustained, workshop participants need continuing acceptance, reassurance, and active encouragement to persist with the behavioral changes they have made in their daily lives.

Going forward, programs should encourage a subset of particularly engaged MAP® workshop champions to form community change clubs (CCCs) to serve as peer support networks after the intervention has ended. Facilitators should introduce this concept early in the workshop and prompt the formation of the CCCs midway through the workshop, once strong participants begin to emerge. This will allow adequate time to ensure that participant networks are formed and committed prior to the last session. Also, the project results showed that many participants still hold inequitable views on several GEM scale areas. Refresher workshops (possibly as part of the CCCs) would be important to help participants continue to progress in their reflections around gender equality.

Table 3. Percentage of men who correctly answered HIV/AIDS knowledge and attitude questions pre- and postintervention, Kinondoni District, Tanzania		
Common Measures	Preintervention (%)	Postintervention (%)
Knowledge of HIV prevention		
People can reduce their chance of getting the AIDS virus by having just one uninfected sex partner who has no other sex partners.	76	83
People can reduce their chance of getting the AIDS virus by using a condom every time they have sex.	79	82
Beliefs/misconceptions about HIV/AIDS		
People cannot get the AIDS virus from mosquito bites.	81	89
People cannot get the AIDS virus because of witchcraft or other supernatural means.	71	78

Future interventions should consider conducting a second postintervention interview with participants six months to one year after the workshop. A longitudinal approach that measures participants' knowledge, attitudes, and behavior over many years would be ideal, though funding challenges can make this impractical for most projects. Also, further research in this area is important, and it would be useful to look at how to ensure that evaluation methods are rigorous and can yield sufficient evidence.

Inclusion in MAP® of Women and Community Leaders

The CHAMPION Project was successful in recruiting nearly as many female as male (1:3) MAP® facilitators and participants. The project's mixed group adaptation of the original MAP® manual (intended to engage men only) enhanced the gender-transformative potential of the intervention and should be replicated in the future in a systematic way. This could also include adapting the MAP® workshops to promote discussion about femininity as well as masculinity and to look more at relational issues in regard to gender. In addition, offering influential ward, district, regional, and national leaders the chance to complete the MAP® workshop would further ensure that these key influencers understand, support, champion, and employ the concepts in their work during and beyond the workshops.

Expansion of Target Population to Include Youth

Though addressing harmful beliefs about gender norms among youth was beyond the scope of the project, future programs should consider taking a life-cycle approach to transforming beliefs about gender, equality, and health-seeking behavior. While targeting adults with MAP® messages is critical, children and adolescents often hold less rigid gender norms and are more open to change (Barker & Ricardo, 2006).

Parents participating in MAP® workshops should be coached to influence their children's attitudes and behaviors related to gender norms, because these attitudes are socialized from childhood. Future workshops should build the capacity of field facilitators to work with youth, conduct outreach with young people, and train them to form peer education groups, a model that has proved successful in other CHAMPION intervention populations.

To reinforce improved attitudes about gender equity and positive health-seeking behavior among youth resulting from youth-oriented MAP® workshops, projects should simultaneously work at the policy level to include in school curricula messages about gender equity. When the next curriculum review occurs, projects should be involved to ensure that stories and messages in textbooks emphasize gender equity and do not reinforce inequitable gender norms. Also, programming should look at how to promote gender equality throughout the school system.

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[1] All male and female community members selected to participate in a MAP® workshop participated as individuals and did not attend with their spouses.

[2] Participants were asked if they "agree," "partially agree," or "disagree" with each of the 24 GEM Scale statements, as well as supplemental HIV knowledge and attitudes questions. Each response was scored on a three-point scale where 1=agree, 2=partially agree, and 3=disagree. Individuals' responses to each item were aggregated to create a composite GEM Scale score.

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