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## Testing the effectiveness of the Men as Partners Program (MAP) in Soweto, South Africa

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# **Testing the Effectiveness of the Men as Partners Program (MAP) in Soweto, South Africa**

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## EXECUTIVE SUMMARY

This project was conducted to evaluate the effectiveness of the Men as Partners (MAP) program in South Africa in terms of: changing men's gender attitudes, norms and behaviors; changing aspects of gender dynamics in relationships; reducing the prevalence of unwanted pregnancy risk behaviors at individual and community levels; and increasing male involvement in GBV and HIV prevention and in HIV care and support activities. The study was conducted in collaboration with EngenderHealth and Hope Worldwide.

This study was implemented in several phases. Prior to introducing the intervention and undertaking the evaluation, a qualitative and quantitative diagnostic study was conducted. The main purpose of this formative research was to explore the socio-cultural context of and factors influencing the various forms of gender-based violence, sexual abuse of children, definition of masculinity and femininity, and risky sexual and reproductive health behavior. As part of the qualitative component, 14 focus group discussions were conducted with men and women across three main age groups (15–24, 25–34 and 35–54) and the interviews were split equally by sex. The quantitative component included a household probability survey in project areas with 2578 respondents (920 men and 1589 women).

The results of the quantitative community baseline survey confirmed the persistence of stereotyped perceptions of gender roles. For example, most of the respondents believed women should take care of the home and cook for the family and that men need sex more than women. Over half (55%) of the respondents had been sexually active in the last 12 months, and more than one-half of these have had more than one sexual partner (although less than half as many admitted having had sex with a non-regular partner during the period; partnership dissolution and multiple “stable” partnerships were high). A minority of respondents used condoms, and of those who did, even fewer used them consistently. However, over one-half of the respondents reported partner support for behaviors such as attending antenatal care and HIV voluntary counseling and testing (VCT). Moreover, a high proportion of respondents said they had discussed with their partners issues such as sex, contraception, HIV testing and child rearing. A lower proportion of female respondents than would have been expected reported having experienced slapping (18%), being hit with a fist or another object (10%) or being kicked or beaten up (9%).

The intervention activities that were implemented were MAP workshops, public demonstrations and participation in community action teams. To evaluate the interventions, interviews were conducted with workshop participants and their partners at the time they registered for the workshops and six months after they had ended. A total of 315 workshop participants and their partners were interviewed (202 men and 84 women) at the baseline, of which it was possible to follow-up 108 men and 30 women six months later as part of the endline survey.

The evaluation of the interventions showed that about 30% of the workshop participants had also attended other MAP activities or participated in community action teams (CATS). The workshop participants highly rated the workshops, particularly the facilitation by peer educators, and the fact that it had improved their knowledge of gender and HIV issues. As a consequence, men were more willing to accept joint decision-making with women, were more tolerant about women taking the initiative for condom use, were more knowledgeable about HIV transmission mechanisms and were more likely to support their partners during pregnancy. Some

respondents mentioned, however, that there was insufficient time for workshop activities, that some facilitators' style needed to be improved and that MAP workshops were not adequately advertised.

Other results showed that MAP workshops reached mainly younger men and the unemployed. While these are some of the key audiences, in some instances men could not attend MAP workshops for the full duration as they had to seek employment opportunities. It is recommended that future MAP activities should find ways of targeting older men when follow-up workshops are scheduled, and working men perhaps by conducting workshops during the weekend or considering other recruitment strategies. Also, MAP peer educators should find ways of retaining men and women for the full duration of the workshops to increase the impact of the interventions on both women and couples.

Several research and intervention challenges were experienced during the study. These included: a) change of project coordinators, b) high drop-out rates of female partners, potential contamination in control areas, locating female partners, no follow-up interviews in control sites, recruitment of workshop participants, implementation of intervention activities and lack of monitoring of activities. Despite these challenges, it was encouraging to note a number of positive and relevant changes among workshop participants. It is encouraging to note that despite varied levels of exposure and methodological and implementation difficulties that some important changes were observed within the high HIV context in South Africa.

## **ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
CATS	Community Action Teams
ARV	Anti-retroviral drugs
EAs	Enumeration Areas
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
MAP	Men as Partners
NGOs	Non-Governmental Organizations
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
STIs	Sexually Transmitted Infections
VCT	Voluntary Counseling and Testing



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## **BACKGROUND AND CONTEXT**

### **Links between Gender-based Violence and Reproductive Health/HIV/AIDS**

Gender-based violence<sup>1</sup> (GBV) is recognized as a health issue whose negative consequences go beyond women's health to the welfare of their children and family, and impacts on countries' economic and social structure. The World Bank estimates that at a global level, gender-based violence accounts for 5 percent of the healthy years of life lost (World Bank, 1993). There is increasing recognition of the relationship between gender issues and a range of adverse reproductive health including HIV outcomes. Studies have identified a significant relationship between indicators of gender inequalities and discussion of HIV and condom use (Jewkes R et al, 2003). Women's low power and high male control in intimate relationships is generally associated with increased HIV risk behaviors and HIV infection (Dunkle K, et al 2003). Two studies, both focusing on women accessing voluntary counseling and testing (VCT) for HIV services in Dar es Salaam (Maman S. et al, 2000) and Soweto (Dunkle K, et al 2003) found that HIV positive women were significantly more likely than women who were negative, to have experienced violence in an intimate relationship. In addition to its association with an increased risk of a range of physical and mental health problems such as acute physical injuries, depression, anxiety disorders, and substance use, gender-based violence impacts negatively on reproductive health of girls and women including maternal mortality (Mehta B., 2000) poor outcome of pregnancy and birth (Curry MA, et al 1998), gynecological morbidity (Schei B, et al 1989), and vulnerability to STIs, HIV (Martin S.L, et al 1999 and Dunkle K, et. al, 2003), non-use of contraceptives and unwanted pregnancy (Martin et al, 1999).

Although our understanding of the underlying factors that determine gender-based violence is limited, some studies have identified higher age (Schuler S R , et al), higher number of children (Michael A K et al, 2003), and higher level of education for women (Michael A K et al, 2003), as factors associated with a reduced risk of violence. Woman's and male partner's consumption of alcohol (Michael A K et al, 2003), perception that a male partner is likely to have been exposed to HIV (Michael A K et al, 2003), and woman's early age at sexual debut (Michael A K et al, 2003) are associated with higher risk of violence. Experience of child sexual assault and forced first intercourse are associated with increased risk of intimate partner violence and adult sexual assault by non-partner (Dunkle K et al, 2003). Studies in South Africa show that violence is strongly influenced by community norms regarding the use of violence to resolve conflict, women's challenge of traditional gender roles, and sexist attitudes among men (Jewkes R et al 2002).

In the last decade, this realization of the interplay between GBV and reproductive health outcomes contributed to the formulation of policies related to women's lives and international recognition of violence against women as a violation of their human rights as well as their sexual and reproductive health rights. In 1993, the United Nations General Assembly adopted the

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<sup>1</sup> We use the term GBV rather than "violence against women" to distinguish acts which are perpetrated against women because of their gender from other acts such as assault during robbery or parental/teacher assault, which may affect women but are unrelated to their gender; and to recognize that there is violence perpetrated by women against some men due to their gender and that has its roots in gender power relations.

Declaration on the Elimination of Violence against Women. Gender-based violence was broadly defined in this Declaration as “any act of gender-based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether in public or private life” (United Nations, 1993). This encompasses but is not limited to, “physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs” (Heise, L et al, 1999).

## **Prevalence of GBV in South Africa**

Similar to many countries in sub-Saharan Africa, South Africa faces high levels of both gender-based violence and negative reproductive health outcomes. The occurrence of rape is particularly high and South Africa is rated among countries with highest reported rape cases in the world (Kim J, 2000). The 240 incidents of rape and attempted rape per 100,000 women each year reported to the police “represents the tip of an iceberg of sexual coercion (Jewkes R et al, 2002).” Gender-based violence in South Africa takes place within the context of general high levels of violence both in the public and private domains. Media reports consistently suggest that South Africa ranks among the most violent countries in the world. The issue of sexual violence and violence against women in general is currently gaining considerable political importance and visibility.

Studies have come up with varying proportions of reported experience of different forms of GBV in South Africa. The 1998 South Africa Demographic and Health Survey (SADHS 1998) indicated that in the past 12 months, 19.2 percent of currently married women interviewed reported economic abuse defined as spouse/partners who have some resources regularly failing to provide money for food, rent or bills while having money for other things. During the same period, 6.3 percent had experienced physical assault by current or ex-partner and 3.7 percent by a non-partner in the last 12 months. Seven percent of women reported they have ever been forced or persuaded to have sex against their will by their current or ex-partner and 4.4 percent experienced rape<sup>2</sup>. Further, a comparison of different age cohorts suggests a steady increase in the proportion of women reporting having been raped before the age of 15 years. Women aged 15-19 years were almost twice as likely to report having been raped than those aged 20-24 years.

A provincially representative population-based survey of gender-based violence in three South African provinces (Jewkes R et al, 2001) found higher prevalence of physical abuse by an intimate partner in the past 12 months compared to the SADHS. Self-reported prevalence of physical violence by sexual partner was 10.9 percent in Eastern Cape, 11.9 percent in Mpumalanga and 4.5 percent in Northern (Limpopo) Province. A study among antenatal care

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<sup>2</sup> A follow-up validation study indicates significant under-reporting of both physical and sexual violence (SADHS 1998:94).

clients accessing voluntary counseling and testing (VCT) for HIV in Soweto (Dunkle K et al 2003) revealed even higher reported prevalence of different forms of GBV; 30.1 percent of participants reported being physically (25.5%) or sexually (9.7%) assaulted by a male partner in the last 12 months. Another 22.5 percent reported psychological (emotional and/or financial abuse) only.

In a study of men in Cape Town, 69 percent reported having used some emotional tactic against their sexual partner, and 15 percent said they tried to rape or actually raped a wife or girlfriend during the previous 10 years. The baseline survey results from the on-going Stepping Stones intervention trial in Umtata in Eastern Cape reveal that in the past 12 months, 41 percent of young men aged between 16 and 30 years<sup>3</sup> reported that they had inflicted physical violence on their intimate partners. Attitudes in support of different forms of GBV are high both among men and women in South Africa. In a study based in Johannesburg, 40 percent of men interviewed held the attitude that it is okay for a man to punish his wife through some form of physical or psychological abuse (CIET). In the same study, 27 percent of female youth expressed the attitude that “forcing sex with someone you know is never sexual violence”.

## **HIV and STIs Situation**

Both STIs and HIV are major problems in South Africa with a reported annual incidence of 11 percent or 4-5 million new STI cases annually, among adults and a national HIV prevalence of 15.6 percent among persons aged 15-49 years and 5.6 percent among children aged 2-14 years (Mandela N 2002) in 2001. The Nelson Mandela/HSRC study of HIV indicates a prevalence of 17.7 percent among women, while the Department of Health 2002 antenatal survey indicates a national prevalence of 26.5 percent among antenatal mothers with KwaZulu-Natal province having a high of 36.5 percent.

Low uptake of voluntary counseling and testing (VCT) for HIV and behaviors to prevent Mother to Child transmission (MTCT) of HIV such as the use of antiretroviral (ARV) drugs and appropriate infant feeding options; multiple sexual partnerships, low and inconsistent condom use are some of the factors associated with the high STI incidence and HIV prevalence. Studies have demonstrated the effectiveness of VCT (Coovadia HM, 2000) as a HIV prevention and control strategy and effectiveness of antiretroviral therapy (Zidovudine and Nevirapine) in the prevention of MTCT of HIV. The PMTCT program in South Africa is just emerging from its pilot phase. The Department of Health (DoH) has introduced the provision of Nevirapine to HIV positive pregnant mothers in public hospitals. Currently DoH is expanding provision of VCT services by increasing VCT centers in the provinces.

## **Risky Sexual Behavior**

In South Africa multiple sexual partnerships are high, particularly among men. The Nelson Mandela/HSRC study indicated that of those who had sex in the past 12 months, 13.5 percent of males and 3.9 percent of females aged 15 years and above had more than one sexual partner and youth aged 15-24 years (23% male and 8.8% females), were more likely to have had more than one partner. Less than one-third of males (30.3%) and females (24.7%) used a condom during

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<sup>3</sup> Results from baseline data analysis were communicated verbally by the principal investigator, Rachel Jewkes.

their last sexual intercourse and significantly higher proportions of youth (15-24 years) used a condom during their last sex (57.1% males and 46.1% females) (Mandela N 2002).

## **Gender Norms and Male Involvement**

Gendered cultural role definitions largely account for male behavior that contributes to the public health problems described above, and to lack of male involvement in key sexual and reproductive health/HIV areas. The unequal balance of power between women and men, which has its roots in gender norms and role definitions, contributes to male vulnerability to HIV and STIs. HIV/STI risk behaviors in men are condoned and encouraged. A number of studies conclude that contemporary gender roles encourage men to equate risky behavior with manliness and, conversely, to regard health seeking behaviors as “unmanly” (Courtenay, 1998). Traditional gender roles “limit men’s options regarding how they can behave, put “stress and strain on men,” encourage “more sexual partners and sexual activity,” promote “beliefs that sexual relationships are adversarial,” and lead to “more negative condom attitudes and less consistent condom use” (Noar SM et al, 2001). Expectations that men are self-reliant, sexually experienced, and more knowledgeable than women inhibit young men from seeking information about sex and protection against infections or admitting their lack of knowledge for fear of undermining their manhood (UNAIDS 1999).

Lack of male involvement in pregnancy and antenatal care and in PMTCT programs have been identified as major bottlenecks to effective program implementation (Horizons, 2002)<sup>4</sup>. Involvement of men in AIDS care and support activities is low (Nqobile Mavimbela et al, 2003). Dominant social norms create the expectation that pregnancy and antenatal care are women’s domain and that women will assume the burden of responsibility for taking care of family and community members weakened or made ill by HIV/AIDS. It is clear that women’s health is compromised in a myriad of ways by contemporary gender roles and norms that grant men power over women and condone GBV and consequently compromise women’s and men’s ability to protect themselves from HIV and other STIs.

## **EngenderHealth’s MAP Program: Addressing Both GBV, RH and HIV**

The interrelationship between GBV and negative sexual and reproductive health outcomes, as well as the high prevalence of both GBV and negative sexual and reproductive health outcomes in South Africa clearly indicate the need for programs that simultaneously address both problems. Spurred by the recognition that men’s attitudes and behaviors can either impede or promote sexual and reproductive health, many sexual and reproductive health organizations across the world have launched initiatives to encourage positive male involvement.

In South Africa, in 1998, EngenderHealth initiated a *Men As Partners (MAP)* program with a local partner, Planned Parenthood Association of South Africa (PPASA). The purpose of the MAP program was defined in two ways: (i) to challenge the attitudes, values and behaviors of men that compromise their own health and safety as well as the health and safety of women and children; (ii) and to encourage men to become actively involved in HIV/AIDS related

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<sup>4</sup> Personal communication with Edward Phillip, National Programs Manager, Hope Worldwide, South Africa.

prevention, care and support activities, and in preventing GBV. EngenderHealth has applied lessons learned during the initial implementation to build new working relationships with other South African Non-governmental organizations (NGOs).

Since its inception, the MAP program has conducted educational workshops with groups of men in a wide variety of settings and from many walks of life: workplaces, trade unions, prisons, faith-based organizations, community halls, and sporting arenas. The EngenderHealth MAP Program is based on a gender and human rights theoretical framework. The MAP program is based on three principles, each related to an understanding of the many negative ways in which the unequal balance of power between men and women plays itself out.

Firstly, contemporary gender roles are seen as often having devastating health consequences for women, placing them at risk for violence, limiting their ability to negotiate the terms and conditions of sex, and severely compromising their sexual and reproductive health including increasing their vulnerability to HIV/AIDS and placing the burden of care and support for people living with AIDS squarely on women's shoulders. In this analysis, gender roles confer on men the ability to influence and/or determine the reproductive health choices made by women, whether these choices are about utilization of health care services, family planning (Obisesan, K et al 1998), condom usage or sexual abstinence (Horizons 2001).

Secondly, contemporary gender roles are viewed as also compromising men's health by encouraging men to equate a range of risky behaviors – the use of violence, alcohol and substance use, the pursuit of multiple sexual partners, the domination of women – with being manly, while simultaneously encouraging men to view health-seeking behaviors as a sign of weakness. Such gender roles leave men especially vulnerable to HIV/STI infection, decrease the likelihood that they will seek HIV testing, and increase the likelihood of contributing to actions and situations that could spread HIV infection and other STIs.

Thirdly, men are seen as having a personal investment in challenging the current gender order both because it is in their health interests to do so, and also because they often care deeply about women placed at risk of violence and ill-health by these gender roles.

## **STUDY PROBLEM**

There is little understanding of the effectiveness of intervention models that seek to transform gender relations, reduce gender-based violence and improve reproductive health in South Africa. Stepping Stones, a behavioral intervention to prevent HIV transmission that is widely used in sub-Saharan Africa was adopted for South Africa in 1995. This model is based on exposing female and male community groups to a curriculum covering gender issues, gender-based violence, sexuality, and reproductive health knowledge, attitudes and behavior, and developing assertiveness skills through workshops.

The EngenderHealth MAP project is different from the Stepping Stones in the sense that it focuses mainly on men. Although EngenderHealth has conducted an evaluation of the degree to which the knowledge and attitudes of workshop participants change, these evaluations have rarely assessed the effectiveness and impact of this model in achieving both GBV and SRH/HIV

behavior-change goals. Further, although the MAP Program has been adapted for the South African context, there has not been a systematic effort to analyze the knowledge, beliefs and practices of the target population to inform and improve it for local use.

## **OBJECTIVES**

The ultimate objective of this study is to provide program managers, policy makers and donors with information to guide the design and implementation of integrated gender and reproductive health/HIV/AIDS programs and policies. Specifically, the study aims to:

- (1) Determine and document factors associated with gender-based violence in the specific socio-cultural and economic context of South Africa by conducting a formative diagnostic study of beliefs, attitudes and behaviors related to gender roles, sexual, contraceptive and HIV protection behaviors, and partner communication and interaction on sexual and reproductive health.
- (2) Assess the effectiveness of male involvement behavior change communication strategies in:
  - a) Changing men's gender attitudes, norms, and behaviors
  - b) Changing aspects of gender dynamics in relationships
  - c) Increasing male involvement in prevention of GBV and in HIV prevention, care and support activities.

## **METHODOLOGY**

### **Formative Diagnostic Study of Gender and Sexuality Related Perceptions**

The study included both qualitative and quantitative components, the procedures for which are described below.

#### ***Qualitative Component***

As part of the larger evaluation of the MAP program, CASE, a local research organization, was commissioned by FRONTIERS to conduct an initial qualitative formative study to explore local meanings of gender, various forms of gender-based violence as well as reproductive health practices. This was carried out in 21 townships in Soweto where no MAP activities had been conducted. The specific objectives of the formative research was to identify the socio-cultural context of and factors influencing the various forms of gender-based violence, sexual abuse of children, definition of masculinity and femininity, and risky sexual and reproductive health behaviors. The study also aimed to determine factors which encourage or discourage male involvement in HIV and reproductive health services as well as to investigate the nature and coverage of HIV, reproductive health and gender based violence related services in the communities under study. The feasibility of implementing a program aimed at targeting men in the communities was also explored and included the willingness of key stakeholders, opinion

leaders and community members in providing support to the project and for men to participate in activities targeting them.

The qualitative component included 14 focus groups discussions (two each with males aged 15-24, 25-34 and 35-54 and two each with females of the same age groups) as well as two male-female groups with community and opinion leaders such as teachers, health professionals and elected councilors. Each group had between 8 and 12 participants. In total, 143 people participated in the focus group discussions. In addition, a total of 20 in-depth interviews were conducted in the same sites in Soweto and interviews were split equally by sex and age. The interviews were conducted with male and female community and opinion leaders such as religious leaders, police, health activists and business people. Almost all the respondents that participated in the formative study were black African with the exception of a Colored male in the 15-24 years group and an Indian male in the 25-34 years group. The majority of the respondents were unemployed and had lived in Soweto most of their lives.

CASE and FRONTIERS staff conducted a one-day training session with the interviewers and the focus group moderators. The focus of the training was on moderating and interviewing skills, responsibilities of each role and ethical procedures. The focus group discussions and in-depth interviews were conducted in the preferred language of the respondents and were then transcribed and translated into English. The formative research laid the foundation for the intervention and informed the strategic project design and the development of the survey questionnaire.

### *Quantitative Component*

A community baseline survey was conducted in 2004 and was designed to provide community level data on the perceptions and attitudes related to gender dynamics, gender roles, risky sexual practices of the respondents and HIV prevention. This survey was carried out in 32 townships in Soweto, Gauteng Province: Chiawelo Ext 3, Dlamini, Diepkloof gender dynamics (Zones 1, 3, 4 and 6), Dube, Emdeni, Jabavu, Jabulani, Klipspruit and Klipspruit Extension, Kliptown, Mapetla Zones 1 and 2, Meadowlands (Zones 5 and 6), Molapo, Moletsane, Moroka, Mofolo (South, Central and North), Naledi (Ext 1 and Ext 2), Orlando (East and West), Phiri, Pimville (Zone 6), Protea Glen, Senaone and Zondi.

To estimate the sample sizes we used a four-stage random probability selection process in which the 2001 census zones were first selected to then select enumeration areas, households and individuals within household with more than one eligible respondent (i.e., men and women 15 to 34 years of age). The sample was designed with the assistance of Statistics South Africa (SSA), a local professional provider.

Separate sample sizes were estimated for men and females taking as a reference the variations in prevalence of the key indicator of interest for each sex. In the case of women aged 15-34, the indicator used was the proportion of women that said that forcing sex with someone you know is not sexual violence (27%). The sample size was also estimated considering that an endline would be conducted to assess the effects of the interventions on community inhabitants in target areas and considering the need to determine a 30 percent reduction in prevalence of this attitude, an 80 percent power for detecting the reduction and five percent significance level, a sample size of



1072 women in 16 clusters for each the intervention and control areas were determined<sup>5</sup>. In practice, an 83% response rate was achieved and a total of 1,534 women 15 to 34 years of age were interviewed in the community sample.

To estimate the sample size of men we used the proportion of men (40%) who said that a man can use violence to punish his wife and the same assumptions used to calculate the women's sample. We arrived at a sample size of 16 clusters and 560 men in each study domain. Correcting for a 15 percent non-response rate, the final male sample was 40 men per cluster, 640 per domain and a total sample of 1,280 men. In practice, the response rate was 80% and the total number of interviews conducted was 902.

Semi-structured questionnaires were developed to collect information on gender attitudes and norms; a gender-based violence attitude scale; sexual experience and prevention of STIs and HI; pregnancy, children and access to voluntary counseling and testing for PMTCT; partner and relationship control; intimate partner violence and coping; sexual violence perpetrated by a person other than an intimate partner and coping; sexual abuse, knowledge about HIV/AIDS, STIs and access to HIV testing; participation in care and support and prevention of HIV/STIs and violence against men, women and children.

Regarding the ethical procedures, the moderators and interviewers were trained on how to solicit informed consent, explaining the risks and benefits of the study and maintaining confidentiality. All focus group participants and individual in-depth interview respondents were informed about the nature and purpose of the study and were required to sign a consent form. In the case of minors<sup>1</sup>, informed consent was obtained both from the parent and the participant. The participants were also asked to give their signed consent for the discussion or interview to be tape-recorded.

## **Workshop Evaluation: Pre and Post Workshop Participant Survey**

*Design:* In order to evaluate the impact of workshops on the participants' beliefs, attitudes and behaviors, we used a non-experimental design with interviews with workshop participants before and after the intervention<sup>6</sup>.

*Sample and Data Collection Procedures:* Hope Worldwide field staff recruited workshop participants in the 16 intervention townships in Soweto by conducting special events, like distribution of condoms or placing information booths, and inviting men who seemed to be eligible to attend the workshop. The eligibility criteria to be study subjects included: (i) age

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<sup>5</sup> Originally it was proposed that the study use a before and after design with control and intervention groups in order to assess the effects that the MAP activities had on community beliefs, intentions and behaviors. However, due to the implementation problems discussed ahead, the endline study was never conducted and the objectives of the study were changed accordingly. Thus, the resulting sample is of a size to comfortably estimate the true parameters related to the beliefs, attitudes and behaviors of the communities in the 32 townships in Soweto included in the sample. The same is true of the sample of men.

<sup>6</sup> Originally it was proposed to use 16 townships as an experimental area and 16 townships as a control area, so as to have a true experimental design with measurements before and after the intervention and a control group. However, the endline survey was not conducted because of the problems to implement the intervention explained later.

between 15-34 years; (ii) in a steady heterosexual relationship with a partner living in Soweto; (iii) residing in the intervention sites; (iv) was to be in Soweto for a minimum of 12 months from the date of the workshop; (v) and willing to participate in the workshops and for his partner to be interviewed. Considering a 20 percent loss to follow-up, it was planned that a sample of 160 men and 160 female partners would need to be interviewed before workshop participation, and 12 months after in each of the intervention and control areas.

A small questionnaire to determine their eligibility as study subjects was applied to all those that attended the workshops during the first workshop session, either before the beginning, during a break or at the end of the sessions. In the baseline, a total of 286 valid interviews with eligible respondents (202 men and 84 women) were achieved (see Table 1).

Female partners could only be interviewed provided the male respondent agreed to have his partner involved. The females would be contacted once the male partner agreed to the interview and appointment was made. The interview was conducted either at her house or in any other place she preferred and that allowed for the confidential exchange of information. The planned recruitment of 160 female partners pre-intervention into the study was not achieved due to: a) rejection of the female partner of the interview; b) the relationship had broken-up since the male partner had been interviewed or the woman said she had never had a relationship with him; c) some male participants provided incorrect contact details of the female partner. Taking into account the planned sample of 160 female partner interviews in the pre-intervention, the female sample shortfall was 47.5%.

**Table 1: Number of Pre and Post Workshop Valid Interviews by Sex**

Period	Sex of Respondent		
	Men	Women	Total
Pre-Intervention	202	84	286
Post-Intervention	124	39	163
Matched Pre-Post Interviews	108	30	138

To conduct the endline survey, four interviewers and one Hope Worldwide supervisor received four days of training. Participation criteria for follow up for the respondents had to be amended to take into account high rates of partner change and to ensure that female partners interviewed would have been in a relationship with the male for at least a period of six months. In tracking the respondents, interviewers made first contacts with the male respondents, who were requested their consent before contacting his partner.

A follow-up rate of over 56% (n=178) was achieved at a 12-month post intervention (137 were males and 41 were females). Of these, 15 were excluded from the analysis (6 were refusals, 6 wrong addresses; one mentioned that he did not attend MAP, one mentioned that the relationship ended and one had relocated). This left a total of 163 completed interviews, for a 57% effective follow-up rate. Of these 76% (n=124) were males and 24% (n=39) were females. It was further found that there were a number of individuals who were interviewed post-intervention for which there was no pre-intervention data collected. In the end, only 108 men and 30 women could be paired pre and post intervention, implying that there was a loss to follow-up of about 50%. Due to the low follow-up rate of the female respondents, the results on key variables for the female

respondents' cannot be generalized and will not be reported. Therefore, the results on key variables will be reported only for the men that could be paired (n=108).

*Ethical Procedures:* As in the case of the community surveys, all survey respondents were informed about the study objectives, procedures, benefits and risks. They were informed that violence issues would be discussed during the interview and asked if they are concerned that this might put them at risk. Interviewers were trained on putting the participant at ease when asking sensitive questions and the need to maintain confidentiality. As part of providing support, interviewers were required to provide telephone contacts for violence counseling agencies within the city for further support. Respondents were also assured they had the right to stop the interview at any point in time and that they could refuse to answer any or all of the questions, even after consenting to participate in the study. For respondents aged 15-17 years, parental or guardian consent to interview was first sought before the individual adolescent's consent. There was no compensation to respondents for participating in the surveys. All data was stored, analyzed and reported in formats that would not allow identification of the individual participants.

*Data Collection Instruments:* The questionnaires used to evaluate the workshop were the same than those used in the community survey with modifications to incorporate in the endline data on the participants' exposure to the interventions.

*Data Analysis:* The data was analyzed using paired-wise t-tests. Because of the small number of women that we were able to follow up, we only present the comparison of the answers given by males before and after the workshops.

## **Characteristics of the Interventions**

Two types of activities were conducted as part of the MAP program implemented by Hope Worldwide, with technical assistance from EngenderHealth, in the 16 intervention communities: training men through workshops and community mobilization, sensitization, education and advocacy activities.

### **Training Men through Workshops**

Hope Worldwide field staff recruited workshop participants by conducting different activities, such as distribution of free condoms and information booths, and invited those that seemed to meet the eligibility criteria to attend the workshops (although this criteria was not formally assessed until the participants presented them to the workshops). Hope also visited different community-based organizations (clinics, churches, soccer clubs, health care providers, schools) in the intervention areas and asked them to promote attendance to the workshop.

The first step to implement the workshops was identifying and training community peer educators to facilitate the workshops. These peers were trained on the MAP Manual and on conducting workshops to ensure smooth and consistent delivery of the MAP principles, such as handling and dealing with groups, issues of interaction with participants and facilitation. Of the fifteen peer educators that were trained by Hope Worldwide, only the ten with the best skills

were hired to facilitate the workshops. Three consultants from EngenderHealth assisted these peers with coordination of the workshops, supervision and compilation of monthly reports.

It was planned that each of the 16 intervention areas would have a minimum of 4 MAP workshops per year during the 2 years of project implementation, i.e., 64 workshops each year or 128 workshops during the two year project, each with an average of 30 participants. However, implementing the workshops proved more challenging than had been planned and only 51 workshops with 1,479 participants were conducted during a period of nine months in the first year of activities (due to financial constraints, HOPE did not implement the second year of activities.) A total of three townships in the intervention areas received 4 workshops as planned; another three sites received only three workshops, five other sites received two workshops, whilst another five townships received only one workshop.

Although the workshops were supposed to take place only with men, several partners of the invited men requested to attend the workshop and several local organizations started referring women interested in them, so a modified version of the workshop was offered also for women. Of the 1,479 persons that attended the workshop, 989 were men and 490 were women. Because this project was focused on the effects of these workshops on males, in the rest of this document we discuss the results achieved by the workshops among the 989 male participants.

Of those who attended the workshops, 481 men and 233 women completed the 4-day workshop, giving a dropout rate of a little more than 50%. This indicates that there is a need either for establishing more stringent eligibility requirements to insure that those that register for the workshop attend the full four sessions, or else, to reduce the length of the workshop to make it easier for a larger proportion of the people to attend all the sessions. Some the reasons identified for them not attending the four sessions were that several participants were job hunting and needed to use whichever opportunity that was presented to them, and the lack of a suitable place to conduct the workshop sessions in Kliptown, an informal settlement with a lot of corrugated iron houses that are dense and where there are no public areas like a community centre or church building. Also, by the middle of the study, peer educators were beginning to show signs of burnout, and there was a need to train more of them. However, since the second year of activities was not implemented due to the financial constraints, this was not done.

MAP topics and exercises that were covered in the workshops included the following: why work with men; positive male role models; gender values clarification; healthy and unhealthy relationships; violence clothes line; violence in the daily routine; HIV handshake (a group exercise to generate discussion on HIV transmission); personal impact of HIV; power and gender; gender fishbowls; defining rape; types of violence; and sexual rights and responsibilities.

## **Community Mobilization, Sensitization, Education and Advocacy Activities**

In the MAP Program, workshops are expected to be complemented by a variety of community mobilization, sensitization and advocacy activities. To enable fieldworkers and volunteer participants to conduct field activities, meetings were held with the City of Johannesburg Health Department and with 32 community stakeholders in the 16 intervention areas to introduce the surveys and the characteristics of the intervention and to request their assistance in conducting these activities. We also advised them about other community mobilization and advocacy

activities that would be planned and that they would be invited to participate in. Input was sought from these stakeholders on the proposed interventions and the best way to implement them. Over 90% of these initial meetings led to a workshop that the stakeholders helped to organize.

In general terms, the MAP Program advises to recruit workshop attendants to become volunteers in community mobilization and education activities. On the last day of the four-day workshop, participants are invited to form Community Action Teams (CATs). Seven CATs were formed at Moletsane, Chiawelo, Moroka, Jabavu, Diepkloof, Dobsonville and Jabulani. In Moletsane, Jabulani and Moroka), these CATs sought to raise awareness on HIV, GBV, drug and alcohol abuse as well as crime in their localities through individual interaction with friends and distribution of IEC materials on special occasions, such as World Aids Day in Moroka. Other community mobilization and education activities included the organization of a beauty pageant in Jabulani, where they included short messages for the audience on drug and alcohol abuse as well as STIs and HIV, and the organization of a sports day in Moletsane, which was attended by 179 men. During the event, local community leaders addressed the community members on HIV and domestic issues and we distributed HIV and STI brochures and other educational materials.

Finally, men from six of the intervention townships (Moletsane, Meadowlands Zone 5, Kliptown, Chiawelo Ext 3 and Pimville) attended a 700-strong Men's March arranged by the implementers in collaboration with the MAP Network, South African Men's Forum and Commission on Gender Equality, with a theme "Not in My Name". The aim of the march was to raise awareness about Violence against Women and Children as well as to provide a space for men to raise their views. This march conveyed a strong message to all the inhabitants in these townships about the unacceptability of domestic violence in their communities.

## RESULTS

The results are divided into three main sections: a) results of the qualitative findings on the feasibility of introducing strategies on male involvement, b) quantitative results on gender and sexuality related perceptions in communities; and c) the evaluation of the impact of workshops on their participants.

### Results of the Formative/Diagnostic Study in Communities

#### *Qualitative Findings on the Feasibility of Introducing Strategies on Male Involvement in Reproductive Health*

In this section, we present the results of the qualitative study that refer to issues related to the design and implementation of the MAP Program. Results referred to substantive issues related to gender norms and decision making, gender-based violence, contraceptive use and sexuality, HIV/AIDS and STI prevention and treatment and the like are presented in the following section to complement the quantitative findings and provide a better explanation for the reader.

One of the main purposes of the qualitative study was to assess the perceptions of community inhabitants about the introduction of strategies to involve men in reproductive health issues. Several informants pinpointed the difficulty of mobilizing men into action for RH and GBV initiatives. Most people only had vague ideas about how an intervention targeting men could be set-up. It was generally accepted that it is easier for women to come together for a joint cause than men. In one interview, the participant suggested that it would be good to bring men together and talk to them about gender issues but one would have to use an existing structure (e.g. meetings on services or rent) as an entry point.

An important observation made was that gender plays a role in determining who is likely to participate in the intervention. A male youth mentioned that it is the “*fatherly types*” (i.e. men who exhibit gender egalitarian behavior) who tend to participate in community initiatives. This is a useful observation given that the project would then run the risk of reaching mostly the men who would benefit the least from the intervention; it also underlines the need to develop innovative strategies to reach and motivate the participation of the more conservative men who would benefit from the intervention.

The idea that reproductive health and HIV is more of a “*woman’s issue*” emerged at the start of the discussions on puberty and physical development. The participants were asked to describe what they understood by the term reproductive health. For some, reproductive health was synonymous with “*women’s health*” because it is mainly concerned with maternal and child health. This shows that the workshops and community activities need either to include a full explanation of reproductive health or else to refer to the separate components of reproductive health (i.e., family planning, prenatal care, STI prevention and treatment, others) as needed.

Another obstacle that the participants identified for active participation of males in the program was the stigma concerning HIV/AIDS. A female respondent who belonged to a home-based care program in her community mentioned that there were only two male members in this group and she attributed this to a combination of stigma around HIV and also the perception that HIV/AIDS/RH activities are best suited for women. The inclusion of men in reproductive health

would therefore require a good measure of mindset changing to demonstrate that their involvement could have positive outcomes for their own health as well the health of women and children.

Other barrier to male participation that was identified was the denial or minimization of the severity of gender-based violence and other problems. Men would not be involved in an intervention if they did not recognize that a problem exists in the first place. The preoccupation with other “manly” activities such as work, drinking in shebeens, stokvels or sports means that men have little time for engaging in reproductive health issues. This in a way reveals the low degree of importance assigned to these activities.

Individual circumstances such as unemployment and poverty were also mentioned as possible obstacles.

*“And the other thing is that a man cannot participate in community affairs, especially if he knows that he does not have food at home.” (Male, 35-54)*

Respondents were asked their opinions about how these perceived barriers could be tackled and what strategies they thought would work in targeting men. Educational workshops combining drama and entertainment with education to debunk some of these myths on men’s participation were recommended as a useful starting point. Secondly, it was suggested that it was important that an intervention targeting men should be run by men, because potential participants would take the program seriously only if other men led it.

Role models, peer pressure and positive examples were mentioned as factors that could influence male participation either positively or negatively. For example, men who have positive attitudes concerning male involvement could encourage their peers to go for voluntary counseling and testing (VCT) or discuss and encourage them to practice safe sex. Another example mentioned here was the use of role models such as sports stars to give talks to men about the negative aspects of GBV and to promote safe sex behavior. Concerning HIV/AIDS prevention, it was felt that the mobilization of willing HIV positive men to give talks to other men in the community would greatly encourage risk reduction. To address GBV, men could play a greater role in protecting women by forming community groups to investigate and collectively address it. All these imply concrete advice for programs seeking to change attitudes and behaviors in community, concretely to recruit peer educators and use admired sport and other model figures to display the desired attributes.

It was suggested that the MAP intervention consider targeting youth who might be more open to change and use them to set an example to the older people in the community. Service providers also have an instrumental role to play in sensitizing men about where and how to participate, for example by demonstrating what men can do to assist a woman in labor or how to care for an HIV positive person.

Although male participation specifically in PMTCT was not discussed in detail, this is one area of RH where men have a vital role to play because the essential components of PMTCT such as access to antiretroviral treatment (ART), prevention of unwanted pregnancy among HIV positive women or formula feeding would require women to have some consent and/or support from their male partners. Drawing from the general discussions on male involvement in RH and GBV, it

was evident that there is room to integrate men in PMTCT provided that the programs address the stereotypes highlighted earlier and also educate men on how they can get involved. For example, some men indicated that they would be willing to accompany their wives to family planning clinics but were fearful about the community's interpretation of this.

### ***Results of the Quantitative Component – Community Baseline Survey***

The majority of both male and female respondents had secondary level of education and unemployment was high (see Table 2). Most respondents were in a regular relationship and only a small proportion was married. The mean age of both male and female respondents was 23.6 years. Most pools of respondents were largely unemployed.

**Table 2: Socio-demographic Characteristics of Respondents by Sex in 32 Townships in Soweto**

Characteristics	Sex	
	% Men n=902	% Women n=1534
<b>Age</b>		
15 – 19	27	28
20 – 24	30	31
25 – 29	24	24
30 – upwards	19	17
<b>Level of Education</b>	<b>n=888</b>	<b>n=1512</b>
Primary (grade 1-7)	6	3
Secondary (grade 8-12)	76	80
Post Matric (university, technikon)	18	17
<b>Employment Status</b>	<b>n=713</b>	<b>n=1177</b>
Self-employed	6	2
Employed (full, part, casual)	35	25
Doing some training / schooling	8	7
Unemployed	51	66
<b>Relationship Status</b>	<b>n= 853</b>	<b>n= 1478</b>
Married	5	6
A regular partner	72	73
Currently no partner	5	7
Never had a partner	13	13

### **Gender Egalitarian Attitudes and Behaviors**

Stereotypes about male and female appropriate roles still hold. About two-thirds of both men and women believe that the most important role for a woman is to take care of her home and cook for her family and those activities such as changing diapers and feeding the children is the mother's responsibility (see Table 3). However, although there are significant differences between men and women in beliefs regarding decision making at home, less than half of the respondents of both sexes held what could be the most traditional beliefs and attitudes, such as that a man should decide what type of sex to have or have the final word about decisions at home. One of



the most startling results are the high proportion of women and men alike that hold perceptions that support multiple sexual liaisons, like the view that men need other women sexually even if sex with his wife is fine, and that men need sex more than women do (a belief significantly more common among men.) Nevertheless, only a minority of respondents of both sexes held negative views about the use of condoms in intimate settings or showed a high tolerance for intimate partner violence.

**Table 3: Respondents' Gender Related Beliefs and Attitudes**

Gender Related Beliefs and Attitudes	Men % Agree	Women % Agree	P-Value
	(n=920)	(n=1589)	Men vs. Women
<b>Performance of household tasks</b>			
A woman's most important role is to take care of the home and cook for her family	77	75	0.352
Changing diapers, giving the kids a bath and feeding the kids are the mother's responsibility	71	69	0.388
<b>Decision Making Attitudes</b>			
It is a man who decides what type of sex to have	37	29	<0.001*
A man should have the final word about decisions at home	50	34	<0.001*
<b>Norms on Men and Sex</b>			
A man needs other women sexually, even if sex with his wife is fine	48	51	0.373
Men need sex more than women do	53	63	<0.001*
You don't talk about sex, you just do it	19	16	0.107
<b>Norms on Condom Use</b>			
I would be outraged if my partner/husband asked me to use a condom	25	21	0.125
Women who carry condoms on them are easy	36	24	<0.001*
<b>Attitudes regarding Sexual Coercion and Rape</b>			
A woman should tolerate violence in order to keep her family together	18	17	0.525
It is okay for a man to hit his wife if she refuses to have sex with him	6	5	0.602
If a man has paid <i>lobola</i> (bride wealth), he has the right to have sex with his wife any time even when she does not feel like having sex	10	8	0.183

Given this, the MAP program would need to underline contents to debunk the myth that men have a greater need for sex that provide a quasi-biological justification for having multiple sex partners and to present home-making and care for the children as a dual responsibility. The program already includes contents regarding most of these differences.

## Partner Control in Intimate Relationships

Table 4 shows that among those respondents that are in a relationship, men had a tendency to be significantly more jealous and suspicious than women of the interactions that the partner has with persons of the opposite sex. Even though they are not the majority, a sizable number of respondents seem to feel uncomfortable when the partner greets persons of the opposite sex and when they make an effort to have an attractive appearance. Also, a minority but important proportion of both men and women display control-oriented behaviors such as expecting the partner to always be at home when they arrive, wanting to know always where the partner is, seeking that the partner does what he or she wants him/her to do, preventing the partner from seeing friends or relatives and the like. A surprising result was the significantly larger proportion of women than men who felt they could leave the relationship with the partner anytime they wanted to. This could be linked to the high levels of unemployment that were identified in the sample.

**Table 4: Perceptions about Partner Control in Intimate Relationships**

Control-Related Perceptions	Men % Agree	Women % Agree	P-Value
	(n=805)	(n=1387)	Men vs. Women
Is quite comfortable when I greet women / men I know	75	66	<0.001*
Expects me to be at home when she / he comes	60	60	0.341
Becomes jealous when I wear things that make me look too handsome / beautiful	36	48	<0.001*
I could leave our relationship anytime I wanted to	38	49	<0.001*
Does what she/he wants even if I don't want her to	27	27	0.688
When we disagree, she gets her way most of the time	25	29	0.058
Always wants to know where I am	64	62	0.221
Tries to keep me from seeing friends	23	22	0.499
Tries to restrict contact with my family of birth	12	13	0.588
Is often suspicious that I am unfaithful	41	32	<0.001*
Expects me to ask permission before seeking health care	8	10	0.107

## Sexual Practices and STI/HIV Risky Behaviors and Prevention

### *Respondents Sexual Behavior*

A high proportion of both men and women had been sexually active in the past twelve months. Of those that had ever had sex, the majority (93% men and 79% women) indicated that they were willing to have sex during their first encounter. However, 13% of the women reported that they were sweet-talked into sex, while reported 4% being raped. The mean age at first sexual debut was 16.4 years. Male respondents (46%) stated that they had their first sexual experience with female partners five or more years younger than them. Female respondents (61%) confirmed that their first sexual experience was with partners older by 5 years or less.

Table 5 shows that of those respondents that were sexually active, interestingly more women than men reported having more than one partner in the last six months ( $p < 0.001$ ). However, men were more likely than women to have sex with a casual partner in the last year ( $p < 0.001$ ).

**Table 5: Respondents' Sexual Behavior**

	Men % Agree	Women % Agree	P-Value Men vs. Women
	(n=920)	(n=1589)	
Ever had penetrative sex	81	79	0.280
<b>Of those that were sexually active</b>			
Had sex past 12 months	72	69	0.129
Had more than one partner in the last 6 months	50	57	<0.001*
Had sex with casual / non- regular partner last 12 months	26	9	<0.001*

## Pregnancy and STI/HIV Prevention Behavior

### *Use of methods to prevent pregnancy*

Of those who had ever been sexually active, the majority reported having used a contraceptive method in their lifetime (Table 6). There was a significant gender difference in the respondents' current use of method; more men reported using a method than women ( $p = 0.031$ ). The main methods currently used are male condoms (92% men and 41% women) followed by injectables (used by 41% of the women) and the pill (used by 14% of the women).

**Table 6: Respondents' Use of Method to Prevent / Delay Pregnancy**

	Men % Agree	Women % Agree	P-Value Men vs. Women
	(n=920)	(n=1589)	
Ever used method to prevent / delay pregnancy	60	62	0.314
Used method to prevent / delay pregnancy during <b>first sexual</b> encounter	25	35	<0.001*
<b>Currently</b> using a method to prevent / delay pregnancy	51	47	0.031

### *Condom Use and Consistency*

Table 7 shows that the majority of those that have ever been sexually active have used a condom, with a greater proportion of men than of women having done so. The results from the formative study support this finding. In one male group (25-34), most of the respondents appeared to be strongly pro-condom and only discussed risky sex practices in relation to their peers. They were adamant that they would not compromise when it came to safe sex as the following statements illustrate:

*"People are no longer trustworthy, my brother. If you have unprotected sex with a girl today, you won't know where she goes after that, and what she is going to do."*

*“I fully agree with him. As I am here, I don’t know her whereabouts and what she is doing there.”*

*“A condom must be the first thing on our minds. When I have a condom with me, I must definitely, use it but if I do not have it, she must ask me, where is the condom? Without a condom, then, nothing must take place.”*

**Table 7: Condom Use and Consistency**

	<b>Men % Agree</b>	<b>Women % Agree</b>	<b>P-Value Men vs. Women</b>
Of those that were sexually active	(n=745)	(n=1256)	
<b>Condom Use</b>			
Ever used condom	89	84	0.006*
Used condom during the last sexual encounter with current partner	71	63	0.010*
<b>Consistency in Condom Use Last Sex</b>			
Every time	42	31	0.001*
Most of the time	22	24	
Sometimes / rarely	35	42	
NON REGULAR PARTNER			
<b>Condom Use</b>			
Had sex with non-regular partner past 12 months	32	11	0.000*
(Of those that had a non-regular partner)	(n=237)	(n=135)	
Used condom during last sex with non-regular partner	89	83	0.006*
<b>Consistency in Condom Use</b>			
Every time	76	56	0.001*
Most of the time	12	24	
Sometimes / rarely	8	9	
Never	4	6	

The baseline results further show that of those that had ever used a condom, women were less likely than men to use a condom during last sex ( $p < 0.05$ ). This finding is confirmed by the results of the formative study which found that women reported “side effects” of condom use in one female group (25-34). Some women disliked condoms because they caused an allergy manifested by a rash in their private parts. It was also thought that government condoms (cheap in quality) were more likely to cause these reactions.

Consistency in condom use was significantly lower with a regular partner than with a non-regular partner and women were significantly less likely to consistently use a condom or to use one in the last sexual relationship with a non-regular partner than men. This finding is supported by the results of the formative study which identified factors that discourage consistent condom use. The key factors noted in the formative study were the nature and duration of relationships and the timing of sex. Condoms are more likely to be used in short-term casual relations than in stable regular relationships; when they are used within a marriage, they are more likely to be used for contraceptive than for infection prevention purposes. Additionally, condoms would regularly be used at the start of a new relationship but this would fall away once trust has been

established. The concept of “trust” as a discouraging factor is well documented. This implies that risk is mainly seen in the context of casual sex situations, and less so in the context of “stable” relationships, even though the evidence shows that sex with non-regular partners is a common occurrence that is more or less tolerated and thus, that the risk might be equally high in these “stable” relations. Other factors discouraging regular condom use that were mentioned were drinking and partying among youth. Some of the young male respondents argued that in such situations sex is spontaneous (unplanned) and that they do not always carry condoms unless they think that they are likely to have sex. Additionally, the intoxication from alcohol and drugs would inhibit condom use<sup>14</sup>. This is reflected in the quotes from a male group aged 25-34:

*“You do not plan sex when you are drunk or in a night club. It just comes depending on how you got a girl.”*

*“You see with me, when an opportunity presents itself I take it with both hands. Imagine a girl saying we can have sex today. I won’t disagree, I’ll go for it!”*

### ***Knowledge of HIV and STI Transmission Mechanisms, Symptoms and Treatment Seeking Behavior***

Overall, the knowledge of the respondents with regard to transmission of STIs was good for both men and women with no large differences between them. Ninety percent or more of those interviewed knew that persons who look healthy can transmit HIV and that anyone can get infected with HIV if a condom is not used. Likewise, more than 90% know that HIV cannot be transmitted by handshakes or sharing a cigarette. However, still a sizable majority believe that HIV can be transmitted by mosquito bites or ignore that breastfeeding mothers can transmit HIV to their babies (Table 8).

**Table 8: Knowledge of HIV Transmission Mechanisms by Sex**

Beliefs	Men % Agree	Women % Agree	P-Value Men vs. Women
	(n=920)	(n=1589)	
Many people who are infected with HIV can look healthy	91	92	0.335
If you really love your partner, it is not necessary to use a condom	20	17	0.220
Any person can become infected with HIV by having sex without a condom with someone who is infected by HIV	92	85	<0.001*
Mothers can pass HIV to their babies through breast milk	79	84	0.001*
Mosquitoes can pass HIV just like they can pass Malaria	24	22	0.588
A person can get HIV by smoking the same cigarette as someone with HIV	5	5	0.699
A person can become infected with HIV by donating blood	31	35	0.196
People who are careful to have sex only with healthy looking partners won’t become infected with HIV	13	13	0.546
People who are infected with HIV can give it to other people by shaking hands	2	2	0.500
A man can get cleansed of HIV if he has sex with a virgin	2	1	0.325
A woman can get cleansed of HIV if she has sex with a virgin	2	1	0.815

Other data showed that only around five percent of those who had ever been sexually active reported having any STI symptoms in the last three months. Women were more likely to report STI symptoms than men ( $p < 0.01$ ). Seventy percent or more of the respondents said they had sought treatment for these symptoms, that they had told the partner about them and that they had abstained from sex while on treatment.

## HIV Testing and Disclosure of the Results

With regard to HIV testing, Table 9 shows that women were more likely (54%) than men (29%) to have gone for an HIV test ( $p < 0.001$ ). The majority of those that had tested had discussed their results with either a partner or somebody else. Of those who had tested but did not discuss results with their partners, 15% felt that there was no need for doing so while another 15% reported that they did not have a partner at the time when they had the HIV test. Thirteen percent of these respondents felt that their results were confidential and that they were not obliged to share them with their partners. Of the 83 percent who discussed the results with someone else other than their partner, 61% mentioned that they discussed their results with a family member, followed by an employer (38%) and a friend (21%). Regarding those respondents who have never gone for an HIV test, the main reasons mentioned for not doing it were that they were afraid (19%), while 13% mentioned that they were still virgins. Other respondents (8%) mentioned that they had never gone for an HIV test because they believed that they were HIV negative as they are not feeling sick.

**Table 9: HIV Testing and Disclosure of the Results by sex**

Testing and disclosure variables	Men % Agree	Women % Agree	P-Value Men vs. Women
	(n=920)	(n=1589)	
<b>HIV testing and disclosure</b>			
Ever gone for an HIV test	29	54	<0.001*
<b>Among those that had gone for an HIV test</b>	<b>(n=264)</b>	<b>(n=861)</b>	
Ever discussed results with any partner(s)	84	85	0.288
Ever discussed results with anyone else	83	83	0.326
<b>Couple HIV testing among those that had gone for an HIV test with partner</b>	<b>(n=90)</b>	<b>(n=214)</b>	
Gone for joint HIV testing with partner(s) in past 12 months	62	61	0.980
Partner tested during visit	76	77	0.241

The formative study looked at meanings of safe sex and also explored at length the reasons why high-risk behavior is resistant to change especially in a context of a high HIV/AIDS infection rate. The gender differences in the meaning of safe sex are interesting. For men, safe sex tends to be limited to condom use while for women safe sex has wider connotations including abstinence from sex, avoidance of casual sex, monogamy, contraception and HIV testing. Non-penetrative sex is rarely considered as safe sex but one male respondent mentioned “heating the wire” referring to masturbation as an example of safe sex. A point worth noting was mentioned by a

young male respondent who felt that although contraceptives such as pills and injections protect women from unwanted pregnancies, they render women at risk of HIV/AIDS and STIs.

## Partner support during last pregnancy

Table 10 shows that of the 37 percent of males that had made a woman pregnant, more than 90 percent said they had encouraged their partners to receive antenatal care (ANC) during their last pregnancy, although only slightly more than half had accompanied their partners to the clinic. The results also showed that women presented a similar, but significantly less optimistic picture of the support provided by their partners than men did. The formative results showed that many men feared that if they accompanied their partners to the antenatal clinic they would be seen to be under the control of their wives or that they would be deemed as having been bewitched by their wives.

The stigma particularly concerning HIV/AIDS awareness and prevention was also highlighted. Only few respondents reported that they accessed VCT jointly as a couple during last pregnancy. Of those who did not access joint VCT as a couple, work commitments (21%), lack of exposure to VCT information (14%) and lack of interest (11%) were mentioned as the main reasons. When the respondents were asked if their partners would support their infant feeding options if they were HIV positive, a majority of the female respondents were of the opinion that their partners are more likely to support exclusive substitute / formula feeding ( $p<0.001$ ) than exclusive breastfeeding option ( $p<0.001$ ).

**Table 10: Partner support during last pregnancy by sex**

Partner support indicator:	Men % Agree	Women % Agree	P-Value
			Men vs. Women
<b>Of those that were sexually active</b>	<b>(n=745)</b>	<b>(n=1256)</b>	
Support for ANC during last pregnancy			
Have you ever been pregnant or made a woman pregnant	37	64	<0.000*
<b>Of those that had been / made a woman pregnant</b>	<b>(n=275)</b>	<b>(n=806)</b>	
I / partner encouraged me/ her to access ANC	92	85	0.002*
I / partner accompanied me/ her for ANC	56	46	0.004*
<b>VCT access for PMTCT during last pregnancy</b>			
I / partner accessed VCT for PMTCT	59	56	0.001*
Partner and I accessed VCT jointly as a couple	24	22	0.627
Provider talked to me / partner about VCT	69	76	0.001*
Provider talked to me / partner about PMTCT	67	73	0.001*
<b>Perceived men support for infant feeding options for PMTCT</b>	<b>(n=920)</b>	<b>(n=1589)</b>	
Support for exclusive breast feeding option	56	42	0.001*
Support for exclusive substitute / formula feeding	78	64	0.001*
Support for a female partner / wife's choice of feeding option	65	55	0.001*

## Communication in Intimate Relationships

Regarding partner communication in intimate relationships, there seems to be a high level of partner discussion on sex, methods to protect each other from HIV, using contraceptives to prevent unwanted pregnancy as well as discussions on having children with their partners (Table 11). However, there is less discussion about having an HIV test amongst intimate partners. Men were significantly less likely than women to engage in a discussion with their partner about having an HIV test as well as to discuss having children. These findings contradict the results of the formative study where lack of communication between partners, particularly around sex and among older generations, was reported. The main reason for this is that questioning or discussing anything related to sex is seen as questioning a man’s authority or wisdom and therefore a woman’s duty is limited to responding to a man sexually:

*“I doubt if old people like our fathers do discuss such issues. This is because the woman remains a woman and a man remains a man. One would always want to demand sex from his woman, not taking into consideration if the woman is menstruating [for example] ...” (Male, 25-34)*

The qualitative study results also found that age differences among partners also played a role in determining the nature and extent of discussions on sex. For example, in relationships between younger women and older men, the girls tended to be constrained in discussing or negotiating the terms of sex with their male partners because they are less experienced sexually and also because they tend to be intimidated by the older men who have the overall power and control over the relationship.

**Table 11: Communication in Intimate Relationships by Sex**

Communication in intimate relationship variables	Men % Agree (n=805)	Women % Agree (n=1387)	P-Value Men vs. Women
	Ever discuss sex together	91	91
Ever discuss having children together	68	76	<0.001*
Ever discuss together using contraceptives to prevent unwanted pregnancy	78	78	0.757
Ever discussed together methods to protect each other from HIV	87	86	0.900
Ever discussed with any partner(s) about having an HIV test	41	52	<0.001*

## Experiences of Gender-based Violence

The levels of emotional and sexual abuse were quite low (Table 12) considering the national levels for the country. However, the prevalence of physical abuse amongst female respondents was fairly high. There was a significant difference; women were three times or more likely than men to report physical abuse from their partners such as slapping, throwing things, shoving, pulling their hair, hitting with a closed fist, kicking, choking or burning on purpose. Physical abuse is even more frequent than such psychological abuse as insulting, humiliating, intimidating or threatening, or than forcing partners to have intercourse when it is not wanted.



**Table 12: Experiences of Gender-based Violence**

Gender-Based Violence Indicators	Men % Agree	Women % Agree	P-Value Men vs. Women
	(n=805)	(n=1387)	
<b>Emotional Abuse. Partner ...</b>			
Insulted you or made you feel bad about yourself	12	14	0.536
Belittled or humiliated you in front of other people	6	7	0.425
Done things to scare or intimidate you on purpose	5	8	0.029*
Threatened to hurt you or someone you care about	3	7	0.003*
<b>Physical Abuse. Partner...</b>			
Slapped you or thrown something at you	5	18	<0.001*
Pushed you or shoved you or pulled your hair	4	11	<0.001*
Hit you with a fist or something else that could hurt	3	10	<0.001*
Kicked you, dragged you or beat you up	1	9	<0.001*
Choked you or burnt you on purpose	1	3	0.004*
Threatened to use or actually used a gun, knife or other weapon against you	2	3	0.055
<b>Sexual Abuse. Partner...</b>			
Physically force you to have sexual intercourse when you did not want to	3	4	0.537
Have sexual intercourse when you did not want to because you were afraid of your partner	2	4	0.091
Force you to have oral sex with him	1	1	0.972
Force you to have anal sex with him	1	1	0.892
Force you to do something sexual that you found degrading or humiliating	1	1	0.412

## Participation in Care and Support Activities

Table 13 demonstrates that women are more likely than men to participate in HIV, AIDS and GBV care and support activities, although the proportions are quite low (less than one fifth of all women). The formative study found that knowledge of organizations and institutions locally available to provide various services in the community was low. People mentioned common services such as police, local clinics and churches as well as a few NGOs that provide prevention, care and support in HIV/AIDS and GBV but did not appear to know much about the nature of services provided. This shows a need for promoting service centers in communities.

**Table 13: Participation in Care and Support Activities**

	Men	Women	P-Value
	% Agree (n=920)	% Agree (n=1589)	Men vs. Women
<b>Participation in HIV/AIDS activities</b>			
Caring for families that are affected by HIV/AIDS	19	28	<0.001*
Volunteering with a community/religious group that provides care and support to people living with HIV/AIDS	13	19	<0.001*
Participating in a HIV infected and/or affected support group	10	18	<0.001*
<b>Participation in GBV activities</b>			
Volunteering with a community-based organization that provides support to women, children and men who are survivors of sexual or domestic violence	12	18	<0.001*
Participating in community-based marches in support of eradication of violence against women and children	14	19	0.005*
Participating in any other activities aimed to eradicate violence against women and children	15	20	0.007*

## Impact of the Workshop on Participants

Despite the goal of having 160 individual interviews with men who had participated in the workshops and an equal number of interviews with the partners, due to different problems we were only able to make only 108 matched pre and post interviews with men who had attended the workshop and only 30 matched pre and post interviews with their female partners. Because this number of interviews with women was too small to arrive at reasonable conclusions regarding the effect of the workshops, in what follows we focus our attention only on the men that attended the workshop.

### *Participant's Evaluation of the Workshop and its Effects*

A large majority of those who attended a MAP workshop indicated that they first attended a MAP workshop in 2005 and 74% (n=85) stated that Hope Worldwide conducted the workshops while 3% mentioned EngenderHealth. Sixty-eight percent of the respondents attended the MAP workshops for one-to-four days and the remainder attended more than four sessions. Of those who attended MAP workshops, almost all (99%) rated peer educators' knowledge and skills in conducting the workshops as good.

Ninety-five percent of the respondents said that MAP workshops changed their way of thinking about gender, mostly in terms of eliminating violence against women, sharing housekeeping chores and using condoms to prevent HIV, as well as to a lesser degree, teaching boys to respect girls, supporting their partner in using contraceptive methods and other ways (Table 14).

**Table 14: Proportion of workshop participants that changed their way of thinking about different gender and HIV/AIDS issues by Survey**

<b>Beliefs that were Changed as a Consequence of the MAP Workshops</b>	<b>Men % Yes (N=108)</b>
Taught me to stop violence against women and children	57
Encouraged me to teach young boys to respect girls	34
Encouraged me to respect women	13
Encouraged me to use condoms to prevent the spread of STI/HIV and pregnancy	51
Taught me to support my partner in using FP	21
Encouraged me to change my gender norms and attitudes	40
Taught me that household chores and child upbringing is not primarily a women's responsibility	41
Taught me that caring and supporting the sick is also a men's responsibility	37
Increased my knowledge if STI/ HIV and AIDS and GBV	20
Taught me to promote gender equity	14

When the respondents were asked about the strengths of the MAP workshops, 31% said that peer educators were good at facilitating the workshops and 21% stated that MAP improved their knowledge on gender and HIV issues. Though percentages were very low, other strengths mentioned were that MAP activities were informative, that workshops changed men's attitudes and behaviors and that having men as a target group was a good move. Thirty-six percent of the respondents reported that MAP workshops did not have any weaknesses. With regard to the weaknesses of MAP workshops, respondents mentioned that there was insufficient time for workshop activities, that the facilitators needed to improve their style and that the MAP workshops were not properly advertised and should be more widely promoted.

***Participation in other MAP-related activities***

When participants were asked in an open way if they had attended any other MAP-related activities, only 11% of the respondents said they had done so. However, when directly asked, 30 percent said that they participated in community action teams and 27% of all men said they had participated or attended a MAP community event or activity during the last year, mostly about gender-based violence, organized by Hope Worldwide. Of those who were members of community action teams, 93% mentioned that their team was still active and most indicated that their team met once a week. Fifty-eight percent of those whose community action team was still active stated that they received moral and financial support as well as training from Hope Worldwide. Eighty-five percent mentioned that free condoms were distributed in the community where they live. The majority of these (62%) mentioned that Hope Worldwide distributed the condoms.

Very few respondents (n=8) of those that had participated in MAP workshops mentioned that they had been trained as peer educators to enable them to conduct MAP workshops. Of these, three mentioned that Hope Worldwide trained them and all of them had conducted a MAP workshop in the last year. When respondents were asked about what could be done to improve the MAP program in Soweto, 36% of those who participated recommended that coverage of MAP activities need to be improved and that more time should be allocated for MAP workshops (14%).

## Effects of the Workshops on Beliefs, Attitudes and Behaviors

Table 15 suggests that participation in the workshop changed the beliefs and attitudes of the participants to make them more equitable. The largest changes observed were in terms of the proportion of respondents who thought a man should always have the last word about decision at home, the belief that men need more sex than women and the belief that women who carry condoms are easy. Other changes in cognitive elements were modest.

**Table 15: Proportion of Men who agreed with Different Gender-Related Beliefs and Attitudes by Survey**

Gender-Related Beliefs and Attitudes	Men		
	Pre- % Agree	Post % Agree	P- Values
	(N=108)	(N=108)	
<b>Performance of Household Tasks</b>			
A woman's most important role is to take care of the home and cook for her family	74	67	0.224
Changing diapers, giving the kids a bath and feeding the kids are the mother's responsibility	52	51	0.733
<b>Decision-making Attitudes</b>			
It is a man who decides what type of sex to have	38	33	0.452
A man should have the final word about decisions at home	50	38	0.036*
<b>Norms on Men and Sex</b>			
A man needs other women sexually, even if sex with his wife is fine	47	44	0.614
Men need sex more than women do	58	48	0.085
You don't talk about sex, you just do it	18	20	0.515
<b>Norms on Condom Use</b>			
I would be outraged if my partner asked me to use a condom	32	25	0.171
Women who carry condoms on them are easy	36	20	0.004*
<b>Attitudes regarding sexual coercion and rape</b>			
A woman should tolerate violence in order to keep her family together	16	8	0.073*
It is okay for a man to hit his wife if she refuses to have sex with him	2	2	1.000
If a man has paid <i>lobola</i> (bride wealth), he has the right to have sex with his wife any time even when she does not feel like having sex	15	14	0.797

## Partner Control in Relationships

Of the 108 men who were interviewed, only 66 continued in a stable relationship since the time of the baseline. In addition to the very high implicit rate of partnership dissolution during the one year of project activities which complicates the implementation of preventive health activities, Table 16 shows that there were very minor, if any, changes on the perceptions about attempts by the partner to control the respondents' behavior.

**Table 16: Perceptions about Partner Control in Intimate Relationships by Survey**

Variables Related to Perceptions of Partner Control	Men		
	Pre % Agree	Post % Agree	p-values
	(N=66)	(N=66)	
Is quite comfortable when I greet women I know	67	69	0.468
Expects me to be at home when she comes	75	75	1.000
Becomes jealous when I wear things that make me look too handsome	36	42	0.349
When we disagree, she gets her way most of the time	36	30	0.453
Always wants to know where I am	68	42	0.003*
Tries to keep me from seeing friends	21	27	0.397
Is often suspicious that I am unfaithful	43	19	0.003*
Expects me to ask permission before seeking health care	27	21	0.321

### **Beliefs, Attitudes and Behaviors related to STI /HIV**

The percentage who reported having had a sexual relationships in the last 12 months declined slightly, from 77 to 68 percent. Partly as a consequence of this, the proportion of men that said they had had multiple partners in the last six months also decreased, from 46 percent to 33 percent. Table 17 shows that of those who remained in a stable relationship in the post intervention survey, condom use with current and casual partner dropped in the last 12 months. Overall, consistency in condom use with both regular and non regular partner also decreased during post intervention.

**Table 17: Condom use and consistency with regular partner by Survey**

Condom use	Men		
	Pre % Agree	Post % Agree	P-values
	(N=66)	(N=66)	
<b>Condom Use with Regular Partner</b>			
Used condom during the last sexual encounter with partner	56	52	0.581
<b>Consistency in Condom Use in the last 6 months</b>			
Every time	38	19	0.001
Most of the time	14	14	1.000
Sometimes / rarely	19	29	0.058
Never	29	39	0.085
<b>Non-Regular Partner</b>			
Used condom during last sex with non-regular partner	40	13	0.000
<b>Consistency in Condom Use</b>			
Every time	32	19	0.010*
Most of the time	2	0	0.158
Sometimes / rarely	3	0	0.045
Never	62	81	0.000

The respondents' knowledge of HIV transmission was fairly good and did not change much between the pre- and post-intervention periods (Table 24). However, more men post intervention agreed with the statement that a person can become infected with HIV by donating blood (p=0.007).

**Table 18: Knowledge of HIV Transmission Mechanisms by Survey**

	Men		
	Pre % Agree	Post % Agree	p-values
	(N=97)	(N=97)	
Many people who are infected with HIV can look healthy	93	94	0.740
If you really love your partner, it is not necessary to use a condom	19	21	0.579
Any person can become infected with HIV by having sex without a condom with someone who is infected by HIV	95	91	0.132
Mothers can pass HIV to their babies through breast milk	75	77	0.696
Mosquitoes can pass HIV just like they can pass malaria	21	22	0.853
A person can get HIV by smoking the same cigarette as someone with HIV	4	1	0.180
A person can become infected with HIV by donating blood	35	52	0.007*
People who are careful to have sex only with healthy looking partners won't become infected with HIV	6	15	0.038*
People who are infected with HIV can give it to other people by shaking hands	5	0	0.024*
A man can get cleansed of HIV if he has sex with a virgin	0	2	0.158
A woman can get cleansed of HIV if she has sex with a virgin	1	2	0.319

Of those who had been sexually active during the last 12 months (n=108), only five percent said they had experienced an STI symptom, the same proportion as in the pre-intervention survey. However, in the post-intervention follow-up, a substantially larger proportion of those with symptoms said they had sought treatment (80 percent), told their partner about their symptoms (60 percent) and abstained from sex while on treatment (80 percent) than in the baseline (33, 50 and 33 percent, respectively). Men's HIV testing increased during the intervention period, from 39% to 43%, as well as going for a test with a partner (from 12 to 18 percent), and discussing the results with the partner.

### **Partner Support during Pregnancy**

Of the men that were sexually active, more men reported in the endline survey that they had ever made a woman pregnant. Of those that had made a woman pregnant, more men also reported encouraging their partner to access ANC as well as accompanying their partners for ANC (Table 19). With regard to perceptions on infant feeding options for PMTCT, men were more in support of exclusive formula feeding as opposed to exclusive breastfeeding.

**Table 19: Partner Support during Pregnancy by Survey**

	Men		
	Pre % Agree	Post % Agree	P- values
	(N=108)	(N=108)	
Have you ever made a woman pregnant	34	43	0.019
<b>Support for ANC during last pregnancy</b>			
Encouraged your partner to access ANC	26	37	0.007
Accompanied your partner for ANC	22	31	0.011
<b>VCT access for PMTCT during last pregnancy</b>			
Partner accessed VCT for PMTCT	19	30	0.028
Partner and I accessed VCT jointly as a couple	7	15	0.045
Provider talked to me / partner about VCT	19	31	0.002
Provider talked to me / partner about PMTCT	18	31	0.002
<b>Perceived men support for infant feeding options for PMTCT</b>			
Support for exclusive breast feeding option	45	25	0.000*
Support for exclusive substitute / formula feeding	93	94	0.783
Support for a female partner / wife's choice of feeding option	52	71	0.001

## Communication in Intimate Relationships

Table 20 shows that among those who were in a relationship, communication in intimate relationships regarding sex and desire for children improved during the project period. However, discussions around protection from HIV, especially regarding HIV testing, declined in the post-intervention (from 59% to 25%).

**Table 20: Communication in Intimate Relationships by Survey**

	Men		p- values
	Pre % Agree	Post % Agree	
	(N=66)	(N=66)	
Ever discuss sex together	91	98	0.242
Ever discuss having children together	64	74	0.897
Ever discuss together using contraceptives to prevent unwanted pregnancy	63	62	0.849
Ever discussed together methods to protect each other from HIV	83	74	0.134
Ever discussed with any partner(s) about having an HIV test	59	25	0.000

Participation in HIV/AIDS and GBV care and support activities such as caring for families affected by HIV/AIDS, participating in support groups for PLWHA or gender-based violence survivors or other advocacy activities against domestic violence decreased little or not at all during the project period.

## **CHALLENGES AND LIMITATIONS**

During the course of the project, we faced a number of challenges and limitations that are discussed in this section. We discuss first research-related limitations and then the challenges faced in implementing the interventions.

### **Research-related Limitations**

#### *Selection criteria for recruiting men into the MAP workshops*

According to the protocol, one of the criteria for selection of men in the intervention was that the eligible respondent must be in a steady heterosexual relationship. However, there was no uniform definition of a “steady relationship”; it depended on the respondent. For some respondents, having a girlfriend was good enough to be considered a “steady relationship”. Some peer facilitators indicated that they recruited the participants based on the assurance from the male respondent that the relationship would last at least for a year. The recruitment team did not emphasize the duration of the relationship as a criterion. The interviewers indicated that the “steady relationship” criterion posed great challenge since it was difficult to guarantee whether people will remain in relationships for at least a year given the instability of relationships in the younger age groups, or whether those who were currently not in relationships will remain single. Most men could meet other selection criteria but could not qualify due to not being in stable relationships. As seen in the individual interviews with men and their partners, the bulk of the respondents were between the ages of 20-24, when commitment to relationships is uncommon.

#### *Locating partners*

Locating partners of men participating in the study posed yet another challenge as they would either denied the relationship, had moved to a new location, or simply did not keep appointments for interviews. Of those women who were located, some refused to participate due to lack of information received from their male partners. In addition, some men in the study did not feel comfortable with their partners being interviewed in their absence. This could have been a reason for the difficulty in achieving the sample for the female partners.

#### *High drop-out rates of female partners*

One of the purposes of interviewing female partners was to verify the information gathered from their male counterparts. This could not be done given the female sample was not reached during the pre-intervention survey and the high dropout rates of those who were recruited into the study so the data from the female respondents could not be reported.

#### *Confusing and confounding factors*

During collection of follow-up data, weekly meetings were held with interviewers to identify the challenges experienced. Illustrations of some of these challenges were:

- One of the female and one of the male respondents died (due to AIDS and a mob attack, respectively) during the project period. In these cases, the interviewers felt uncomfortable about interviewing their partners because the questions were insensitive or irrelevant.



- During pre-intervention data collection, some male respondents had two or more female “stable” partners but gave the details of only one of them in the interview. Subsequently, the respondents broke up with the female partners that had been interviewed, but continued having a stable relationship, confusing the interviewer as whether the partner should be interviewed or not and the researchers as whether these partners should be included in the data base (they were not).
- Due to imperfect control procedures, some respondents had been exposed to previous workshops implemented by EngenderHealth and its partners. The extent of contamination is not known.

### ***Lack of follow-up interviews in control sites***

Due to the financial limitations that Hope Worldwide faced, the shortening of the project’s duration and the reduced number of activities in communities, participant organizations agreed that it did not make sense to conduct the endline survey in intervention and control areas to evaluate if there had been an impact in the community. These changes completely altered the project’s design, making difficult the attribution of any observed changes to project activities, since the project was left without a control group which could be used to compare the results obtained in the intervention group.

## **Implementation-related Limitations**

### ***Change of project coordinators***

Coordinators from all three-partner organizations (i.e., FRONTIERS, Hope Worldwide and EngenderHealth) resigned during the different stages of the project. Although new coordinators were employed to continue with the project, there were challenges in the hand-over as the original coordinators had already left and there was a lack of documentation of the processes to allow easy continuation.

### ***Contamination between sites***

Sources of contamination were identified at two levels. First, MAP workshops were attended by some participants from both intervention and control sites. Although when choosing the study sites, contamination was controlled for by pairing zones to ensure different pairs have a distance of a minimum 10-kilometre radius from each other and from each of the others pairs, in reality this was not practical. Some control sites were very close to intervention sites and there was no strategy to ensure that residents from the control sites could not attend workshops in the intervention sites. Furthermore, the peer educators indicated that in some instances, participants had friends in the control sites that they invited to come with them to the workshops. Second, MAP activities were conducted at some control sites by both the implementing partners as well as other NGO partners. In the end, although the project was left without a control group, this contamination did not affect the results that were presented.

### ***Reduced implementation of activities***

In addition to eliminating the second year of activities due to the financial problems faced by Hope Worldwide, only three of the seven planned activities were implemented by the partners

during the first year of activities (i.e., community peer education, public demonstrations and training of men through workshops,) and at a lower level of intensity than had been planned. The intervention activities that were not conducted included community mobilization sensitization, education and advocacy; stakeholders' sensitization and advocacy; HIV/AIDS support groups and distribution of IEC materials.

***Insufficient monitoring and follow-up of activities***

Some of the participants attended multiple workshops, thus denying the recruiters the opportunity to recruit new participants; only about half of the participants completed the four workshop sessions; there was a high level of discontinuation in the workshops and data collection was sometimes incomplete, as well as there was insufficient documentation and monitoring of the process of intervention activities.

## DISCUSSION AND RECOMMENDATIONS

Despite the research and intervention challenges that resulted in a reduced ability for the evaluation to produce conclusive results about the impact of the intervention, it is encouraging that a number of positive changes were observed among men who were exposed to the MAP workshops on some key variables.

Regarding the implementation process, only a small proportion of eligible men participated in activities other than the workshops, underlying the need of MAP implementing agencies to reinforce these components. The results further illustrated that MAP workshops reached mainly younger men and the unemployed. While this is good, in some instances, these men could not attend MAP workshops for the full duration as they had to seek employment opportunities. Future MAP activities should find ways of targeting older men and working men perhaps by conducting workshops during the weekend or considering other recruitment strategies. Also, MAP peer educators should find ways of retaining men for the full duration of the workshops.

Positive indications were seen among men who were exposed to the MAP workshops with regard to improved norms and attitudes supportive of gender egalitarian relations, reduction in the reported number of non-regular partners, less partner control, partner support during pregnancy as well as communication in intimate relationships. There was also an increase in men's HIV testing post-intervention.

Some negative changes were also observed for the men who were exposed to the MAP workshop. For instance, condom use with non-regular partners was reported less in the post-intervention, even though the MAP manual explicitly discusses these topics. Participation in care and support activities also decreased slightly during the post-intervention, as did men's support for exclusive breastfeeding.

When the respondents were asked about the strengths of the MAP workshops, themes that emerged were that peer educators were good at facilitating the workshops and that MAP improved their knowledge on gender and HIV issues. Other strengths mentioned were that MAP activities were informative, that workshops changed men's attitudes and behaviors and that having men as a target group was a good move. Regarding the weaknesses of MAP workshops, some respondents mentioned that there was insufficient time for workshop activities, that facilitators' styles needed to be improved and that MAP workshops were not properly advertised.

As mentioned in the limitation section, this evaluation does not have the power to look at the impact of the intervention on the female partners. The majority of the women were not exposed to the MAP workshops because the recruitment strategy was tailored in getting men into workshops rather than females. Further planning efforts could look at improving the recruitment strategy and ways of retaining women in the workshops or other activities in order to increase the impact of the interventions on women and couples. Future research is required in this regard.

Furthermore, collection of monitoring data for intervention activities was noted as one of the limitations of the MAP workshops. In the future, monitoring needs to be strengthened, including monitoring the number of days attended, number of workshops and location and other process elements of the interventions.

Given this experience, it is debatable whether changes in social norms and attitudes relative to gender and violence can be documented over a short period and it may well be that these may require longer term exposure to more robust and systematic interventions. It is encouraging to note that despite the methodological and implementation difficulties that some important changes were observed among men within the high HIV context in South Africa.

## **DISSEMINATION AND UTILIZATION**

Midway through the study, a dissemination workshop was held at the Chris Hani Baragwanath Hospital to report on the findings of the formative study and a community baseline survey. These results were useful to the implementing partners, Hope Worldwide and EngenderHealth as they could see areas where they could strengthen the reach, the content and the monitoring of the MAP activities. Other MAP implementers from partner organizations may also benefit from these findings.

Using the lessons learned from the collaboration with EngenderHealth and Hope Worldwide, technical assistance will be provided to the National Department of Health through its Women's Health and Genetics Unit to systematically develop a strategy to address male involvement in reproductive health. In addition, Kagiso Communications has also requested FRONTIERS to be part of an Advisory Panel for a CDC -funded activity to increase men's involvement in PMTCT.

## REFERENCES

- Ciet. Beyond Victims and Villains: The Culture of Sexual Violence in South Johannesburg. A Summary report [http://www.ciet.org/www/image/country/safrica\\_victims.html](http://www.ciet.org/www/image/country/safrica_victims.html)
- Coovadia HM. 2000. *Access to Voluntary Counseling and Testing for HIV in Developing Countries*. Ann NY Acad Sci 2000 – 918: 57-63.
- Courtenay, W.H. 1998. *College men's health: An overview and a call to action*. Journal of American College Health, 46(6), 279-290.
- Curry MA, Perrin N, Wall E. Effects of abuse on maternal complications and birth weight in adult and adolescent women. *Obstetrics and Gynecology* 1998:92; Jejeebhoy SJ. Association between wife-beating and fetal and infant death: impressions from a survey in rural India. *Studies in Family Planning* 1998:29; Petersen R, Gazmararian JA, Spitz AM, Rowley DL, Goodwin MM, et al. Violence and adverse pregnancy outcomes: a review of the literature and directions for future research. *American Journal of Preventive Medicine* 1997:13.
- Department of Health, MRC and Measure DHS 1998. *South Africa Demographic and Health Survey*.
- Heise, L., Ellsberg, M. and Gottemoeller, M. (1999). *Ending Violence against women*. Population Reports, Series L, No. 11. Baltimore, Johns Hopkins University School of Public Health, December.
- Horizons Program Report 2002. Integrating HIV Prevention and Care into Maternal and child Health Care Settings. Lessons Learned from Horizons studies, July 23-27, 2001 Maasai Mara and Nairobi, Kenya Consultation report.
- Horizons Report, Spring 2001; Laing, 1987
- Jewkes R. et al 2002, op.cit.; Jewkes R, Penn-Kekana L, Levin J, Ratsaka M, Schriber M. Prevalence of emotional and, physical, and sexual abuse of women in three South African Provinces. *South African Medical Journal* 2001: 91 (421-8).
- Jewkes Rachel and Naeema Abrahams. *The epidemiology of rape and sexual coercion in South Africa: an overview*. *Social Science and Medicine* 2002:55 (1231-1244).
- Jewkes Rachel, Penn-Kekana L, Levin J, Ratsaka M, Schriber M. 2001. Prevalence of emotional, physical and sexual abuse of women in three South African Provinces. *South African Medical Journal*, vol.91 (5): pp.421-428.
- Kim Julia C. 2000. "Rape and HIV Post-Exposure Prophylaxis: The Relevance and the Reality in South Africa" Discussion Paper WHO Meeting on Violence Against Women and HIV/AIDS: Setting the Research Agenda, Geneva, 23-25 October 2000. [http://www.wits.ac.za/radar/PDF%20files/rape\\_pep.PDF](http://www.wits.ac.za/radar/PDF%20files/rape_pep.PDF)

- Kristin Dunkle, Rachel Jewkes, Heather Brown, James McIntye, Glenda Gray and Sioban Harlow. June 2003. Gender-based violence and HIV infection among pregnant women in Soweto. A technical report to the Australian Agency for International Development.
- Maman S, J. Mbwambo, G. Kilonzo, E. Weiss, and M. Sweat. 2000. History of partner violence is common among women attending a voluntary counseling and testing clinic in Dar es Salaam, Tanzania. Oral presentation at XIII International AIDS Conference. Durban, South Africa. July 9-14.
- Martin et. al. 1999. *ibid*; Rachel Jewkes, Caesar Vundule, Fidelia Maforah, Esmé Jordaan. Relationship dynamics and teenage pregnancy in South Africa. *Social Science and Medicine* 2001:5: 733-744; S. L., Kilgallen, B., Tsui, A. O., Maitra, K., Singh, K. K. and Kupper, L. L. 1999. *Sexual behaviors and reproductive health outcomes: Association with wife abuse in India*. *Journal of the American Medical Association*, 282 ; Gazmararian JA, Lazorick S, Spitz AM, Ballard TJ, Saltzman LE, Marks JS. 1966. Prevalence of violence against pregnant women. *Journal of American Medical Association* 1996; 275.
- Martin S. L., Kilgallen, B., Tsui, A. O., Maitra, K., Singh, K. K. and Kupper, L. L. 1999. *Sexual behaviors and reproductive health outcomes: Association with wife abuse in India*. *Journal of the American Medical Association*, 282; Garcia-Moreno C, Watts C. Violence against women: its importance for HIV/AIDS. *AIDS* 2000:14 Supplement 3.
- Mehta, B. 2000. "Marital violence and its impact on women's health". Paper presented at the Regional (Southeast Asia) Workshop on the Impact of gender-based violence on the health of women, New Delhi, April 5-7.
- Michael A. Koenig et.al 2003. *ibid*; Jewkes R, Levin J, Penn-Kekana L. Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science and Medicine* 2002:55 (603-170).
- Michael A. Koenig, Tom Lutalo, Feng Zhao, Fred Nalugoda et.al. Domestic violence in rural Uganda: evidence from a community-based study. *Bulletin of the World Health Organization* 2003: 81 (1).
- Nelson Mandela/HSRC Study of HIV/AIDS: South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey, 2002.
- Noar, S.M. & Morokoff, P.J. 2001. The Relationship between Masculinity Ideology, Condom Attitudes, and Condom Use Stage of Change: A Structural Equation Modeling Approach. *International Journal of Men's Health*, 1(1), 2001.
- Nqobile Mavimbela, et al. 2003. Can Households Support and Care for OVC: Key Baseline Indicators for the Goelama Program, NMCF and Population Council Study Report.
- Obisesan, K., Adeyemo, A., & Fakokunde, B. 1998. Awareness and Use of Family Planning Methods Among Married Women in Ibadan, Nigeria. *East African Medical Journal*, 75(3), 135-37.

Rachel K. Jewkes, Jonathan B. Levin, Loveday A. Penn-Kekana. Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. *Social Science and Medicine* 2003: 56 (125-134).

Schei B, Bakketeig LS. Gynaecological impact of sexual and physical abuse by spouse. A study of a random sample of Norwegian women. *British Journal of Obstetrics and Gynaecology* 1989:96.

Schuler SR, Hashemi SM, Riley AP, Akhter S. Credit programs, patriarchy and men's violence against women in rural Bangladesh. *Social science and Medicine* 1996: 43 (1729-42).

UNAIDS. 1999. *Gender and HIV/AIDS: Taking stock of research and programs*. Geneva.

United Nations. 1993. Declaration on the elimination of violence against women. Proceedings of the 85<sup>th</sup> Plenary Meeting, Geneva, United Nations General Assembly, December 20.

World Bank. 1993. *World Development Report 1993: Investing in Health*. New York, Oxford University Press.