

The Men as Partners Program in South Africa: Reaching Men to End Gender-Based Violence and Promote Sexual and Reproductive Health

DEAN PEACOCK

ANDREW LEVACK

EngenderHealth, Johannesburg, South Africa

This article presents lessons learned from the Men as Partners (MAP) Program in South Africa. MAP is an ongoing, multi-faceted intervention designed to engage men in reducing gender-based violence and to promote men's constructive role in sexual and reproductive health, including HIV/AIDS. The program is carried out through a partnership of civil society organizations collaborating with governmental and academic institutions to transform the behaviors of men and the norms of masculinity. This article is based on (a) qualitative interviews with professionals from MAP Network organizations and a summary of a small-scale evaluation carried out with MAP participants; and (b) on reflections by the authors, who are directly involved in the ongoing implementation and management of MAP in South Africa. The article provides a case study of a complex intervention seeking to change men's attitudes and behaviors through the use of an ecologic approach that utilizes strategies at many levels to effect personal and social change. As such, it has important implications for work with men in South Africa and elsewhere.

Keywords: gender equality, HIV/AIDS, gender-based violence, prevention, South Africa, men

Ten short years after celebrating the end of apartheid, South Africans now find themselves faced with yet another bitter struggle. This time the battle is against

Correspondence concerning this article should be sent to Dean Peacock, EngenderHealth, CIVICUS House, 24 Gwigwi Mrwebi Street, Newtown, 2001 Johannesburg, South Africa. Electronic mail: dpeacock@engenderhealth.org.

International Journal of Men's Health, Vol. 3, No. 3, Fall 2004, 173-188.
© 2004 by the Men's Studies Press, LLC. All rights reserved.

HIV/AIDS and violence against women—twin epidemics that are both driven in critical ways by social norms about gender, power, and violence and that currently threaten the lives of millions of South Africans.

The statistics make startlingly clear the extent and severity of these two public health crises. With an adult HIV-prevalence rate of more than 20 percent (UNAIDS, 2002), South Africa's AIDS epidemic is one of the most severe in the world. In some provinces, more than 30 percent of women of childbearing age are estimated to be infected (Dorrington, Bradshaw, & Budlender, 2002). In 2002, it was estimated that there were 6.5 million people in South Africa living with HIV/AIDS (Dorrington, Bradshaw, & Budlender, 2002).

The HIV/AIDS epidemic disproportionately affects women's lives both in terms of rates of infection and the burden of care and support they carry for those with AIDS-related illnesses. Indeed, young women are much more likely to be infected than men. A recent study by the University of the Witwatersrand indicates that women make up 77 percent of the 10 percent of South African youth between the ages of 15-24 who are infected with HIV/AIDS (Pettifor et al., 2004).

Women's greater vulnerability to HIV/AIDS is in part explained by the very high levels of sexual and domestic violence reported across the country. For instance, 10% of sexually experienced females aged 15-24 reported that they had ever had sex because someone physically forced them, and another 28% reported that they did not want to have their first sexual encounter, indicating that they were coerced into sex (Pettifor et al., 2004). Research also indicates that many women continue to experience violence throughout their lives; a study in 1991 reported that violence was present in 50 percent to 60 percent of marital relationships (Vogelman & Eagle, 1991).

Estimating the incidence of rape in South Africa is challenging, yet all analyses lead to the conclusion that sexual violence in South Africa is at epidemic levels. South African Police Service (1999) statistics chronicle 51,249 cases of rape reported to police in 1999, while Rape Crisis Cape Town (2001) believes that the real figure is at least 20 times higher—the equivalent of one rape every 23 seconds. These figures give South Africa the highest per capita rate of reported rape in the world (Rape Crisis Cape Town, 2001). Considering these figures, it is not surprising to learn that a 1998 survey found that one in every three Johannesburg schoolgirls has experienced sexual violence at school (Andersson et al., 1998).

OVERVIEW OF THE MEN AS PARTNERS PROGRAM

In 1998, spurred by the need for a response to HIV/AIDS and violence against women, and recognizing the centrality of working with men to achieving this goal, EngenderHealth and the Planned Parenthood Association of South Africa (PPASA) initiated the *Men as Partners (MAP)* program. The purpose of the MAP program was defined in two ways: 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; and to encourage men to become actively involved in preventing gender-based violence as well as in HIV/AIDS related prevention, care, and support activities. To achieve its goals, the MAP program was launched in eight of

THE MEN AS PARTNERS PROGRAM

South Africa's nine provinces, establishing a presence across the country, including urban, semi-urban, and rural communities.

Building on the success and visibility of its early work, EngenderHealth has expanded substantially and has collaborated with a wide range of partners. These have included:

- multilateral bodies such as the Commonwealth's Secretariat on Gender, HIV/AIDS & Human Rights, the United Nations Development Programme, UNIFEM, UNICEF, the Global Coalition on Women and AIDS, the UN's Division for the Advancement of Women and UNAIDS; spell out "and"?
- Government departments and institutions such as the Department of Social Development, the Department of Health, the Office on the Status of Women, the Commission on Gender Equality, and the South African National Defence Force;
- Tertiary Education Institutions in the Western Cape: The University of Stellenbosch, the University of Cape Town, the University of the Western Cape, Cape Technikon, and Peninsula Technikon;
- National NGOs, such as Hope Worldwide, and research focused organizations, such as the University of Witwatersrand based Perinatal HIV Research Unit and Reproductive Health Research Unit, as well as the Population Council's Frontiers Programme;
- arts-focused programmes, such as the Artist Proof Studio, Youth Channel Group, and the Youth Empowerment Programme.

The wide array of organizations involved in the MAP Network have developed many successful MAP initiatives and activities and, in the process, have provided training and technical assistance to a broad range of key stakeholders, including various government departments at the national and provincial levels as well as traditional healers, faith-based leaders, the police, youth-serving organizations, in- and out-of-school youth, teachers, and other CBOs and NGOs. MAP Network members have also built on the successes of the MAP workshop process by conducting a series of community education events—each of which has included the participation of between 300 and 600 people and received substantial media attention. As a result of this work, across the country, thousands of men participate in MAP workshops and community activities each month, often expressing a firm commitment to gender equality and to reducing risk behaviour.

MAP APPROACH

While the central foundation of the MAP programme has historically been the implementation of workshops that explore gender roles, the programme has expanded its activities substantially over the past few years and now works more broadly to promote gender equality and to reduce the spread and impact of HIV/AIDS. At present the programme works to effect change using the following strategies: workshops aimed at changing knowledge, attitudes, and behaviour; mobilising men to take action in their own communities; working with media to pro-

mote changes in social norms, collaborating closely with other nongovernmental organisations and grassroots community-based organisations to strengthen their ability to implement MAP programmes, and advocating for increased governmental commitment to promoting positive male involvement.

USING A HUMAN RIGHTS FRAMEWORK

MAP workshops use a human rights framework to enable men to recognize the ways in which contemporary gender roles mirror the oppressive relations of power characteristic of apartheid. This oppression has 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 the service of promoting gender equality and protecting women from HIV/AIDS, MAP draws the connections between sexism and racism and other forms of oppression and strives to get men to see the ways in which gender equality is a fundamental human right of comparable importance to those fought for during the anti-apartheid years. This approach connects gender equality to South Africa's rich tradition of social justice activism and situates it squarely within human rights discourses and traditions embraced by most South African men. Many MAP educators come from activist backgrounds and apply their expertise to devising strategies that get men to take a proactive stand for gender equality and against women's oppression. MAP activist Dumisani Rebombo put it this way:

If you think of South Africa during the Apartheid regime, most white people directly or indirectly benefited from the system. Most of them didn't care much, it was not an issue; they just lived their lives. In the same way, gender inequalities benefited me as a man, or perhaps as a black man over a black woman. It was life as usual. Power is enjoyable, I guess. I accepted the status quo. Being introduced to gender education made me to stop and start thinking and feeling. Then I started looking at the traditions of my culture and things that are done, which, in my eyes, are very oppressive to women. I looked at the safety of women in general on the street in this country—you see young men forcefully pulling young girls, and it is accepted. I looked into the education system—I think it favours the men. I looked at the teachings of the bible, such that today I am very uncomfortable with the sermons that are preached. I came to this conviction that gender is not a woman's thing. There is a tendency to label gender as a woman's thing. But masculinities are spoken in relation to femininities. How we construct these masculinities is the issue. We need to construct them in such a way that no-one gets hurt, no-one gets oppressed. (Engender-Health, 2004)

"to" stop
in
original?

Bible cap
in
original?

Mbuyiselo Botha, of the South African Men's Forum, a MAP Network member organization, reinforced the link between gender inequality and broader issues of social justice. He said:

What has kept me going is the philosophy that says, our own liberation as men, as black South Africans, cannot be removed from the total liberation of women in this country. That has been a driving force. It would be very hypocritical to talk of liberation when you know that a large section of the society is still in bondage. They still face violence, still face death, they still face rape on a daily basis, as if it is business as usual. (EngenderHealth, 2005)

HELPING MEN TO SEE THE DOUBLE-EDGED NATURE OF CONTEMPORARY
GENDER ROLES

To challenge men's power and control over women and to promote gender equality, MAP workshops utilize a second strategy—helping men to see that the benefits and privileges conferred upon them in a sexist society come at a prohibitively high cost. MAP makes this point in a number of ways.

First, contemporary gender roles can compromise men's health by encouraging men to equate a range of risky behaviors—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. A number of studies demonstrate clearly that such gender roles leave men especially vulnerable to HIV infection, decrease the likelihood that they will seek HIV testing, and increase the likelihood of contributing to actions and situations that could spread the virus. Noar and Morokoff (2001) documented the effects of “masculinity ideology” on condom usage and sexual and reproductive health in general and indicate that traditional men's gender roles lead to “more negative condom attitudes and less consistent condom use” and promote “beliefs that sexual relationships are adversarial.” Similarly, a recent study of antiretrovirals treatment in Johannesburg conducted between April and June of 2004 reported that women accessing ARVs “outnumbered men by a ration of 2 to 1” (Hudspeth, Venter, Van Rie, Wing, J., & Feldman, 2004). This same study reported that women's CD4 count at initiation of treatment was also significantly higher than men's (100 cells/ μ l in women and 85 cells/ μ l in men) and concluded by saying, “The observation that two thirds of patients were female, with 23% of women referred from prevention of mother to child transmission programmes, underscore the need for programmes that target HIV-infected men” (Personal Correspondence, 2004). These findings were similar to those reported in a study of VCT uptake in the Khayelitsha clinic outside Cape Town, South Africa, where fully 70 percent were women (Coetzee et al., 2004).

Second, MAP workshops encourage men to reflect on the ways in which they, too, are affected by men's violence against women. Men are encouraged to consider the ways in which they and countless other men are affected by the pain suffered by victims they know and care about—their daughters, mothers, sisters, friends, colleagues. They are also given the opportunity to consider the ways in which they, and

Wing only
author
with first
initial?

two-thirds?

underscores?

men in general, are cast as potential perpetrators and have their relationships with intimate partners and acquaintances infused with fear and distrust by women's pervasive fear of violence. In workshops and community activities, MAP helps men to see that the use of violence and the domination of women may grant some men a fleeting sense of power, but that, in the long run, the values and attitudes endorsing this behavior inevitably also produce men who are disconnected from their own humanity, isolated, and often hell-bent on a futile and self-destructive quest to prove their manhood. Sgidi Sibeko, a MAP coordinator working for Hope Worldwide, captured these sentiments when he said:

I attended a workshop in which there was an activity looking at positive role models for men, and participants mentioned Mandela and people like that. The facilitator asked us to "bring it home" and to think of role models in our own lives. And I couldn't find any in my life. I thought of my father, I thought of my uncle, I thought of the men around me, and I was blown away because I could not come up with a man as a positive role model. That challenged me a lot. It was very hard to think that I might be associated with the bad image that men have—as perpetrators and so on. I was really impacted by the bad image of men as the perpetrators of violence, men are the rapists. So I said, I want to change, I want to make a difference, I want to play a positive role in other young boy's lives. (EngenderHealth, 2005)

STRATEGIES AND ACTIVITIES OF MAP IN SOUTH AFRICA

MAP uses programmatic strategies at many levels to effect changes in men's attitudes, values, and practices. These levels currently include workshops aimed at changing knowledge, attitudes, and behavior; mobilizing men to take action in their own communities; collaborating closely with other nongovernmental organizations to build their capacity to implement equivalent MAP programs; and advocating for increased governmental commitment to promoting positive male involvement.

MAP WORKSHOPS

Since its inception, the MAP program has conducted educational workshops with groups of men and mixed-sex groups in a wide variety of settings, such as workplaces, trade unions, prisons, military bases, faith-based organizations, community halls, and youth clubs.

Workshops are typically carried out with various groups of men and mixed-sex audiences over a period of four to five days. The process employed is participatory and nondirective, acknowledging the experiences that all participants bring with them. The approach is built on principles of adult learning that explore participants' values about gender, traditional gender roles, power dynamics that exist based on gender, gender stereotypes, and male and female perspectives on gender. All of the activities strive to increase men's awareness of the inequities that exist between men

and women. They also allow an opportunity to share progressive views of gender relations in an environment that is safe and supportive. Information on HIV/AIDS prevention, healthy relationships, sexual rights, sexual violence, and domestic violence follows the initial activities, and the exercises on these health issues constantly refer back to the subject of gender. For example, an activity about HIV will explore the ways in which gender roles can increase the likelihood that men engage in unsafe sex or deter men from playing an active role in caring for and supporting those left chronically ill by AIDS. Similarly, facilitators might use role plays to examine men's attitudes toward health-seeking behaviors and challenge the notion that a "real man" uses health services only when he's already seriously ill. Using interactive gender-values-clarification activities, workshop participants share and discuss their attitudes toward family planning, antenatal care, and parenting and examine the ways in which gender roles restrict the choices available to both men and women. A common question that workshop facilitators ask during the discussion of any activity is "how does this issue affect men and women differently?"

The workshops are carried out by a cadre of well-trained MAP educators from an extensive network of partner NGOs, CBOs, and governmental organizations. All MAP educators are required to undergo an intensive training process. The importance of adequate training for MAP educators cannot be understated. In order to facilitate MAP workshops effectively, educators must be well prepared to challenge harmful attitudes that condone violence and the oppression of women. Without substantial training an educator runs the risk of facilitating a workshop that could further perpetuate harmful attitudes and beliefs. Therefore, educators begin their training by experiencing a MAP workshop as participants. This allows educators an opportunity to adequately explore and reexamine their own personal values about gender and health. After the initial workshop, educators are required to carry out "teach-backs," in which they facilitate a MAP workshop in a community setting. The teach-backs provide an opportunity for new educators to receive substantial feedback from their peers and MAP master trainers. Once trained, MAP educators continue to receive ongoing technical assistance through additional trainings offered by members of the Men as Partners Network.

Recruitment strategies for MAP workshops vary, since some workshops are carried out with participants in workplace settings or prisons, while for others outreach workers and peer educators from MAP partners organizations invite volunteers to convene at a particular site in a community. In no instance are men paid for their participation. However, workshops usually provide a catered lunch and a small reimbursement for transportation. Unemployment in South Africa is variously estimated at between 30 and 40 percent, depending on whose statistics one uses (Kingdon & Knight, 2000), and can run even higher in some of the communities where MAP workshops are provided. Some men, therefore, attend MAP workshops in an attempt to gain skills that will assist them in the job market. This poses a difficult ethical dilemma for MAP workshop organizers. The current MAP curriculum does not provide job-skills training, even though it is a major priority for a large number of workshop participants. While no research points conclusively to a link between unemployment and higher rates of men's violence or risk-taking behaviour, HIV prevalence is especially high in marginalized communities, and men often cite

unemployment as a risk factor for violence against women. As a result, the MAP Network is currently developing a set of activities intended to open up discussion among men about their experiences of unemployment, including explorations about possible relationships between perceived loss of self worth and increased sexual risk taking.

The MAP workshops are usually carried out over a period of five days and typically entail a total of 35 hours of educational activities. The number of MAP workshop participants varies but ideally consists of about 20 participants. Workshop content is drawn from the *Guide for MAP Master Trainers and Educators*, jointly developed by EngenderHealth and PPASA. Each day focuses on a particular theme. Day One looks at the gender socialization process and power imbalances between men and women. Day Two examines how gender issues impact sexuality, parenting, and relationships between the sexes. Day Three looks at the intersection between gender socialization, health-seeking behaviors, and HIV transmission. Day Four focuses on domestic and sexual violence. The final day focuses on ways that men can redefine masculinity and play an active role in their communities to address gender inequality, responsible fatherhood, HIV/AIDS, and gender-based violence.

MOVING BEYOND WORKSHOPS: COMMUNITY ACTION TEAMS

MAP workshops are an important strategy for increasing men's involvement in HIV/AIDS related prevention, care, and support and for getting men to take a more proactive stand against violence against women and girls. However, much contemporary research suggests that positive change promoted by an intervention such as a workshop is likely to be eroded once individuals return to their families, communities, and day-to-day lives. Sustained change, research suggests, is best promoted by a more ecological approach. Ecological approaches recognize that individuals often reflect the values of their families, communities, and societies and that "effecting sustained change requires addressing the multiple problems of (the individual) wherever they arise; in the family, the community, the health care and school systems" (Currie, 1998). One young MAP participant illustrated this point:

Before the workshop, I thought that a man was the head of the house and that women could not work in the mines and do heavy-duty work but should take care of the family. Now I do believe that we are all equal and women can do whatever they want to do. But when I talk to my friends about this, they say I am crazy. (EngenderHealth, 2005)

Successfully addressing public health problems, especially endemic problems like HIV/AIDS and violence against women, requires going beyond individually focused solutions. To address this, the MAP program has introduced Community Action Teams—a practical way to mobilize men to take action at the local level and sustain their commitment to gender equality. During workshops, participants are invited to plan and join Community Action Teams designed to promote and sustain change in their personal lives and in their communities. Community Action Teams

THE MEN AS PARTNERS PROGRAM

work closely with trained staff from NGOs and CBOs within the MAP Network to support events such as health fairs, theatre and performance pieces, and painting of murals with gender-related themes. Other less formal activities by Community Action Teams include one-on-one counselling and condom distribution. A key element to the Community Action Teams is the support that members of the teams provide each other. Through joint participation in the group, team members reinforce a social norm of men taking an active stand for HIV/AIDS prevention and the elimination of gender-based violence.

BUILDING A “BIG TENT” TO REACH LARGER NUMBERS OF MEN

EngenderHealth and PPASA have worked hard to expand the reach of the MAP program by establishing close working relationships with organizations capable of reaching millions of South African men. These include the Solidarity Centre, an umbrella organization that works with the three major labor federations representing more than three million union members; the AIDS Consortium, representing 800 community-based HIV/AIDS focused organizations; and the South African National Defense Force, with a membership of about 65,000. Together EngenderHealth and PPASA provide ongoing training and technical assistance to a core group of staff in each of these organizations, who in turn run workshops in their unions or community-based organizations or in the military. In addition, to make sure that the MAP approach is integrated into more clinical settings, EngenderHealth also works with Hope Worldwide, a national NGO working in the area of HIV/AIDS prevention, care, and support, and with the Peri-Natal HIV Research Unit at Africa’s largest hospital, the Chris Hani Baragwanath Hospital in Soweto.

perinatal
one word?

EVALUATION OF THE MAP PROGRAM

In March 2002, PPASA and EngenderHealth implemented a quantitative evaluation in order to test the impact of the MAP workshop methodology on men’s knowledge, attitudes, and practices related to a variety of reproductive health issues (Kruger, 2003). The study enrolled 209 men who successfully completed a five-day MAP workshop. Eleven MAP workshops were carried out for the study. Interviews were conducted with participants before the workshop, immediately after the workshop, and three to four months later. The evaluation instrument focused on questions related to the exercises that were covered during all the workshops. These included knowledge, attitude, and practice related questions on male and female gender roles, HIV/AIDS and other STIs, relationships, gender-based violence, and practices between partners related to reproductive health.

Out of the 209 post-workshop participants, 139 interviews were completed three to four months after the training. In total, 66 percent of all the participants who completed the training were traced three or more months after the training had been completed. Challenges existed in tracking workshop participants because many of the participants were young men who were transient and unemployed. Tracking of participants was also difficult because physical addresses and telephone numbers were not always readily available for the men.

The findings presented in the evaluation have been calculated using only the 139 respondents who completed a pre-training interview, an immediate post-training interview, and a three-month post-training interview. The mean age of these participants was 33, and ages ranged from 18 to 74. Fifty-nine percent of the participants were unemployed; 67 percent had completed secondary school.

CHANGES IN PARTICIPANT KNOWLEDGE

The data indicate that factual knowledge related to HIV/AIDS increased immediately after the training and that the knowledge generally continued to increase three months after the training. Before the workshop, only 26 percent of the men could successfully respond to the question related to how HIV could be transmitted; three months after the workshop, 45 percent of the men could successfully respond to this question. Before the workshop, 73 percent of the men could correctly answer the question about how condoms should be stored; three months after the workshop, 89 percent of men could correctly answer this question.

CHANGES IN PARTICIPANT ATTITUDES

Participants demonstrated positive attitudinal changes for most of the issues covered in the training. There was a sustained attitudinal change for most questions related to male and female gender roles. For example, before the workshop, 54 percent of the men disagreed or strongly disagreed with the statement that men must make the decisions in a relationship; three months after the workshop, 75 percent of the men disagreed or strongly disagreed with this statement.

Participants also demonstrated some attitudinal changes related to HIV/AIDS issues after the training. Before the workshop, only 57 percent of the men thought it was okay for a woman to refuse to have sex without a condom; three months after the workshop, 70 percent of the men thought it was okay for a woman to refuse to have sex without a condom.

In general, the data indicate that there has been a general positive attitudinal shift regarding issues related to sexual violence and relationships. Before the workshop, 43 percent of the men disagreed or strongly disagreed with the statement that sometimes when a woman says "no" to sex, she doesn't really mean it; three months after the workshop, 59 percent disagreed or strongly disagreed with this statement. Before the workshop, 61 percent of the men disagreed or strongly disagreed with the statement that women who dress sexy want to be raped; three months after the workshop, 82 percent disagreed or strongly disagreed with this statement.

CHANGES IN PARTICIPANT PRACTICES

In terms of practice-related questions, all except one question illustrated a positive behavioral shift after three months, although in some cases the shift was minimal. Before the training, 70 percent of the men indicated that they had jointly decided with their partner whether or not to use contraception; after three months, 79 percent

of the men indicated that they had jointly decided with their partner whether or not to use contraception.

Before the training, 58 percent of the men said that they did not control the finances in the house; this increased to 71 percent after the training. Regrettably, the survey did not inquire about reported condom use or reported acts of violence toward a partner.

MAP EDUCATOR PERSPECTIVES

The process of change evident in the research findings is also captured in the words of MAP educators and activists. Gertie Mbhalata, one of a small number of women using the MAP methodology, described her experiences as a young woman sometimes working with elders and with men:

I think that one of my biggest challenges is that I am young and I am a woman and I have to concentrate on males. Because we are in a rural area where people still believe or trust their traditional leaders, [I thought] it would be best to market the program to the leaders first. So it was very challenging for me to approach them because there is this myth that a young person can't discuss [sexuality] with an older person—the older person is the one who knows all of these things. But . . . I broke the myth that a young person can't discuss that with older people and that a young woman can't really discuss that with older men. (EngenderHealth, 2005)

Boitshepo Lesetedi, MAP Coordinator at PPASA, put it this way:

I realized it was impossible to work around issues of gender when you haven't started with yourself, because I was carrying my own baggage, and own myths and stereotypes. So it became more of my own life than work, realizing how much freer I could be when I don't have to be doing what has supposedly been men's role. (EngenderHealth, 2005)

Finally, MAP educator Patrick Godana described his involvement in the following way: "Being involved in MAP work has helped me to see the beauty of life" (EngenderHealth, 2005).

FURTHER EVALUATION PLANS

Together with the Frontiers Programme of the Population Council and Hope Worldwide, EngenderHealth has begun a three-year impact study to determine the efficacy of the MAP approach. This evaluation will examine changes in interpersonal behaviour among MAP programme participants and will also assess the impact that the intervention has had at the community level. To date, extensive baseline research

PEACOCK and LEVACK

has been carried out in 16 intervention sites and 16 control sites in communities near Johannesburg.

LESSONS LEARNED AND CONCLUSIONS

PRESENT MEN AS POTENTIAL PARTNERS CAPABLE OF PLAYING A POSITIVE ROLE IN THE HEALTH AND WELL-BEING OF THEIR PARTNERS, FAMILIES, AND COMMUNITIES

Despite high levels of male violence against women, it is important to recognize that many men care deeply about the women in their lives, including their partners, family members, coworkers, neighbors, and community members. Given the opportunity and the know-how, many men are eager to challenge customs and practices that endanger women's health and support the well-being of women. Asset-based approaches that redefine men's involvement in the promotion of gender equality as examples of strength, courage, and leadership have been especially useful in this regard.

ENCOURAGE MEN TO PLAY AN ACTIVE ROLE IN CARE AND SUPPORT FOR THOSE ILL WITH HIV/AIDS RELATED ILLNESSES

Much attention has been paid to the ways in which contemporary gender roles condone men's violence against women and compromise women's ability to make choices about their sexual and reproductive health. Less attention, however, has been granted to the ways in which gender roles also create the expectation that women will assume the burden of responsibility for taking care of family and community members weakened or made ill by HIV/AIDS. A 2002 household survey conducted in South Africa reported that "in more than two thirds of households women or girls were the primary caregivers. Almost a quarter of caregivers were over the age of 60 and just under three quarters of these were women" (Henry Kaiser Family Foundation, 2002). To date, then, little has been done to develop interventions that explicitly encourage men to play a more active role in care and support activity. Therefore, it is imperative that men begin to share this burden of care and support.

A 1998 UNAIDS study conducted with men in Tanzania shed light on men's lack of involvement in care and support and revealed that on occasion "male heads of households would wish to do more when their partners fall ill but were curtailed by cultural definitions of maleness and the roles defined which determine masculinity" (Aggleton & Warwick, 1998). These findings have been supported by EngenderHealth's experiences working to promote greater male involvement in HIV/AIDS related care and support. In focus groups conducted in Soweto in March 2003, many men identified traditional gender roles and the fear of losing respect from their peers as significant deterrents to participating in care and support activities. When asked what might prevent other men from playing a more active role, men identified a number of obstacles. In one group, participants answered that some men would see doing work traditionally performed by women as an "affront to their dignity" (Kruger, 2003). Others answered that many men simply did not have the knowledge or skills necessary to provide support or to be more involved in domestic activities

and would not want to risk being seen as ignorant or incompetent. Additionally, some men discussed being afraid that their involvement in care and support activities might create the perception that they, themselves, were HIV positive, which they feared might lead to stigma and social exclusion (Kruger, 2003).

These focus-group discussions suggest that it is imperative that interventions focus not only on increasing men's awareness of the need for their involvement in care and support but also on the need to explore and shift social norms at the community level so that more men can provide the support their conscience tells them is necessary.

BUILD ORGANIZATIONAL CULTURES THAT ARE COMMITTED TO WORKING WITH MEN

No amount of training and capacity building is likely to be effective without the buy-in of senior leadership within partner organizations. To ensure that each organization remains committed to working with men to prevent HIV/AIDS and violence against women, the MAP program includes workshops with senior management and other key staff within each organization on the relationship between gender equality, violence against women, and HIV/AIDS. To ensure that MAP programs complement the other work of the organization, EngenderHealth assists partner organizations to integrate male involvement strategies into their existing efforts so that these are enhanced and made more effective.

PROVIDE ONGOING SUPPORT TO GENDER ACTIVISTS TO AVOID SECONDARY TRAUMA AND BURNOUT

Given that the MAP methodology asks educators to talk about violence and abuse in every workshop, it is important to provide educators with the support that they need to process their own experiences with violence. In addition, educators run the risk of experiencing secondary trauma resulting from constant exposure to other people's stories of violence. Reuben Magoni of Hope Worldwide made this point clearly:

I used to be one of those guys who were abusive. It was really difficult for me to come to terms with that. Actually, I asked to be excused from facilitating that because I feel really conflicted with that. I couldn't talk about it for two or three workshops. But I spoke about it with my other colleagues and I went through a healing process. A month later I could talk about it. I felt great because I could talk about my experiences openly, then help other people to talk about theirs. (EngenderHealth, 2005)

Sgidi Sibeko, of Hope Worldwide, described the impact of a MAP workshop in which rape and sexual assault were being discussed:

This participant said that if he found a man raping a woman, he would kill him. I thought, let me probe around that issue and ask him more what does he mean. And the guy said that his mother

had been raped by a man who was considered a family friend. "And as a result I was conceived. I am a product of rape and from that day on my mum hated me." One lady cried and another one said that a lady that she lived with was raped on her way to work. And then she started crying. This gentleman stood up and left and the two ladies went outside as well. And then another participant said that a friend of hers was raped as well at a party at knifepoint by some guys. Now the mood changed. Unfortunately, that day I was alone. I stopped the workshop briefly and went outside to counsel the participants there and some other participants who had been to our workshops before helped. Now that obviously poses a challenge for support because you are opening up a wound and you're doing nothing to help heal that wound. So there is a lot of emotional support that is needed, through counseling for example. But also in the form of support groups of men that are committed to change, of men who want to do things differently, where they can go and draw their strength. Because it is a difficult thing when you are a man alone trying to do things differently. (Engender-Heath, 2005)

Similarly, there is tremendous pressure on men to conform to traditional gender roles. There are, for instance, many prohibitions on men being visibly involved in "domestic" activities (EngenderHealth, 2005). Comments by MAP educator Steven Ngobeni make clear just how important it is to provide ongoing support and break the isolation that many men feel as they begin to resist traditional gender roles:

When you talk about changing norms and values, it's not easy. The moment I decided to get married I told myself I wanted to be an example of change in my community. One thing I became very strong with was when they said she must go to the veld (bush) and fetch firewood. Just because she is the wife, it is what she is expected to do! But even when I made the means to get the firewood there, there were still some problems because it is not the firewood that they want. They want to see this woman go into the veld and fetch that firewood and come back with the firewood on her head. It is a very challenging situation. Some people are saying horrible things against me and my wife, [but] I have to take a stand so the society can see that change is inevitable. (Engender-Health, 2005)

DEVELOP COHERENT, COORDINATED, AND STRATEGIC PROGRAMMING

Consumed with the task of reconstructing the country after years of apartheid rule, the South African government's response to the HIV/AIDS and violence against women has been inconsistent, characterized at times by inadequate resource allocation, confusing public statements, and poor coordination with and inclusion of the

NGO sector. This lack of coherence has also been true at times of both civil society and the private sector. Existing within this context, the already inadequate social service infrastructure inherited from the apartheid regime has quickly become overwhelmed. To address this, and to improve the cohesion of NGO and private sector responses to HIV/AIDS and violence against women, the MAP methodology now includes a focus on facilitating relationships between collaborative partners. The MAP Network meets on a monthly basis to learn from each other's successes and challenges, to benefit from diverse skills, and to avoid duplication and wasting scarce resources. More recently, EngenderHealth worked with a range of national government departments to establish the National Coordinating Committee on Men and Gender Equality, consisting of key stakeholders from civil society, government, and business, which will promote greater collaboration among government departments and between government and civil society.

REFERENCES

- Aggleton, P., & Warwick, I. (1998) *A comparative analysis of findings from multi-site studies of household and community responses to HIV and AIDS in developing countries*. Geneva: UNAIDS.
- Andersson, N., Mhatre, S. Mqotsi, N., & Penderis, M. (1998). *Prevention of sexual violence: A social audit of the role of the police in the jurisdiction of Johannesburg's Southern Metropolitan Local Council*. Johannesburg: CIETAfrica.
- Coetzee D., Hildebrand, K., Boule, A., Maartens, G., Louis, F., Labatala, V., et al. (2004, April 9). Outcomes after two years of providing antiretroviral treatment in Khayelitsha, South Africa. *AIDS*, 18(6), 887-895.
- Currie, E. (1998). *Crime and punishment in America*. New York: Henry Holt and Company, Inc.
- Dorrington, R.E., Bradshaw D., & Budlender D. (2002). *HIV/AIDS profile of the provinces of South Africa—Indicators for 2002*. Centre for Actuarial Research, Medical Research Council and the Actuarial Society of South Africa.
- EngenderHealth. (2004). *Men as partners programme South Africa: 2002-2004. Final report to the Ford Foundation on outcomes and lessons*. Johannesburg: EngenderHealth.
- EngenderHealth. (2005). *Men as partners programme promising practices guide*. Johannesburg: EngenderHealth.
- Henry Kaiser Family Foundation. (2002). *Hitting home, how households cope with the impact of the HIV/AIDS epidemic. A survey of households affected by HIV/AIDS in South Africa*. The Henry Kaiser Family Foundation.
- Hudspeth, J., Venter, W.D.F., Van Rie, A., Wing, J., & Feldman, C. (2004). Access to and early outcomes of a public South African antiretroviral clinic. *The Southern African Journal of Epidemiology and Infection*, 19(2), 48-51.
- Kingdon, G., & Knight, J. (2000). Are searching and non-searching unemployment distinct states when unemployment is high? The case of South Africa. *Centre for the Study of African Economies Working Paper WPS/2000-2*. Oxford: Economics Department, University of Oxford.

- Kruger, V. (2003). *Being willing to love and support them: An EngenderHealth report on focus group discussions held in Soweto by the HOPEworldwide men as partners staff*. Johannesburg: EngenderHealth.
- Kruger, V. (2003). *MAP evaluation report*. Johannesburg: EngenderHealth.
- 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), 43-58.
- Personal correspondence with Dr. F. Venter, University of Witwatersrand, October 11, 2004, based on unpublished data of a retrospective medical file review of all adult patients on ARV treatment during the first 10 weeks of a public antiretroviral clinic in Johannesburg, South Africa, focusing on demographics, clinical presentation, and response to antiretroviral treatment.
- Pettifor, A., Rees, H., Stevens, A., Hlongwa-Madikizela, L., MacPhail, C., Vermaak, K., et al. (2004). *HIV & sexual behaviour among young South Africans: A national survey of 15-24 year olds*. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand.
- Rape Crisis Cape Town. (2001). Retrieved March 2001 from the World Wide Web: <http://www.rapecrisis.org.za>
- South African Police Service. (1999). *The incidence of serious crime in South Africa between January and December 1998*. Pretoria: Crime Information Analysis Centre, Crime Intelligence, South African Police Service.
- UNAIDS. (2002). Report on the global AIDS epidemic. Geneva: UNAIDS.
- Vogelman, L., & Eagle, G. (1991). Overcoming endemic violence against women. *Social Justice, 18*(1-2), 199.

is this
consistent
with Internet
references
in first
article?