Men As Partners: lessons learned from engaging men in clinics and communities

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Introduction

> In an urban community in South Africa, a victim of domestic violence, afraid she'll be beaten again, acquiesces to the drunken insistence of her husband and endures intercourse.
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> In a peri-urban community in Bolivia, a mother of four secretly obtains birth control despite her husband's objection, risking accusations of infidelity, violence, and abandonment.
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> In a rural community in Nepal, a young married man accompanies his wife to the local health post for antenatal care visits.
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> Walking home from work on the outskirts of Manila, a young man discusses birth control options with his girlfriend.
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> In Guinea, a group of men trained as peer educators conduct home visits to local families to explain different reproductive-health issues.

The settings and specifics may vary, but scenes like these take place every day in communities across the world. In many countries, all too often men act in ways that contribute to a variety of public-health problems, such as domestic and sexual violence, sexually transmitted infections, spiralling rates of HIV/AIDS, and high rates of maternal and infant mortality. However, as these vignettes also make clear, men can, and often do, play a critical role in promoting gender equity, preventing violence, and fostering positive sexual and reproductive-health outcomes for themselves, their partners, and their families.

Spurred by the recognition that men's attitudes and behaviour can either undermine or promote sexual and reproductive health, many sexual and reproductive health organisations around the world have launched initiatives to encourage positive male involvement. This chapter describes the lessons learned by one such initiative: the Men As Partners (MAP) programme at EngenderHealth.[1] In this chapter, we present the framework for the MAP programme, and explore how it is applied to engage men in service-delivery settings and communities. We also share lessons that we have learned as a result of implementing the MAP programme in a variety of contexts and countries to address a diversity of reproductive-health issues.

The purpose of the MAP programme

EngenderHealth is a New York-based organisation working internationally on reproductive health. Developed in 1996, the original goal of the MAP programme – in collaboration with local partners – was to increase access to information and services that could contribute to men sharing the burden of disease and pregnancy prevention with women, who have shouldered this responsibility for too long. The programme currently focuses on promoting the constructive role that men can play in reproductive health, including the prevention of HIV, STIs, and gender-based violence, and in maternal care and family planning. Most importantly, the MAP programme is working actively to promote gender equity by engaging with men to challenge the attitudes and behaviour that compromise their own health and safety and that of women and children.

The MAP framework

Since 1996, the MAP programme has evolved to ensure that a critical part of its approach is an understanding of gender dynamics and the negative ways in which the unequal balance of power between men and women can play out. As a result of lessons learned from its programming, EngenderHealth realised that health-service providers and community members needed to make the link explicit between gender issues and reproductive and sexual-health behaviour, so that information and knowledge were translated into practice effectively. In addition, we found that we had to work with men to examine current gender roles, in order to increase awareness that these roles pushed them into unsafe sexual behaviour and prevented them from seeking services that could help them. In so doing, we encouraged men to develop alternative and more healthy ways of defining their own masculinity.

The MAP programme is therefore based on the following three related elements of constructive male involvement: first, that current gender roles often give men the ability to influence or determine the reproductive-health choices made by women; second, that current gender roles also compromise men's health by encouraging them to equate a range of risky behaviours with being 'manly', while encouraging them to view health-seeking behaviour as a sign of weakness; and third, that men have a personal investment in challenging the current gender order, and can be allies in the improvement of their own health, and the health of the women and children who are often placed at risk by these gender roles.

These three fundamental principles of constructive male involvement are applied by MAP in both service delivery and community settings. In the former, trainers work with service providers to ensure an understanding of gender issues

and how they can affect men's and women's reproductive-health decision making, including the use of and access to health services. In work with communities, facilitators ask men to reflect on their own values about gender, to understand the power relationships that exist based on gender, to assess gender stereotypes, and to examine and challenge the traditional gender roles that can compromise an individual's health and safety.

We have found that the MAP framework can be applied in a variety of cultural settings and with different groups of men, such as men in prisons, men in the armed forces, and men in HIV-positive support groups. Based on the identities and needs of the men we work with, we adapt the framework by emphasising different cultural and gender issues, depending on the overall goal of the MAP programme in any given setting.

Before initiating a programme, MAP assesses the needs of the men with whom it is intending to work. This information is then incorporated in any subsequent programme that is implemented. In an urban setting in Nepal, for example, men may be putting themselves at risk by not going to seek health services, because they equate the use of formal reproductive-health services with being less 'manly'. As a result, many may be seeking out traditional providers if they have health concerns. In a MAP programme in such an environment, we would work with both traditional and formal-sector providers to help them understand men's needs, and we would also implement outreach work in order to help men feel more comfortable about seeking healthcare from formal-sector providers. In South Africa, when working with men in HIV-positive support groups, we might adapt the framework to emphasize gender issues related to the household and to caring responsibilities, since women bear the burden of taking care of family members who are sick, and men may see household responsibilities as being less 'masculine'.

Working with men in service-delivery settings

Most reproductive-health services offered around the world in service delivery settings such as clinics or health posts are geared almost exclusively to women. Men are generally the forgotten reproductive-healthcare clients, and their involvement often stops at the clinic door. When they accompany their partner to a facility, men may find no programmes encouraging or allowing them to participate in reproductive-health decision making with their partner, or to address their own reproductive and sexual healthcare needs.

Over the last few years, often at the behest of female clients, health institutions have realised that the constructive involvement of men in reproductive health is essential in order to reduce negative outcomes significantly, especially with

respect to the HIV/AIDS epidemic. Health-service providers are now making concerted efforts to reach men both in communities and in clinics, and to offer services that address both men's and women's healthcare needs, either alone or as partners.

Facilities have faced several challenges as they try to reach more men, however: men have only brief contact with reproductive-healthcare systems; providers may not know how to interact and work with male clients; and services need to be provided for men without compromising women's autonomy or their independent access to similar services.

To address these challenges, EngenderHealth offers technical assistance to facilities and providers to help them advance the delivery of reproductive-health services to men. The MAP programme has been implemented in several countries, including Pakistan, Nepal, and Bolivia. The programme involves training using a three-part curriculum on men's sexual and reproductive health. The first part focuses on working with providers and sites to address organisational and attitudinal issues that may inhibit men from using services. The second addresses communication and counselling issues that health workers may face when interacting with men or couples. The third offers training to providers in the clinical management of men's sexual and reproductive-health concerns. At the end of the training, facilities develop an action plan that they can implement to increase men's access and use of the services. This can include the implementation of new services at the site, a change in clinic hours so that more men can attend, a separate entrance for men to come into the clinic, outreach in the community, and so on.

Service delivery and community links

Since an improvement in the type of services offered is not normally sufficient to increase their use, EngenderHealth also works with facilities and providers to stimulate demand for men's reproductive-health services within the community. In Guinea, for example, EngenderHealth brought together information, education, and communication specialists from the Ministry of Health, representatives from non-government organisations, representatives of the national media, and community members to develop messages about male involvement and maternal and child mortality. These were then shared with the community through a series of interrelated activities, including home visits by trained peer educators, mosque lectures by trained *imams* (Muslim religious leaders), roundtable discussions on radio and television, and community-wide fairs. In Nepal, EngenderHealth has trained men of all ages in the community to serve as reproductive-health peer educators to provide basic counselling to men and couples in the community. In Pakistan, barbers were trained to provide

messages to male clients on family planning and other reproductive-health issues. The trainings include an exploration of gender issues to help participants understand the impact that traditional gender roles can have on the lives of both men and women.

The impact of working with men in service-delivery settings

Evaluation of MAP's work at the service-delivery level has focused on assessing whether its training efforts have led to changes in practices among service providers and community members and to a greater use of services by men, with or without their partners. Such evaluation is important in order to understand whether increasing the quality of, and access to, services for men can lead to a change in the level of demand and use of these services. Evaluations have highlighted three primary changes.

Increased knowledge, and positive attitudes among service providers and community members towards men's involvement in reproductive health
An analysis of the knowledge, attitude, and practice surveys carried out before and after the workshops conducted by EngenderHealth in various countries suggests that participants are becoming more positive in their attitudes about men and reproductive health after receiving the training. As one trained doctor commented, 'Through the training, we were able to identify specific problems for men in the centre. This helped a lot and increased the influx of patients, because awareness is greater about coming to the centre.' A nurse at another clinic observed that the training 'has been very practical. Before, I only worked with women ... [Now] I am more knowledgeable about men's illnesses and how to deal with men. It is also very surprising – I did not think it would be easy for them to talk to me or for me to talk to them.' Finally, as a doctor at one clinic explained, 'Within my community and mosque, people ask me for advice. The training has opened my relationship with my clients. I used to be very nervous … now I put myself in the place of my clients and listen to find a solution. It has changed my relationship with my children as well – I am more open with them.'

Increased access by men and their partners to reproductive-health and family-planning services
In Pakistan, after the MAP project was implemented, the MAP sites provided over four times as many vasectomy procedures in 2000 as in 1996. In Guinea, several of the providers interviewed during our evaluation in October 2002 stated that the numbers of repeat infections in female clients had been decreasing since they had started to bring their partners in for treatment. In Nepal, providers indicated that many more couples were coming for antenatal care as a result of the MAP project.

Increased range of services offered at facilities
In Bolivia, after the MAP project was initiated, the pilot sites started offering comprehensive assessments of sexual and reproductive-health history, cancer screening, and substance-abuse and mental-health counselling. In Guinea, service sites participating in the MAP programme identified infertility as a leading concern among clients. Since then, they have expanded their diagnostic laboratory services and developed referral linkages to address this client concern.

Working with men in communities

EngenderHealth has also been working with men to respond to the HIV/AIDS epidemic and to violence against women. In South Africa, recognising the urgent need for a response to these two critical issues and the centrality of working with men to achieve this goal, EngenderHealth and the Planned Parenthood Association of South Africa (PPASA) initiated a Men As Partners programme in 1998. The MAP programme was launched in eight of South Africa's nine provinces, establishing a presence in communities across the country, including urban, peri-urban, and rural communities.

The programme addresses attitudinal and behavioural issues that negatively affect the health of both men and women. It also seeks to encourage men to become actively involved in preventing gender-based violence, and in HIV/AIDS prevention, care, and support activities. The strategy applied here builds on the long history of anti-apartheid activism, which lends itself well to an approach aimed at mobilising men, and in the process, galvanising a groundswell of men willing to take a stand to promote gender equity.

Educational workshops have been implemented with groups of men and mixed-sex audiences. Since its inception, the workshops have been conducted with groups of men in a wide variety of settings such as workplaces, trade unions, prisons, faith-based organisations, community halls, and sporting arenas. In their design, the workshops reflect a commitment to deal with the complexities of gender roles and the challenges associated with shifting long-held attitudes, values, and practices. Most workshops are a week long, and often residential. Unlike many other approaches that tend to have a single-issue focus, the MAP workshops address the complexities of how gender roles affect men's lives. They therefore simultaneously address violence, sexual and reproductive health, parenting, support and care for people living with AIDS, and, always, men's roles and responsibilities to end violence and create healthy, thriving communities. They are also beginning to include a focus on activism and social justice.

Almost all MAP activities use and emphasise participatory group approaches which have much in common with the methodology and rationale articulated by Paulo Freire in *The Pedagogy of the Oppressed*[1]. These interactive educational activities are used by the MAP trainer to train workshop facilitators and in community group work. Workshop activities 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 will 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 towards health-seeking behaviour, and challenge the notion that a 'real man' only uses health services when he's already seriously ill. Using interactive activities that explore gender norms, participants share and discuss their attitudes towards family planning, antenatal care, and parenting, and examine the ways in which traditional gender roles restrict the choices available to both men and women. A common question that facilitators ask during the discussion of any activity is, 'how does this issue affect men and women differently?'

The rationale is relatively straightforward for conducting the work of changing men's gender-based attitudes, values, and behaviour in groups rather than relying exclusively on more traditional media-based social advocacy work. Given that men are socialised in groups (in the schoolyard, at home, in religious institutions, on the playing field, in their workplace) it makes sense to provide alternative experiences of group socialisation which challenge them. Such an experience allows men an opportunity to build connections with other men and to experience themselves differently as men. It also permits them to express their dissatisfaction with, and concern about, their habitual roles, in the company of other men.

In some of the workshops, many participants are unemployed or are employed for only short periods of time. As a result, EngenderHealth has started to tackle broader societal issues such as poverty and unemployment, since these can significantly affect men by undermining traditional male identities, leading to increased chances of risky behaviour. These issues are important to acknowledge and address, since they can reinforce traditional gender roles. The relationships between social problems and male identities are discussed in the workshops, helping men to examine how poverty and unemployment have affected their own perceptions of being men, and how these may lead to practices that can put both them and their partners at risk. The MAP programme is also building links with organisations that have more experience in areas such as poverty and unemployment, in order to share successful approaches and to build expertise in tackling other non-reproductive health needs that men may have.

Building a 'big tent' to reach larger numbers of men

Faced with the growing devastation caused by HIV/AIDS and by violence against women, EngenderHealth and PPASA have worked hard to expand the impact of the MAP programme. To achieve this they have pursued two strategies: building capacity within the NGO sector to reach greater numbers of men, and promoting community-based efforts to mobilise men in support of gender equality and social justice. In order to involve greater numbers of men, EngenderHealth and PPASA have recently succeeded in establishing close working relationships with organisations capable of reaching millions of South African men. These include the Solidarity Centre (an umbrella organisation that works with the three major labour federations representing over three million union members), the AIDS Consortium (representing 800 community-based HIV/AIDS-focused organisations), and the South African National Defence Force (with a membership of about 65,000). Together EngenderHealth and PPASA will provide ongoing training and technical assistance to a core group of staff in each of these organisations, who will in turn run workshops in their union, community-based organisation, or the military. In addition, to make sure that the MAP approach is integrated into more clinical settings, EngenderHealth works with Hope Worldwide, a national NGO specialising in 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.

In developing these partnerships, MAP workshops have undergone a number of changes and have become more focused on providing participants with the skills and motivation needed to promote and sustain change in their personal lives, in their organisations, and in their communities. As a result, workshops are sequenced to ensure that each subsequent workshop strengthens and enhances the skills of each participant. As such, the workshops focus on the day-to-day strategies men can use to promote gender equity and positive male involvement, examining community-based efforts underway elsewhere in the world to assist in the planning of local strategies. Workshops will soon offer training in advocacy and research skills, and will include opportunities for participants to practice organising and mobilising skills in order to link their personal changes to greater community change.

The impact of working in communities

At the community level, EngenderHealth's evaluation work has focused on understanding whether the programme has resulted in a change in attitudes and practice relating to gender equity, including issues around sexual violence. The results show that the MAP approach has had significant success in shifting men's attitudes. Post-training assessment of attitudes among MAP workshop

participants, interviewed before the training and again four to six months afterwards, has revealed the following.

- Before the workshop, 54 per cent of the participants disagreed or strongly disagreed that men must make the decisions in a relationship; after the workshop, 75 per cent of the men felt this way.
- Before the workshop, 61 per cent of the participants disagreed or strongly disagreed with the statement that women who dress in a sexy manner want to be raped; after the workshop, 82 per cent of the men felt this way.
- Pre-training, 43 per cent of the participants disagreed or strongly disagreed with the statement that sometimes when a woman says 'no' to sex, she doesn't really mean it; after the workshop, 59 per cent of the men felt this way.
- Pre-training, 43 per cent of the participants disagreed or strongly disagreed with the statement that a man only really becomes a 'man' when he has fathered a child; after the workshop, 72 per cent of the men felt this way.

The process of change evident in the research findings is also captured in the words of MAP educators and activists. As Boitshepo Lesetedi, MAP co-ordinator at PPASA, puts it, 'I realised it was impossible to work around issues of gender when you haven't started with yourself, because I was carrying my own baggage, my own myths and stereotypes. So it became more of my own life than work, realising how much freer I could be when I don't have to be doing what has supposedly been men's role'. MAP educator Patrick Godana describes his involvement in the following way: 'Being involved in MAP work has helped me to see the beauty of life.'

Lessons learned

We have found that the MAP framework can be applied in a variety of settings. Based on the work of EngenderHealth to date on constructive male involvement, we highlight the following lessons:

1. **Present men as potential partners capable of playing a positive role in the health and well-being of their partners, families, and communities**
   Despite gender norms that often lead to men's control of different aspects of their partners' lives, it is important to recognise that many men care deeply about the women in their lives, including their partners, family members, co-workers, neighbours, 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 are willing to participate in reproductive-health decision making that supports the well-being of

women. Approaches that view men in a positive way – as partners or allies – are especially useful in redefining men's involvement in the promotion of gender equity.

2 **Societal crisis can create opportunities for dialogue or for shifts in gender relations**
Several crisis-related situations have led to important shifts in how programmers, researchers, and individuals view gender relationships. The HIV epidemic has led to an increased dialogue and to substantial efforts to reach men and involve them in helping to stem the epidemic in their communities, and encouraging them to participate in equal decision making on reproductive-health issues. Large-scale unemployment and poverty have fostered changes in how women participate in decision making in the household and family, as more women enter the workforce. Such factors have also helped to shape different masculinities, with some men starting to participate in traditionally women-centered domains. High levels of violence in society have prompted an increased emphasis on creating positive role models for young men, and on implementing programmes that reach young boys at an early age in order to help them develop more positive and equitable masculinities.

3 **Reach men where they are**
Instead of seeking or creating new arenas in which to engage men, programmes should utilise the existing key venues where men congregate or can be reached. These include sports and religious events, workplaces, and social locations such as bars or cafés. All of these are important places where information and discussion on a variety of issues can be shared with men. Scaling-up a programme is also easier when working through existing institutions that can reach large numbers of men, such as unions, the military, and industries such as mining or transportation, where men predominate.

4 **Provide private spaces for men to obtain services**
Most reproductive-health services offered around the world in service-delivery settings are geared almost exclusively to women. Having realised the importance of constructive male involvement in reproductive health, these settings have started providing facilities for men only. On many sites, these are provided within the same clinic as the services for women, but special areas within the site are designated for men, or clinic times are established only for men. This has helped to make men feel more comfortable and has encouraged them to seek help.

5 **Provide opportunities for men to share experiences with each other**
Given that men are socialised in groups – in the schoolyard, in religious institutions, on the playing field – it is important and valuable to offer men alternative experiences of group socialisation that challenge their

traditional notions of manhood. Experiences such as these allow men an opportunity to build connections with other men and to explore different aspects of their own identities. In a safe and comfortable environment, they also allow men to express their dissatisfaction with, and concern about, these changing roles in the company of other men.

6 **Build organisational 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 the senior leadership within partner organisations – regardless of whether these organisations are service providers, large trade unions, or corporations. To ensure that key decision makers and managers support the MAP approach, the MAP methodology includes where possible workshops and training with senior management and key staff in each institution on the relationship between gender equity and reproductive health. In the longer-term, MAP hopes to address other aspects of organisational culture, such as recruiting appropriate staff, and more systematic training of staff at all levels.

7 **Involve stakeholders from the beginning**
In any MAP project, EngenderHealth tries to involve key stakeholders from the start to ensure participation and ownership. In Guinea, for example, the Ministry of Health, service providers, community leaders, local reproductive-health organisations, and clients were included in the process from the beginning. This not only helps to gain their support, but also encourages personal reflection and a commitment to adopting a new set of norms.

8 **Build strategic alliances with communities**
To create effective community support for activities that might affect the status quo, it is critical to obtain the support of key local community members. In Nepal, the MAP project ensured that the peer educators who were trained included key political representatives. In Guinea, the project would not have been successful without the active participation of the local *imams,* who played a valuable role as sources of information. Without their involvement and public endorsement, the project probably would not have been so successful in reaching out to men.

9 **Respond to staff needs**
Understanding the needs and roles of clinical staff is an integral part of ensuring successful provision of reproductive-health services for men. A provider's own attitude to sexuality, his or her own feelings about gender, and previous training all play a role in how he or she may interact with a male client (either as an individual or as part of a couple).

10 **Conduct research to identify how men can serve as allies**
A substantial amount of work has been done to date to identify men's reproductive-health needs in different settings and to understand how they

might put themselves at risk. However, there is still a need to understand how to encourage and support men to become allies in improving their own health, as well as the health of the women and children who are often placed at risk by traditional gender roles.

11 **Integrate a strong social-justice emphasis into work with men, and build coalitions with progressive social movements where feasible**
Many movements to involve men, including the growing movement to end men's violence against women, share several goals with civil rights and other social-justice movements. Working together offers many advantages. Social movements gain strength and credibility when they pay attention to issues related to gender equity, and gender-justice activists gain important understanding about activist strategies and the communities in which they work. Given their commitment to principles of equity and liberation, men involved in these movements are, in theory, likely to be natural supporters of constructive male involvement, and are more likely than most to do so actively in their personal and public lives.

12 **Promote activities that go beyond education and individual change**
Many of the organisations collaborating on the implementation of the MAP programme have been historically focused primarily on community education and individual change. Few have prior experience in advocacy, policy change, or community mobilisation. To ensure that partner organisations can take this work on, MAP workshops in some locations now include a focus on advocacy, community mobilisation, social norms campaigns, and policy change.

As the evaluations and learning indicate, significant progress has been made in terms of men's involvement, and changes in attitudes and practices are visible. Perhaps the hope for change is best expressed by one church leader and past MAP participant who said, 'I used to use the Bible to defend patriarchy. I now use it to challenge gender stereotypes.' Such comments remind us that men can play a vital role in helping to achieve more equitable gender relations, something from which both men and women will benefit greatly.

Notes

1 The name 'Men As Partners' has been registered by EngenderHealth.

2 Paulo Freire (1970) *Pedagogy of the Oppressed*, New York, NY: Continuum.