

Research Article

## Engaging Men to Change Health Related Gender Norms: Testimonies of Gender Norms Transformation from Female Sex Partners in Tanzania

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### Abstract

Some population based surveys show significant sex differentials in HIV prevalence among males and females aged 15 - 49. USAID through ENGENDERHEALTH initiated the CHAMPION (*Channeling Men's Positive Involvement in the National HIV/AIDS Response*) intervention to address the negative aspects of gender norms in selected districts of Tanzania. The aim was to promote dialogue about men's roles in changing social norms, increase gender equity and reducing the vulnerability to HIV infection through behavior change. In this study we present women testimonies who are primary sexual partners of those men.

### Methods

Quasi-experimental evaluation study design was used and data was collected at two points. At the baseline for both control and intervention groups, and at the end of the project for both groups. The endline evaluation was conducted after five months using quantitative and qualitative methods. However, in this study we report findings from qualitative part only.

### Findings

Male partners began to exhibit behaviours and attitudes that suggest change in gender norms particularly with regard to; increased knowledge/skills in gender issues, increased role in child care, negotiating about sex, gender division of labour, and decrease in physical and emotional violence.

### Conclusions

Male engagement in behavioural change interventions is important in bringing positive behaviour change that contribute to improved health.

**Key Words:** Partners; Men; gender; transformation; Tanzania

### List of Abbreviations

CHAMPION-Channeling Men's Positive Involvement in the National HIV/AIDS Response; HIV/AIDS- Human Immuno Virus; AIDS- Ac-

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**Sub Date:** June 30<sup>th</sup>, 2018, **Acc Date:** August 08<sup>th</sup>, 2018, **Pub Date:** August 09<sup>th</sup>, 2018

**Citation:** Ezekiel MJ, Kazaura MR, Chitama D, Mosh<sup>1</sup> IH and Mlang'a E (2018) Engaging Men to Change Health Related Gender Norms: Testimonies of Gender Norms Transformation from Female Sex Partners in Tanzania BAOJ HIV 4: 034.

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quired Immune Syndrome; PMTCT-Prevention of Mother to Child Transmission; STIs-Sexual Transmitted Infections; TDHS-Tanzania Demographic and Health Survey; MAP-male as partners.

## Introduction

Gender norms are social expectations of appropriate roles and behaviors for men and women in particular society [1]. The replication of these norms in institutions and practices, are related to men's health-related behaviors, with implications for the whole society [2,3]. Some studies have shown that men and boys who have rigid views about inequitable gender norms are more likely to be violent against a partner, to have had a sexually transmitted infection, to have been arrested and used substances [4]. Other researchers have found associations between beliefs in inequitable gender norms and rates of HIV/STIs transmission, contraceptive use, physical violence, domestic chores, parenting and men's health-seeking behaviors [5,6,7]. Some studies [8] confirmed that gender stereotypes and disproportion expectations about appropriate sexual behaviors for boys and girls influence sexual behaviors of young people.

Determining changes brought by specific health-related programmes lead to lasting and real change on the part of men is challenging. Nonetheless, the number of health programmes with men and boys, based on a gender perspective, has been growing in the past 15 years. Some literature reviews have found a mixed encouraging assessment of programs with men [9,10,11].

From Pulerwitz [12] analysis some studies have shown significant correlations between support for inequitable gender norms and risk for HIV and other STIs. For example, young men from rural areas in India who supported equal gender norms were more likely in the last three months to have had sex with more than one partner, been physically or sexually abusive against a partner, and reported sexual health problems, including. Moreover, in Brazil, endorsement of inequitable gender norms was highly associated with reported STIs symptoms, low contraceptive use, and both physical and sexual violence against a current or recent partner [13].

Gender norms limits male participation in HIV and reproductive health services geared to women, which has implications for women and children's health. It was found that male involvement and support were recognized as critical, but challenging, to improving women's uptake of core Prevention of Mother to Child Transmission (PMTCT) services including deciding to be tested, returning for test results, taking antiretroviral drugs correctly, and choosing and carrying out an infant feeding method [13].

Male involvement during pregnancy is important for HIV prevention.

Pregnancy can be a particularly vulnerable time for women because of high HIV prevalence among individuals of reproductive age, social norms that may condone extramarital partners for men while their wives are pregnant, and low or no use of condoms in marriage [14,15]. However, pregnancy may also provide an opportunity to foster communication within couples by capitalizing on both members' interest in the physical and social well-being of the mother and child. A study in Zimbabwe found that female respondents expected men to be more involved in pregnancy than the men themselves intended to be; while the men focused on financial support and passive involvement, the women also expected emotional support, accompaniment to antenatal appointments, and help with domestic chores. The researchers found that gender norms that frame pregnancy as a woman's domain and the pervasiveness of unwelcoming clinic environments for men who accompany their wives to care are barriers to male involvement in antenatal care [16].

Several Horizons studies also showed significant correlations between support for inequitable gender norms and risk for HIV and other STIs. For example, young men from rural sites in India who supported inequitable gender norms were significantly more likely in the last three months to have had sex with more than one partner, been physically or sexually abusive against a partner, and reported sexual health problems, including STI symptoms [7,12]. Likewise in Brazil, endorsement of inequitable gender norms was significantly associated with reported STI symptoms, less contraceptive use, and both physical and sexual violence against a current or recent partner [18]. Horizons and partners also found evidence that equitable gender attitudes could be protective: In the Ethiopia study, men with gender-equitable attitudes were more likely to report healthy intimate partner behaviors, such as discussing and using condoms and other contraceptives [19].

Male violence against women is the direct result of gender norms that accept violence as a way to control an intimate partner. The use of violence by men against women and girls makes it impossible to prevent HIV infection. A multi-country study found that between one-fifth and one-half of women of reproductive age have experienced physical violence by a male partner [20]. Study from South Africa found that intimate partner violence is significantly associated with HIV seropositivity among women attending antenatal care centers [21]. Despite growing awareness that changing inequitable gender norms is key to realizing sexual and reproductive health, including HIV prevention, [22,23] relatively few interventions had explicitly attempted to address these norms, and even fewer studies had measured the effects of such interventions. Most reproductive health interventions had focused primarily on women, with little attention paid to men [24].

In Tanzania, it was found that there is interrelationship between violence against female partners and infidelity. Horizons and partners

found high levels of infidelity among young couples and found that infidelity or the perception of it is the most common trigger for violence, condoned by many men and some women. For men, violence is justified when women lie to their partners and must be “taught” right from wrong. According to one informant, “there’s time they need a teaching.” There was also widespread acknowledgement that women expect men to provide economic support as part of a sexual relationship and will use sex as a way to remedy resource constraints. Women expect their male partners to provide them with money and gifts, but mistrust men because they often make false promises to have sex. On the other hand, men mistrust women’s intentions, and were concerned that women’s primary motivation for the relationship is financial support [25].

Due to high levels of infidelity and the transactional nature of many sexual interactions, many male and female young people in the Tanzanian study distrusted their sexual partners and accepted partner violence as the norm. Findings from a quantitative survey of young men in the same communities revealed that more than a third agreed there is nothing a woman can do if her partner wants to have other girlfriends, and about half believed that a woman should tolerate beatings to keep the family together [26].

Acceptance of violence against women was also common among women surveyed at a Tanzanian voluntary counseling and testing (VCT) center. Almost half of surveyed females identified at least one situation in which they felt that physical punishment of women was justified [27]. Such situations included disobedience, infidelity, refusing sexual relations, and not performing household chores to the satisfaction of male partners. Female VCT clients who tested positive for HIV were also significantly more likely to have experienced physical or sexual violence from their current sexual partners compared with women who tested negative. In fact, HIV-positive women younger than age 30 were 10 times more likely to report violence than their HIV negative counterparts [28].

Multiple concurrent sexual partnerships are socially condoned and often encouraged for men among many societies in the world and majority of them don’t use condoms. For instance, Tanzania Demographic and Health Survey [29] shows that 21 percent of men and 4 percent of women reported having sex with two or more partners in the past 12 months. Among these men, only 24 percent used a condom during their last sexual intercourse before the study. Transactional and commercial sex remains a major obstacle to HIV prevention efforts as well. For instance fifteen percent of men reported to have been paid for sex in the 12 months prior to the survey [29].

In the world, about 36.7 million people were living with HIV at the end of 2016. Also it is estimated 0.8% of adults aged 15–45 years world-

wide are living with HIV, and the burden of the epidemic continues to vary greatly between countries and regions in the world. Sub-Saharan Africa remains the most severely affected with nearly 1 in every 25 adults (4.2%) living with HIV and accounting for almost two-third of people living with HIV globally [30,31].

HIV prevalence in Tanzania is estimated to be 5.1 percent and an estimated 1.4 million Tanzanians are living with HIV/AIDS [32]. It is estimated that 86,000 HIV/AIDS related deaths occur each year and disrupts family, also there is an increase in the estimated 1.1 million HIV orphans and vulnerable children [33]. The Tanzania HIV and Malaria Indicator Survey (THMIS) (2011 - 12) shows that there are significant sex differentials in HIV prevalence. In 2011 - 12, the overall prevalence of HIV infection among males of 15 - 49 years was 3.8 percent, while for females in the same age group the prevalence was 6.2 percent. HIV prevalence is higher for women than men in all age categories [30].

Tanzania women are still experiencing violence as shown in the most detailed descriptive study in the country carried out in Dar es Salaam and Mbeya regions. The research findings showed that 41% of ever partnered women in Dar es Salaam and 56% in Mbeya had ever experienced physical and sexual violence from their partners. In Dar es Salaam, 33% of ever partnered women had experienced physical and 23% sexual violence [32]. Factors which lead to this situation include wife disobedience which was reported by 10.4 percent of women interviewed and 6.3 percent experienced violence due to refusal of sex with their partners. Violence also reflects the power imbalances between men and women. The Tanzania Demographic and Health Survey (TDHS) shows that 54 percent of women and 38 percent of men age 15 - 49 believe that a husband is justified in beating his wife for certain reasons [29]. These findings show how women’s own views about male gender roles reinforce negative social norms.

Therefore, in this article we present part of findings from an evaluation of group educational sessions conducted as part of an intervention to promote change in men’s perspectives about their gender roles in sexual reproductive health and reduction of HIV and related gender based violence by MAP CHAMPION project in Tanzania. We describe female partners experiences with regard to the effect of the intervention on their male partners on specific aspects in gender relations.

## Methods

Four urban districts were chosen for the evaluation after the intervention of CHAMPION MAP project. Four regions were selected to participate in this study which were Mbeya, Tabora, Mwanza and Dar es Salaam. Later on one district was selected from each of the regions.

These districts were Mbeya City Council; Tabora Municipal Council; Ilemela and Temeke Municipals. From these districts one ward was selected from every district. The control group consisted of regions which were Bukoba and Songea Municipals. Out of these two regions one district was selected from each region. In each district two wards were selected. The four intervention districts were purposively selected by CHAMPION among the 14 “key districts” where the project operated. Women interviewed in this study were selected after interviewing their male partners from a larger study intended to evaluate a project known as Channeling Men’s Positive Involvement in a National HIV/AIDS Response (CHAMPION) in which the study design was quasi experimental. We estimated a sample of 1,620 adult (aged between 25 to 50 years) women and men. During interviews men who reported to have changed gender norms were asked for permission to speak to their spouses. Few of these men accepted to link their spouses to interviewers for further exploration (or triangulation) of their self-reported changes in gender related norms and practices brought

about by the intervention.

By the time of the study, Tanzania Mainland had 24 regions forming 70 districts. We selected six regions as shown in figure 1: Tanzania map attached below (Dar es Salaam, Kagera, Mbeya, Mwanza, Tabora and Ruvuma) [34] to represent Mainland Tanzania. From each region, we purposefully selected one urban district (later to be used by CHAMPION – *Channeling Men’s Positive Involvement in a National HIV/AIDS Response* to train men and women on reducing HIV risk, improving reproductive health outcomes and to increase gender-equitable norms and behaviors. We further selected two wards (a ward is close to the lowest Tanzania government administrative structure at the community level that represent between 1,000 and 21,000 people. In urban settings, wards represent a portion of a town or of a larger city). From the selected wards which participate in CHAMPION, female partners of males who were trained by CHAMPION were purposively selected to participate in this study.



Figure 1: Adapted Map of Tanzania showing studied areas

The study was conducted in six regions which were: 1. Mbeya, 2. Tabora, 3. Dar es Salaam, 4. Mwanza, 5. Kagera, 6. Ruvuma

The intervention study primarily targeted adult females and males from 25 to 50 years. During recruitment of females for interviews this inclusion criteria was strictly adhered to. We identified female primary sex partners purposively after interviewing men who participated in the intervention. The male partners provided contact information of their partners who were later on contacted by researchers to arrange for separate in depth interviews at a later date.

Interviews with female partners of male as partners (MAP) participants were only conducted at endline evaluation stage. In each of the four interventions districts a minimum of 6 - 7 female partners were included in the interviews to triangulate behavior changes reported by male partners. The female partners were obtained after administering a questionnaire to the male partners. The interviewers requested men (a small fraction of men who self reported to have undergone positive behaviour change) participating in the questionnaire survey to allow their partners to be interviewed. Only those females who consented took part in the in key informant interviews after setting up appointments. Key informant interviews were translated, transcribed and subjected to quality checks and cross-checked among the research team members to determine patterns of responses, consistency and accuracy. Key informant guide was used to conduct key informant interviews and it focused on awareness issues of CHAMPION's MAP project, method of HIV prevention used with a partner, attitudes towards condom use, male partner involvement in health care, attitudes of health workers toward men attending health facilities with their partners, testimonies of gender transformation. The information was analyzed manually and categorized into thematic areas to produce themes based on main questions in the interview guide and other issues that emerged inductively as study progressed (see list of themes in box 1).

## Ethical Issues

The study obtained ethical clearance from Muhimbili University Institutional Review Board in Tanzania (IRB number: MU/DRP/AEC/Vol. XVIII/6) and all study participants provided verbal consent prior to the interviews. All study participants who were contacted consented to participate in the interviews. The females were drawn from both comprehensive and modified intervention districts.

## Findings

A total of 26 female key informants were interviewed. Analysis of the key informant interviews identified six [6] thematic areas describing different aspects related to gender norms, health seeking and sexual relationships among partners. The themes highlight and illustrate impact of intervention on male behaviour as reported by their primary partners.

- *Awareness of CHAMPION's MAP project*
- *Method of HIV prevention used with a partner*
- *Attitudes towards condom use*
- *Male partner involvement in health care*
- *Attitudes of health workers toward men attending health facilities with their partners*
- *Testimonies of gender transformation*

Box 1: List of themes

### Awareness of CHAMPION's MAP Project

We sought to determine if female partners were aware of the CHAMPION MAP project. The findings show that majority of the participants interviewed were aware of the CHAMPION MAP project and were also able to describe some of the objectives or activities of the project. For instance, some of the participants mentioned that MAP project was dealing with HIV counselling, testing and HIV prevention, gender equality, equal participation of men and women in various issues concerning their family and how men should treat their wives and marriage issues in general. They further reported that MAP project educated men on the importance of involving their sexual partners or wives in decision making processes pertaining to family welfare at household level. Participants who were aware of the MAP project acknowledged to have been informed by their male partners who participated in MAP intervention. Some of those participants actually participated in the group (female only) education workshops conducted by the MAP project.

In one of the interview, a woman was quoted saying;

*"Yes, I have heard about the Champion project, it is the project that deals with gender based violence and marital relationships... my husband always tells me about that project when he comes back from the training and sometimes. I do ask him about what transpired in the training because most of the things are beneficial to us... women"* (IDI, Mbeya).

While most of the women reported being aware of the project, few of them had limited understanding of the project. They admitted to have heard about the project but could not mention specific activities and goals of the project. They attributed limited awareness to the fact that their partners did not discuss whatever they learned during the MAP training with them.

*"I heard about the project when they were announcing it and they enrolled my husband, since I was in the kitchen cooking I did not get a chance to hear most of the things discussed. What I remember is that*

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they asked my husband some questions and he was enrolled into the project” (IDI, Mwanza).

### **HIV Prevention**

While condoms were frequently mentioned by majority of the participants, findings suggest that condom use might be low among sexual partners. A frequently mentioned reason was that partners were faithful to each other and therefore, did not find it useful to use condoms. Those who used condoms reported to have used them for a short period in postpartum period in order to prevent unplanned pregnancies. While some female partners reported to be faithful in marriage, some of them were not sure about their husbands’s faithfulness particularly when their husbands are away from home.

One participant opined;

*“We never use any means of preventing HIV/AIDS, because we are faithful to each other. So we never use protection. So if I will introduce about using condom he [husband] will not be happy”* (IDI, Mbeya).

On the contrary, for some HIV discordant partners the motivation for condom use was reportedly to prevent infecting the other uninfected partner and unplanned pregnancies.

*“We use condom with my partner .....we have agreed to use condom because....in year 2000 I tested for HIV and was found to be positive....so I had also to take my children to undergo the test but all of them were negative. So the issue was how could I tell my husband about my HIV status? Later on I was courageous to inform my husband about my status. He agreed to undergo HIV test and was negative. From there we decided to use condom so that I will not infect my husband”* (IDI, Temeke).

### **Attitudes Towards Condom Use**

With regard to the attitude towards condom use, our findings reveal that married couple tended to associate condom with extramarital relationships. Some said condoms were used when someone was cheating on her partner or when a woman was breastfeeding. In addition, others went further saying that it was absurd for a woman to ask her husband to use a condom.

One participant said;

*“He always tell me to use condom when I travel but for me it is not easy to cheat on him. May be that is what he does behind my back”* (IDI, Mwanza).

### **Male Partners Involvement in Health Care Issues**

We investigated male partners willingness to accompany their female partners to health facilities. Findings suggest that most male partners accompanied female partners to clinic particularly during pregnancy. Some of them mentioned that it is during the first and second pregnancies that male partners were highly motivated to have their first babies so accompanying their partners to antenatal clinics. This motivation dwindled in subsequent pregnancies. Indeed some reported to have been accompanied by their partners not only for HIV testing and counseling but also occasionally taking the children to the post natal clinics for routine monthly growth monitoring visits. One participant stated:

*“My husband always escorts me to clinic when I am pregnant... we get counseled together but if it happens that he is busy at work I go on my own. Sometimes he takes the child to postnatal clinic but all in all whenever he is free he never refuses to accompany me to health facility”* (IDI, Mbeya).

### **Attitudes of Health Workers Toward Men Accompanying their Partners**

Attitude of the health care workers towards attendance of male partners at the clinic with their female partner was reported by female partners to be positive. Study participants reported that health workers encourage men to attend to health facilities by using different strategies. Some of the strategies mentioned included; attending the couples as a first priority and using the couples as role models for other clients who visit the clinics without their male partners.

*“Health care workers advise us to visit antenatal clinic with our partners and they really seem happy seeing us together, and when you go with your partner you get first priority to be served...the environment is friendly at the health facilities for men to attend at clinics”* (IDI, Mbeya).

However, it was also reported that sometimes male partners shunned accompanying their partners because some clinics dont have enough sitting spaces to cater for large number of clients. Some men were reported to use such circumstances as excuses for not accompanying their partners. In such contexts, the environment was reportedly not very conducive for men. One stated;

*“The environment is not conducive because sometimes if you go with your husband....especially on a busy day you will find there is no place for him to sit”* (IDI, Mwanza).

### **Testimonies of Gender Transformation**

Study participants described events and actions observed in their

partners to substantiate their claims. Testimonies suggest that male partners have begun to exhibit behaviours and attitudes that are suggestive of change in gender norms in specific aspects of life particularly with regard to; increased knowledge in gender issues, increased role in household chores and child care, negotiating about sex, gender division of labour, physical and emotional violence. Indeed some study participants specifically attributed this change to men's participation in MAP workshops.

### Household Chores

Majority of the participants reported that their male partners have changed with regard to household chores. They further narrated that their male partners help them even with household chores something which they never did before attending the training. For example, one participant commented;

*"To be honest my husband could never have helped me with anything at home, he used to be very angry on everything... whenever he comes back home he is so angry and used abusive language even at a very small thing...he turns it to a very big issue to him...but since he started going to the trainings he has changed completely, at least now he can listen to me and take my advice, he can listen to our kids and even sit with us and talk"* (IDI, Mwanza).

### Gender Knowledge

Majority of the participants were of the view that men have learnt a lot from those trainings conducted by CHAMPION MAP. They further narrated that their partners have changed and some of them help them with household chores, buying things for them and even in the decision making women are given opportunity to participate in the process including family planning issues. For instance, in several interviews from different study sites, participants were quoted saying;

*"Men have learnt a lot and have changed. They have received education on family planning and community health..., my partner has changed in gender issues for example; one, he buys me khanga, gives me money... something he was not doing before; and two, when he is free he assists with some household activities. In the case of decision making we now sit together, discuss and then agree on what to do... in a nut shell he has changed a lot and I must give much credit to this [MAP]project"* (IDI, Mbeya).

### Sex Negotiation and Condom Use

Findings suggest there is some discussion among partners about sexual lives and sexual decision making. Those who reported to discuss mentioned that the discussion centred on negative effects of using condoms, importance of being faithful in relationships and others

mentioned that the discussion was also about using condoms when having sex outside their relationships. Among those who discussed sexual lives with their partner, some were quoted saying;

*"It is true that we always discuss and advice one another especially on the issue of sex and that is where he tells me that, if I dont feel like having sex then I have to say because it is my right, and when I am sick he always helps me household chores like cooking and fetching water... things which are all new...I haven't seen him doing these things before"* (IDI, Tabora).

### Child Care

Some of the participants reported that some of their partners even help them to take care of the children and even talking with children.

*"He used to care less about children and even talking to them was very difficult, but nowadays he takes care of them, talks to them about things bothering them ....and takes care of those things after discussing with me"* (IDI, Tabora).

- **Increased gender awareness**
- **Household division of labour**
- **Men's participation in child care responsibilities**
- **Sexual negotiation among partners**
- **Decrease in gender based violence**

**Box 2:** Summary of some aspects of behavior change and gender transformation

## Discussion

Our study aimed at exploring changes in part of men who attended CHAMPION MAP project intervention. The direct quotes of women have been presented to allow the reader to ascertain the validity and dependability of the study findings. Our study findings show the effectiveness of engaging men to reflect critically on their roles and relationships with women and the ability to change gender norms. This is in line with the study by Verma and colleagues [17] in India who found changes among men after session of gender and discussions. In India, both arms of the intervention (group education sessions alone, and group sessions plus a community based campaign that included street theater) led to significant positive changes in gender norms and HIV-related outcomes [17].

Various researches show that in Tanzania women continue to experience violence as shown in the country study carried out in Dar es Salaam and Mbeya regions [35]. Our study provides testimonies that highlight the potential role of community based intervention in reduction of violence among couples in Tanzania and how it brought

changes to men with regards to gender norms including violence against women. World Health Organization's study shows that one of the factors for violence were wife disobedience, refusal to have sex with their partners [35]. Also our study findings show some female testimonies which suggest that there is increasing sexual dialogue among partners brought about by CHAMPION MAP which in the long run might contribute to reduction of these incidents. In addition our study findings suggest that the intervention has contributed to male adoption of less forceful approaches in their sexual relationships with their female counterparts.

Intimate partner violence has been reported in almost all countries in the world throughout human history [37]. These actions have also been increasing due to the fact that in most countries violation of women's rights often goes unrecognized and when recognized unpublished and unsolved [38]. Women who are victims of violence are often unable or afraid to seek health care as in some of the cases they are required to report first to the police station. In some instances these women lack enough money to support them to seek medical care. Sometimes women are often reluctant to disclose experiences of physical or sexual violence due to shame of reprisals [39]. In light of these previous evidence of female reluctance to report violence, the women in our study highlight the fact that with interventions targeting both males and females, women are more capable of speaking out and giving testimonies of both positive and negative experiences in their sexual and social lives. It seems that, the MAP intervention has given voice to the women to share their life experiences and this is a milestone in promoting changes in gender norms-by breaking the norm of silence among female partners and encouraging dialogue among them.

### **Testimonies of Gender Norms**

Our findings show that there is changing gender norms brought by MAP intervention, there is evidence elsewhere showing that some interventions to change gender norms may produce mixed results. For instance, in qualitative evaluation of participatory video reduce gender-based violence in conflict-affected settings, male participants in Rwanda reported that the project encouraged them to treat partners in more equal ways. Also from Liberia testimonies a male respondent described the way video project was responsible for the newfound peace in his relationship and home, he never knew that denying a woman her right is gender based violence (GBV) [40]. However, in the same study female participants described the presence of domestic violence and harmful traditional practices within their community despite the intervention. Still, women were beaten by their husbands, treated like properties and forced into sexual intercourse with their husbands [40].

Our study findings reported different testimonies from women about

changes observed from their partners with regards to gender norms. This corroborates a study done in three southern African countries (Botswana, Swaziland and Namibia) collecting stories of changes from different program participants about population health interventions to reduce gender violence pointed out several changes including knowledge with regards to gender based violence, multiple partners, condom use, HIV and family planning. They reported to be able to share their knowledge with others and the way it has healed them to take action to improve their lives. They also reported how men have changed their attitudes with regards to many partners, gender inequality and ability to criticize gender norms [40].

### **Provider Attitudes/Health System**

Our study findings reported a change of attitude among health care providers when women are escorted by their male partners to health facilities and they are given first priority. However few of the participants reported lack of conducive environment for men in some of the health facilities. This is in the same line as study done by Pulerwitz in Zimbabwe who found that gender norms that frame pregnancy as a woman's domain and the pervasiveness of unwelcoming clinic environments for men who accompany their wives to care are barriers to male involvement in antenatal care and men on their perceptions of the family planning (FP) methods use [12].

### **Limitation of the Study**

The qualitative nature of data collection may have resulted in limitations including interviewer and informant fatigue and social desirability bias. It is important to mention that this study offers insight into a range of experiences and attitudes across several information-rich respondents, but this was applied to female partners of males who attended CHAMPION training. Additionally, given the fact that only those who consented that their partners could be contacted for interviews, there are possibilities of having missed the experiences of men who did not provide access to their wives/female partners to talk to the interviewers.

### **Conclusions**

Male engagement in behavioural change interventions is important in bringing positive behaviour change that may eventually contribute to change of harmful gender norms and consequently improve health. It is of paramount importance to build programs that support long-term, sustained change in gender norms by fostering broad-based, ongoing discussion on manhood, masculinity, and gender dynamics. Only a long-term sustainable strategy that includes a variety of approaches and involving men can successfully promote and support such changes.



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## Declaration

The authors declare no conflict of interest with regard to this study

## Author Contribution

MJE participated in study design, collected and analyzed data and prepared first draft of the manuscript. MRK and DC took part in study design, participated in data collection, analysis and preparation of manuscript. EM took part in preparation of the manuscript. IHM participated in collecting data and reviewing the manuscript. All authors approved the final draft prior to submission.

## Acknowledgement

We acknowledge all study participants for agreeing to participate in our study and share their experience with us. We also acknowledge USAID for funding this study.

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