MEN AS PARTNERS:
SOUTH AFRICAN MEN RESPOND TO VIOLENCE AGAINST WOMEN AND HIV/AIDS.

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In a classroom outside of Johannesburg, a teacher pressures a young student to have sex with him, telling her that she'll fail the class if she does not[1].

Not far away, in a living room late at night, a victim of domestic violence, afraid she'll get beaten again, acquiesces to the drunken insistence of her husband and endures intercourse.

In a one-room house in Kwazulu Natal, a young man listens in confusion and anguish to the news that his sister has been raped. No one knows whether the rapist was HIV positive or not.

In the halls of parliament in Cape Town, a legislator dismisses as unsubstantiated reports that sexual assault rates have reached epidemic proportions[2].

Walking home from work on the outskirts of Bloemfontein, a young man discusses birth control options with his girlfriend.

In a rural community in the Northern Province, a woman struggles to feed, bathe and take care of her ill grandchild. Her husband refuses to help with "women's work"[3].

In a trade union conference room in Braamfontein, a male shop steward argues persuasively that the labor movement has a crucial role to play in promoting responsible fatherhood[4].

This paper draws upon presentations made at three conferences: The Association of Women in Development's (AWID) 9th International Forum, "Reinventing Globalization: New Challenges, New Solutions", October 2002 in Guadalajara, Mexico; the 14th International AIDS Conference, July 2002 in Barcelona, Spain and the International Reproductive Health Priorities Conference, August 2001 in Drakensburg, South Africa.

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The settings and specifics may vary, but the scenes described take place every day in communities all across South Africa. In South Africa, like in many parts of the world, men all too often act in ways that contribute to a variety of public health problems such as domestic and sexual violence, sexually transmitted infections, spiraling 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 sexual and reproductive health. Spurred by the recognition that men's attitudes and behaviors can either impede or promote sexual and reproductive health, many sexual and reproductive health organizations across the world have launched initiatives to encourage positive male involvement.

This paper describes one such initiative–the Men as Partners (MAP) program in South Africa. Developed in 1998 as a collaboration between New York based EngenderHealth (formerly AVSC International) and Planned Parenthood Association of South Africa (PPASA), MAP works with men to promote gender equity in order to foster the sexual and reproductive health of both women and men.

In order to describe the context within which this work occurs, the paper provides a thumbnail sketch of the recent shift within the sexual and reproductive health field towards engaging men as a necessary part of the solution rather than as probable obstacles to it. The paper then provides a brief history of the MAP project and the current

South African context. It then describes the MAP methodology in some detail, focusing especially on the rationale for educating men in groups while also examining the following aspects of the group approach: the nature of the workshops, including content and pedagogy; the training strategies for MAP educators; audience selection and recruitment criteria; and follow up and sustainability. The paper concludes by discussing lessons learned over the last four years, as well as modifications made and anticipated next steps.

The Global Context: Over the course of the last decade, and especially since the International Conference on Population and Development held in Cairo in 1994, many sexual and reproductive health organizations have recognized the centrality of men's attitudes and behaviors to sexual and reproductive health, and have placed an increased focus on promoting positive male involvement (UN Program of Action of the International Conference on Population and Development, 1995). This emphasis reflects, on the one hand, an understanding that gender inequity is a fundamental factor driving both HIV/AIDS and violence against women and, on the other, a recognition that gender equity is only possible if men support and promote it.

Positive male involvement strategies draw upon three interconnected principles, each related to an understanding of the many negative ways in which the unequal balance of power between men and women plays itself out. Firstly, contemporary gender roles are seen as conferring on men the ability to influence and/or determine the reproductive health choices made by women-whether these choices be about utilization of health care services, family planning (Obisesan et al, 1998), condom usage or sexual abstinence (Horizons Report, Spring 2001; Laing, 1987). Secondly, contemporary gender roles are viewed as also compromising men's health by encouraging men to equate a range of risky behaviors– the use of violence, alcohol and substance use, the pursuit of multiple sexual partners, the domination of women–with being manly, while simultaneously encouraging men to view health-seeking behaviors as a sign of weakness. Such gender roles leave men especially vulnerable to HIV 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. Thirdly, men are seen as having a personal investment in challenging the current gender order both because it is in their health interests to do so, and also because they often care deeply about women placed at risk of violence and ill-health by these gender roles.

The Current Context in South Africa: Just 8 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 twin epidemics–HIV/AIDS and violence against women. The statistics make startlingly clear the extent and severity of the public health crisis, a crisis that gives rise to previously unimaginable terms like "child headed household" (Guest, 2001), and threatens to undermine the nascent democracy and the years of struggle that brought it into being. In many parts of the country up to 30% of adults are estimated to be HIV positive (MRC, 2001). Between five and seven million South Africans are expected to die from HIV/AIDS by the year 2010 (MRC, 2001). The statistics on violence against women are no less bracing–South African Police Service statistics chronicle 51,249 cases of rape reported to police in 1999, while Rape Crisis Cape Town 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.

Often the many media stories about HIV/AIDS and violence against women illustrate the ways in which the two epidemics are inextricably connected. A February 3, 2002 article in the New York Times titled "Child Rape Increases at Alarming Rate in South Africa" attributes the increased incidence at least in part to the "popular myth…that the cure (to AIDS) lies in having sex with a virgin" (Swarns, 2002). A January 18, 2002 Mail and Guardian article makes clear how such sexual violence fuels the HIV epidemic: "In South Africa, …the risk of HIV after rape is 40%, given the prevalence of HIV in young men–those most often involved in rape" (Beresford, 2002). Recent reports also make clear just how devastating the HIV/AIDS epidemic will be to the South African economy in both the short and long term. Economists predict that the loss of labor productivity associated with high AIDS death rates will lead to negative annual economic growth. Already the spread of HIV/AIDS and the specter of a widespread illness and death have "contributed significantly to the decline in foreign direct investment" (Deane, 2002).

While violence against women undeniably contributes to the spread of HIV, it should be viewed as a major public health problem in its own right. Indeed violence against women takes a devastating toll on the lives of millions of women and children, and exacts an enormous social cost. Research demonstrates unequivocally that domestic violence is closely correlated with a wide range of public health problems. Adults and children affected by or exposed to violence often suffer adverse sequellae that include aggressive and antisocial behaviors; anxiety, depression, trauma symptoms, and decreased cognitive functioning (The Gallup Organization, 1997; Straus and Murray, 1992). Teenagers scarred by domestic violence are additionally at increased risk for diminished academic performance, substance abuse, teen pregnancy and suicidal behavior-all of which drastically impede their ability to succeed as adults (Fantuzzo et al, 1991). All too often these children, especially the boys and young men, later become trapped in intergenerational cycles of violence themselves (Rossman, 1998; Holden et al, 1998).

Making the context clear: The relationship between sexual and reproductive health and "global apartheid".

Public health systems throughout the developing world often operate on steadily shrinking budgets dedicated to dealing with urgent crises-malnutrition, infant diarrhea, advanced stage tuberculosis and, increasingly, HIV/AIDS. As a result, women in many parts of the developing world receive neither the information nor the services necessary to promote sexual and reproductive health (Outlook, May 1999). Neither public health articles nor public health interventions typically address this, instead describing and/or prescribing a range of more narrowly defined ameliorative solutions sometimes couched in the language of "acknowledging the reality of

resource poor settings". In their seminal article "Global Apartheid", Salih Booker and William Minter re-politicize the discussion about HIV/AIDS and public health services. They write,

> "The global pattern of AIDS deaths--2.4 million in sub-Saharan Africa last year, out of 3 million worldwide; only 20,000 in North America but most in minority communities--also evokes the racial order of the old South Africa. To date, access to lifesaving medicines and care for people living with HIV and AIDS have been largely determined by race, class, gender and geography. AIDS thus points to more fundamental global inequalities than those involving a single disease, illuminating centuries-old patterns of injustice. Indeed, today's international political economy--in which undemocratic institutions systematically generate economic inequality--should be described as "global apartheid." Thus debating what is to be done about AIDS keeps leading back to broader issues. Unless women have the freedom to negotiate the terms of sex, increased awareness and availability of condoms will have only limited impact. Health services deprived of basic resources will be unable to meet the need for treatment or prevention of AIDS. (Booker & Minter, 2001).

Thinking about men's perceptions of health and health seeking behaviors.

Thinking about how men might play a more active role in the health and well being of their partners, children and community, requires an understanding of men's own perceptions of health and health seeking behavior and the ways in which these interact with their life circumstances.

A number of studies conclude that contemporary gender roles encourage men to equate risky behavior with manliness and, conversely to regard health seeking behaviors as "unmanly". Contending that "gender is one of the most important determinants of health behavior" Courtenay writes, "Research consistently shows that men engage in fewer health-promoting behaviors and have less healthy lifestyles than women". He continues, "men of all ages are more likely than women to engage in more than 30 controllable behaviors that are conclusively linked with a greater risk of disease, injury, and death" (Courtenay, 1998).

Supporting Courtenay's thesis, Noar and Morokoff offer a case study of male socialization at work by documenting the effects of "masculinity ideology" on condom usage and sexual and reproductive health in general. He points out that traditional men's gender roles "limit men's options regarding how they can behave, put "stress and strain on men", encourage "more sexual partners and sexual activity", promote "beliefs that sexual relationships are adversarial", and lead to "more negative condom attitudes and less consistent condom use" (Noar & Morokoff, 2001).

Connell's publication of "Masculinities" in 1995 spurred recognition that men are not monolithic and that their experiences, understandings and embodiments of what it means to be a man are shaped by and reflect their life experiences (Connell, 1995). In his article "Political Connections: Men, Gender and Violence", Greig makes clear the importance of the "discourse of masculinities" as opposed to one of "masculinity". He writes, "The term recognizes the heterogeneity of the group of people referred to by the term "men" and suggests that the links between gender identity and…men's lives are complicated by relations of power between men, along lines of economic class, social status, race/ethnicity, sexuality and age" (Greig, 2001). Campbell's paper cited above, provides a clear example of the ways in which some men inhabit a "gender identity" infused by life circumstances with conceptions that normalize risk taking. She quotes a mineworker talking about the fear miners feel as they enter the mineshaft: "You show your manhood by going underground, working in difficult

conditions–this shows that you are a man enough to accept that if you die you are just dead. Once you go underground you are a man and no longer a child".

According to Campbell, the suppression of fear and the lack of intimacy associated with life in the single sex mining hostels create conditions where miners routinely place their lives at risk by pursuing the physical and emotional connection provided by "flesh-to-flesh" sex. She writes: "the continued practice of dangerous sexual behaviors must also be located within a context that provides limited social support and scant opportunities for intimacy" (Campbell, 2001).

In short, prevailing gender roles promote risk taking and link health seeking behavior with an "unmanly" search for safety (UNAIDS, 2001). Given this, efforts to encourage men to think about health and to promote health seeking behavior will have to incorporate strategies that challenge these gender roles and invite men to prioritize their own health as well as the health of others. However, this cannot be done without paying close attention to the ways in which men's sense of themselves as men, and their day-to-day practices, are shaped by their life experiences. Echoing this theme, Campbell writes, "The task of changing mineworkers' sexual behavior, and persuading them to use condoms, for example, cannot be achieved without attention to the broader context of sex and sexuality, including the symbolic role of flesh-to-flesh contact in the face of general loneliness and reduced opportunities for intimate social relationships" (Campbell, 2001).

The broader context alluded to by Campbell includes crushing poverty, forced migration and tremendous social dislocation. As we've seen, it does not include access to life saving HIV/AIDS anti-retroviral therapies-or even to less expensive medication for HIV/AIDS related opportunistic infections. Given this, Campbell's directive that we pay attention to this broader reality, of necessity, requires that we acknowledge this reality and act to change it if we intend to be effective in our HIV/AIDS prevention work. This, in turn, means politicizing our work. Booker and Minter put it succinctly: "AIDS makes it plain. The fight against global apartheid is a matter of life and death for much of humankind and for the very concept of our common humanity" (Booker & Minter, 2001). In his book Infections and Inequalities: The Modern Plagues, Paul Farmer reminds public health and social work practitioners of what this means. He writes: "We keep hearing that we live in a time of limited resources, but how often do (we) challenge this slogan? The wealth of the world has not dried up; it has simply become unavailable to those who need it most… Our challenge, therefore, is not merely to

draw attention to the widening outcome gap but also to attack it, to dissect it, and to work with all our capacity to reduce this gap" (Farmer, 1999).

Men, Gender and Women's Reproductive Health:

While the 1990's saw a retreat in some quarters from a politicized discourse about international public health, the rapidly spreading HIV/AIDS pandemic and concern about limited gains in women's health prompted an important evolution in thinking about men's potential role in their intimate relationships and in their families. This section of the paper will focus on the new paradigms about men's roles and responsibilities that emerged during this period. The paper will then return to questions related to a more proactive social justice agenda in later sections.

From a focus on "women in development" throughout the late 70's and 80's, the 1990's saw a shift towards a "gender and development" paradigm that recognized the importance of attempting to engage men as potential partners in women's economic and social development rather than as probable obstacles to it. A similar shift can be seen within the field of sexual and reproductive health. Prior to the 1990's "reproductive health care providers were accustomed to paying little attention to men except for the diagnosis and treatment of sexually transmitted diseases" (Population Reports, 1998). However, at the International Development Conference on Population and Development held in Cairo in 1994 representatives from over 140 countries formally recognized the urgency of reaching out to men both for their own health and for the health of their partners and children (United Nations, 1995).

The emerging interest in involving men in sexual and reproductive health initiatives reflects an understanding that contemporary gender roles confer on men the ability to play an important role in the sexual and reproductive health of women. As such, men have the power to influence and very often to determine the reproductive health choices made by women-whether these choices be about utilization of health care services, family planning, condom usage or abstinence (Horizons Report, 2001; Laing, 1987; Obisesan et al, 1998). A United Nations Development Programme publication, "Men and the HIV Epidemic" makes clear the rationale for working with men and states, "failures in helping women to change sexual behavior and bringing about more equal gender roles demonstrate that boys and men too must be involved." (Rivers & Aggleton, 1999)

The years since Cairo have seen the mainstreaming of this new perspective-referred to variously as "men's participation", "male involvement" and "men and reproductive health" and "men as partners" that seeks, in the words of Rivers and Aggleton, to "better ways to understand men, to communicate with them, to engage them and to help them take better care of themselves and their partners". Fueled by this more optimistic analysis about men's current and potential role, many different initiatives have been launched since Cairo that attempt to promote men's active participation in sexual and reproductive health as well as in preventing violence against women and promoting gender equity. Perhaps the most prominent of these, the worldwide campaign, "Men Make A Difference" was launched in March of 2000 by the United Nations to engage men in HIV prevention activities (UNAIDS, 2000).

Two examples give a sense of this work, albeit a very incomplete one. In Nicaragua, the Men's Group of Managua meets every other week to hold each other accountable and support each other's attempts to remain violence free. Buttressed by this intrapersonal and interpersonal support, they launched a national campaign making the connection between the hurricane that destroyed large swaths of Honduras and Nicaragua in 1998, and increased male violence against women. Their theme: "Violence against women: A Disaster that men CAN do something about" (Movement, 2000). And in South Africa, self help groups and educational/task groups have laid the foundation for a range of other initiatives which aim to change men's attitudes, values and behaviors. The most public examples of this work include a number of "Men's Marches" to end violence against women and children that have been held since 1997 and have drawn thousands of men out onto the streets in a public repudiation of male violence (Haffajee, 1997; Maisel, 2002 & Mashabela, 2000). Attended by men from all walks of life, these marches represent the public face of dozens of group meetings across South Africa, often in many different configurations, that strive to bring about a major shift in the social norms that jeopardize the health and safety of women and men, girls and boys, and society in general.

MAP History and Mission: In 1998, recognizing the urgent 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 PPASA initiated a 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 8 of South Africa's 9 provinces, establishing a presence in communities across the country, including urban, semi urban and rural communities.

Given the long history of anti-Apartheid activism in South Africa, South Africa lends itself well to an approach aimed at mobilizing men, and in the process, galvanizing a groundswell of men willing to take a stand to promote gender equity. All throughout the country, people continue to work in groups to address community needs and to promote social justice–very often using structures inherited from the anti-apartheid struggle itself. In townships across the country, the civics associations provide a compelling example of one such structure. The civics, as they're known in South Africa, are examples of grassroots democracy taking place in small but formalized groups with elected leaders from the street, block and neighborhood levels meeting on a weekly basis to address local issues and concerns. There is, then, an extensive and well-documented history of people working together in groups to address social justice and human rights issues.[5]

Expanding the Conversation: MAP Workshop Methodology. Since its inception, the MAP program has conducted educational workshops with groups of men in a wide variety of settings and from many walks of life-workplaces, trade unions, prisons, faith based organizations, community halls, sporting arenas. In their very design, the workshops reflect a commitment to dealing with the complexities of gender roles and the challenges associated with shifting long held attitudes, values and practices. Most workshops are typically a week long and often residential. Workshop content is drawn from the Guide for MAP Master Trainers and Educators jointly developed by EngenderHealth and PPASA[6]. Unlike many other approaches which tend to have a single issue focus-domestic violence or sexual and reproductive health or parenting or HIV/AIDS-the workshops address the complexities of how gender roles affect men's lives. As such, they focus on violence, on sexual and reproductive health, on parenting, on support and care for people living with AIDS, and, always, on men's roles and responsibilities related to ending violence and creating healthy, thriving communities. They are also beginning to include a focus on activism and social justice.

Almost all activities utilize and emphasize participatory group approaches that share much in common with the methodology and rationale articulated by Paulo Freire in Pedagogy of the Oppressed. These interactive educational activities are used by the MAP trainer/facilitator, in both PPASA internal staff training and in commun ity 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 engage in unsafe sex or deter men from playing an active role in caring for and supporting left chronically ill by AIDS. Similarly, facilitators might use role-plays to examine men's attitudes towards health seeking behaviors and challenge the notion that a "real man" only uses health services when he's already seriously ill. Using interactive gender values clarification activities, workshop participants share and discuss their attitudes towards family planning, ante-natal 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 rationale for conducting the work of changing men's gender based attitudes, values and behavior in groups rather than relying exclusively on more traditional media based social advocacy work is relatively straightforward. Given that men are socialized in groups–on the schoolyard, at home, in religious institutions, on the playing field, in their places of employment, it makes sense to provide alternative group socialization experiences that challenge. Such an experience allows men an opportunity to build connections with other men and to experience themselves as men differently. A number of theorists write about the ways in which men often feel uncomfortable with contemporary gender roles and gender based behavior, but often maintain silence because of the fear that they will be ostracized if they speak out (Berkowitz, 2002; Katz, 2000). Bringing men together in groups offers them an important opportunity to express their dissatisfaction with and concern about these roles in the company of other men.

Building a "Big Tent" to Reach Larger Numbers of Men: Faced with the growing devastation wrought by HIV/AIDS and violence against women, EngenderHealth and PPASA have worked hard to expand the impact of the MAP program. 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 mobilize men in the service of gender justice and social justice.

In order to involve greater numbers of men, EngenderHealth and PPASA recently succeeded in 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 over 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 will provide ongoing training and technical assistance to a core group of staff in each of these organizations, who in turn will run workshops in their unions, community based organization or in the military. In addition, to make sure that the MAP approach is integrated into more clinical settings, EngenderHealth will also work 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.

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 organizations 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 day-to-day strategies men can utilize to promote gender equity and positive male involvement, examining community based efforts underway elsewhere in the world to assist in the planning of community based strategies locally. Workshops will soon offer advocacy and research skills, and will include opportunities for participants to practice organizing and mobilizing skills.

Given the long history of anti-Apartheid activism in South Africa, South Africa lends itself well to an approach aimed at galvanizing a groundswell of men willing to take a stand to promote both gender equity and social justi ce. Nearly a decade after grassroots, community mobilization brought about an end to Apartheid, people continue to work to address community needs and to promote social justice–very often using structures inherited from the anti-apartheid struggle itself[7].

The intransigent position taken by the South African government in opposition to providing anti-retroviral therapies for people living with AIDS has led to increasingly militant activism around access to medication led by the Treatment Action Campaign. This emerging social movement, which has as its primary demand access to easily available and life saving medication, shares many members with other social movements


and more traditional social service organizations, the Men as Partners program amongst them. It seems both important to foster these emerging relationships and, in so doing, to infuse the more explicitly political agenda and activist strategies of AIDS advocacy and activist groups into the work of social service organizations. While activism and advocacy aren't necessarily gendered activities, it's certainly important that men participate in them.

Lessons Learned:

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 high levels of male violence against women, it seems important to recognize that many men care deeply about the women in their lives including their partners, family members, co-workers, 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 equity as examples of strength, courage and leadership have been especially useful in this regard.[8]

2. **Integrate a Strong Social Justice Emphasis into Work with Men and Build Coalitions with Progressive Social Movements:** Paul Farmer exhorts us to listen to those infected with HIV. He writes: "They are forty million strong and growing…They are not reminding us that antiretroviral therapy is not cost-effective". Instead, he says, "They remind us that sacrosanct market mechanisms will not serve the interests of global health equity" (Farmer, 1999). Their words need to inform our work and strengthen our commitment to social justice. In this regard, it's also worth remembering that the growing movement to end men's violence shares many goals with civil rights and other social justice movements. Working together offers many shared advantages-social movements gain strength and credibility when they pay attention to sexism and to men's violence; and gender justice activists gain important understandings about activist strategies and the communities in which they work. Given their commitment to principles of equity and liberation, men involved in these movements should also be natural supporters of efforts to end men's violence and are more likely than most to take these activities on in their personal and public lives.

3. **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 methodology includes workshops with senior management and key staff within each organization on the relationship between gender equity, violence against women and HIV/AIDS.

4. **Develop a Coherent, Coordinated Response:** 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. To further improve coordination, EngenderHealth hopes to establish a national advisory council comprised of key stakeholders from civil society, government and business who would guide the development and implementation of MAP across the country and would lend their considerable expertise to the task of engaging men.

5. **Promote Activities across the Spectrum of Prevention:** Many of the organizations collaborating on the implementation of the MAP program have historically been focused primarily on community education and individual change. Few have prior experience in advocacy, policy change or community mobilization. To ensure that all partner organizations can take this work on, MAP workshops now include a focus on advocacy, community mobilization, social norms campaigns and policy change.

Research Findings: The MAP approach has demonstrated significant success in shifting men's attitudes about gender equity and violence against women. Post-training evaluation of attitudes among MAP workshop participants in Western Cape Province revealed the following:

- 71% of the participants believed that women should have the same rights as men, whereas only 25% of men in the control group felt this way.
- 82 % of the participants thought that it was not normal for men to sometimes beat their wives, whereas only 38% of the control group felt that way.
- 96% of participants believed that children from abusive homes could become abusive parents, but only 19% of the control felt that this was true.
- 82% of the participants thought that sex workers could be raped, whereas only 33% of the control group thought so (Kruger, 2000).

The process of change evident in the research findings is also captured in the words of MAP educators and activists. Boitshepo Lesetedi, MAP Coordinator at PPASA, puts 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" (Peacock, 2002). 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."

AUTHOR BIO

Dean Peacock is a third year part-time MSW student at San Francisco State University with a concentration in Social Development. He is an activist and consultant currently working for two international organizations- New York based EngenderHealth and the San Francisco based Family Violence Prevention Fund. For the last 11 years Dean has worked in the United States, Latin America and South Africa to end men's violence and to promote egalitarian, non-abusive models of masculinity that improve the lives of men, women and children and contribute to a more just society. In all his work, he draws the connections between contemporary notions of masculinity and a range of public health issues including gender based violence, HIV/AIDS and sexual and reproductive health, especially HIV/AIDS related treatment advocacy, prevention, care and support. At present, he coordinates the Building Partnerships Initiative to End Men's Violence of the Family Violence Prevention Fund and provides training and technical assistance to the Men as Partners (MAP) program in South Africa. He will be moving to Johannesburg, South Africa in July of this year to manage EngenderHealth's work in South Africa.

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end notes

1 Human Rights Watch reports that sexual harassment and abuse of girls by both teachers and male students is pervasive in South African schools. Human Rights Watch, (March 2001). Scared at School: Sexual Violence Against Girls in South African Schools. New York: Human Rights Watch.

2 Many ministers and members of parliament are on record questioning and challenging the veracity of statistics chronicling extremely high rates of violence against women. See, for instance, Phindile Ngubane and Robert Brand, "Mbeki Slams `Speculative' Rape Stats," Star, October 28, 1999.

3 See, for instance, Aggleton, & Warwick (1998) who report that in Kyela, Tanzania 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."

4 Coordinated by the AFL-CIO's Solidarity Centre, each of the three major labor federations-the Congress of South African Trade Unions; the Federation of Unions of South Africa; and the South African Congress of Trade Unions are working to involve men at all levels of the union in challenging male violence and rigid gender roles.

5 For a description of this history, see, for example, Mufson, S. (1990) Fighting Years: Black Resistance and the Struggle for a New South Africa. Boston: Beacon Press; Cobbett, W. & Cohen R. (1988), Popular Struggles for Democracy in South Africa. Africa. World Press: Trenton, New Jersey.

6 Available from EngenderHealth: www.engenderhealth.org

7 See, for instance, Ashwin Desai's 2001 book "We are the Poors: Community Struggles in Post Apartheid South Africa" for an excellent account of the many multi-ethnic social movements organizing for access to HIV/AIDS treatment, land and housing, water and electricity in contemporary South Africa.

8 For examples of activities that redefine courage, leadership and strength in these ways, see articles by Jackson Katz and the "Courage by Degrees" activity developed by Nan Stein in Gender Violence: Gender Justice.