THE EVALUATION OF ENGENDERHEALTH/CHAMPION'S MEN AS PARTNERS (MAP) PROJECT

FINAL REPORT

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ABBREVIATIONS

ANC	Antenatal Care
CATs	Community Action Teams
CHAMPION	Channeling Men‘s Positive Involvement in the National HIV/AIDS Response
FEW	Family-wise Error
GEM	Gender Equitable Men
HIV	Human Immunodeficiency Virus
IDI	Indepth Interview
MAP	Men as Partners
MUHAS	Muhimbili University of Health and Allied Sciences
NGO	Non-Governmemtal Organization
OVC	Orphans and Vulnerable Chidrens
PEPFAR	The President's Emergency Plan For AIDS Relief
PHC	Population and Housing Survey
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RH	Reproductive Health
TDHS	Tanzania Demographic and Health Survey
THMIS	Tanzania HIV Indicator Survey
USAID	United States Agency for International Development
VCT	Voluntary Councelling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

Recent data from population based surveys indicate that there are significant sex differentials in HIV prevalence. In 2011-12, the overall prevalence of HIV among males aged 15-49 was 3.8 percent, while for females in the same age group the prevalence was 6.2 percent. HIV prevalence is consistently higher for women than men in all age groups.

Gender norms—societal expectations of men's and women's behaviors—are among the strongest factors fueling HIV transmission worldwide. Traditional male gender norms encourage men to equate a range of risky behaviors—using violence, abusing alcohol and/or drugs, pursuing multiple sexual partners, dominating women—with being manly. Rigid constructs of masculinity lead men to view health-seeking behaviors as signs of weakness. Young men who adhere to non-equitable views of manhood are more likely to participate in unsafe sexual practices, act violently towards women, and engage in substance abuse, thereby placing themselves, their partners, and their families at higher risk for HIV.

To address the negative aspects of gender norms, USAID through ENGENDERHEALTH intiated the CHAMPION (*Channeling Men's Positive Involvement in the National HIV/AIDS Response)* project in selected districts of Tanzania. The overall goal of CHAMPION is to promote a national dialogue about men's roles and to increase gender equity, and in doing so, reduce the vulnerability of men, women, and children to HIV and other adverse reproductive health outcomes. ENGENDERHEALTH is inspired by the concept of men as facilitators of family health. In this regard the Men as Partners (MAP) training approach has been implemented in order to work with men and women to challenge harmful gender norms and practices defined by the local context. By doing so, it is anticipated that HIV and adverse RH outcomes will be reduced through behavior change after the completion of the training course. At the start of the project, the MAP group education curriculum was adapted to address the specific needs of Tanzanian men and women.

The broad objective of this evaluation was to assess the relative impact of the MAP group education workshops when implemented alone versus combined with community engagement activities. The evaluation assessed the extent to which the intended project objectives have been achieved and the impact which has been realized as a result of project interventions.

The evaluation design was quasi-experimental where data was collected at two points: at the baseline (Pre-test) for both control and intervention groups, and at the end of the project (post-test) for both control and intervention groups. The Endline evaluation was conducted five months after the intervention.While the baseline data was collected to determine the needs of the community and status quo; post-test (post-intervention) data was collected to assess the sustained effects of the program.

Findings

Participants in the evaluation study were 1,383 at baseline and 838 (60.6%) at end-line. Loss-to-follow-up was partly due to unavailability of participants because of the engagement in different economic activities (farming and business), sickness and exit from the study area before or during end-line survey. Almost three quarters of the participants were married or dating someone (74.1%) at baseline and (76.8%) at end-line. More than 95% had at least primary education.
Although both, comprehensive and modified, study arms reported a decreased proportion of having multiple concurrent sexual partners from baseline to end line, the difference between these two arms was not statistically significant. Nevertheless, there was a reported increase of respondents reporting having concurrent multiple sexual partners in the control group by almost more than 65% as compared to the baseline. This increase is almost three times as compared to participants in the comprehensive or modified study arms suggesting a positive effect of the intervention. Reported condom use by study participants with casual partners increased significantly ($p<0.01$) from 21.9% at baseline to 34.4% at end-line in the comprehensive study arm. The decrease observed in the modified arm was not significant.

While there is a significant ($p< 0.05$) reported increase of the proportion of men accompanying partners to receive antenatal care services between baseline and end-line study periods for both comprehensive and modified study arms, there was a reverse in the control study arm. However, such a reported increase is almost the same (13%) in the comprehensive and modified study arms.

The proportion of men reporting utilizing VCT services during ANC visits with partners increased significantly ($p<0.05$) between baseline and end-line study periods in the

comprehensive and modified study arms. No significant increase was reported in the control study arm. The proportion of men reporting testing for HIV when accompanying partners during ANC visits, increased significantly ($p<0.05$) between baseline and end-line study periods only in the comprehensive study arm.

The proportion of women reporting emotional and physical violence decreased significantly in the comprehensive study arm. Although there are decreased reported emotional and physical violence in the other study arms, the decrease is not statistically significant. The proportion of women reporting sexual violence did not decrease significantly in any of the study arms. Items in the GEM scale used during the baseline and at the end-line surveys indicated the very internal consistency ($\alpha > 0.6$) and none of the items indicated a weak contribution to the Equitable Gender Norms.

All study participants had positive (above 48 mean scores) attitude towards gender equitable norms, regardless of the study intervention (comprehensive, modified or control) and of study period (baseline or end-line). However, there were no differences of mean GEM scores between study arms at baseline. At end-line, participants in the comprehensive and modified study arms scored significantly higher points as compared to the control arm. Out of the seven selected independent variables, only sex, age, education level, study period and study arm came out to be significant predictors of gender equitable norms.

Testimonies suggest that male partners have began to exhibit behaviours and attitudes that are suggestive of change in gender norms in specific aspects of life particularly with regard to; increased knowledge/skills in gender issues, increased role in child care, negotiating/discussion about sex, gender division of labour, physical and emotional violence. This behavior change was mostly attributed to male partners‘ participation in MAP workshops.

Conclusions

One of the major findings in this evaluation is the observed change among men in the utilization of reproductive health services being the result of the MAP intervention. Positive changes have also been observed in risk sexual behaviours after the intervention. Furthermore, additional change was observed in reduced reported violence among women. Our evaluation also

demonstrated a higher change towards positive attitude in gender equitable norms. Furthermore, female partner testimonies suggest that men who participated in the MAP workshops have exhibited behavour change in specific aspects such as intimate partner violence, condom use and male ivolvement in sexual reproductive health.

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INTRODUCTION

The purpose of this evaluation was to establish the efficacy of the CHAMPION project‘s MAP community-level training approach in Tanzania in reducing HIV risk behaviors, improving RH, and increasing gender equitable norms among urban, adult Tanzanian men and women (aged 25 years and older). The evaluation also assessed the relative impact of the MAP group education workshops when implemented alone versus combined with community engagement activities.
This report describes the relative impact of two different modes of implementing the Men as Partners (MAP) approach to gender norms transformation. The findings highlights how each model has succeeded in contributing to reducing HIV risk, improving reproductive health (RH), and increasing gender-equitable norms and behaviors among project participants. Findings from this evaluation will help key stakeholders (USAID, other development partners, civil society organizations, Government of Tanzania) to consider if and how to replicate these strategies in future programming to prevent HIV, improve RH and reduce gender based violence.

The USAID mission in Tanzania and partners will use this evaluation to measure the impact of intervententions on changing gender norms in a Tanzanian context and use the lessons learned for future HIV/AIDS programming. It is also expected to inform design of future programs, especially by examining the different modalities for achieving gender equitable norms that support HIV prevention among men and women.The evaluation can also be used as a tool for generating lessons about the opportunities, challenges and obstacles in implementation of programs that can make a difference in health outcomes within a community. Other stakeholders in gender and HIV prevention may find this report useful not only as a tool for learning but also as a guidance to inform policy and practices related to male involvement in sexual and reproductive health particulalarly men‘s role in influencing, initiating and sustaining sexual behavior change. This report gives specific examples and draws attention to gender issues that other evaluators might be interested; particularly some of the methodologies used to ensure the quality of data collection and analysis.

1.1 Background

According to the Tanzania HIV/AIDS and Malaria Survey the adult HIV prevalence in the United Republic of Tanzania is estimated at 5.1 percent and an estimated 1.4 million Tanzanians are living with HIV/AIDS (THMIS, 2012). An estimated 86,000 HIV/AIDS related deaths in Tanzania each year results in disruption of family structures and an increase in the estimated 1.1 million HIV orphans and vulnerable children (OVC) in Tanzania. According to the 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS, 2012), there are significant sex differentials in HIV prevalence. In 2011-12, the overall prevalence of HIV among males aged 15-49 was 3.8 percent, while for females in the same age group the prevalence was 6.2 percent. HIV prevalence is consistently higher for women than men in all age groups.

Gender norms—societal expectations of men‘s and women‘s behaviors—are among the strongest factors fueling HIV transmission worldwide. Traditional male gender norms encourage men to equate a range of risky behaviors—using violence, abusing alcohol and/or drugs, pursuing multiple sexual partners, dominating women—with being manly. Rigid constructs of masculinity lead men to view health-seeking behaviors as signs of weakness. Young men who adhere to non-equitable views of manhood are more likely to participate in unsafe sexual practices, act violently towards women, and engage in substance abuse, thereby placing themselves, their partners, and their families at risk for HIV. In addition, women‘s low status limits the social, education and economic opportunities that help protect them from infection.

In Tanzania, multiple concurrent sexual partnerships are socially condoned and often encouraged for men. In the 2010 Tanzania Demographic and Health Survey (NBS, 2010), 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. Transactional and commercial sex remains a major obstacle to HIV prevention efforts as well. Fifteen percent of men paid for sex in the 12 months prior to the survey (NBS, 2010). Other forms of transactional sex are even more frequent. Gift giving is a standard component of sexual relationships among youth. Peers and family sometimes urge young women to exchange sex to gain financial security. Such relationships create clear power imbalances that increase women‘s vulnerability to HIV. Economically dependent women are less able to negotiate for safer sex,

including faithfulness or consistent condom use, and this dynamic is further complicated when there are significant age disparities between partners.

Violence also reflects the power imbalances between men and women. The TDHS revealed that one-third of Tanzanian women age 15-49 have experienced physical violence in the past 12 months. Twenty percent of women have ever experienced sexual violence, usually perpetrated by their partners or former partners. Fifty-four percent of women and 38 percent of men age 15-49 believe that a husband is justified in beating his wife for certain reasons (TDHS, 2010). These findings reflect how women's own views about male gender roles reinforce negative social norms.

1.2 CHAMPION Project Goals

CHAMPION was a six year project funded by the USAID and managed by the EngenderHealth. The overall goal of CHAMPION is to promote a national dialogue about men's roles and to increase gender equity, and in doing so, reduce the vulnerability of men, women, and children to HIV and other adverse reproductive health outcomes. The concept of men as facilitators of family health is central to the project. It is funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through three sources of funds with specific and complimentary programme goals, which are: Core HIV Prevention (AB and OP); Gender Based Violence (GBV); and The Millennium Challenge Corporation (MCC) goals. The specific goals of the Project are to promote partner reduction and fidelity and reduce high-risk behaviours; to support social norms that discourage multiple partnering, violence, and sexual coercion; and to promote positive health-seeking behaviour by men, including participation in health services and in the national HIV response through a national dialogue about men's roles so as to increase gender equity, and reduce vulnerability to HIV and reproductive health problems.

1.3 Men as Partners (MAP) Project

EngenderHealth's Men as Partners (MAP) approach is being implemented in Tanzania in order to work with men and women to challenge harmful gender norms and practices defined by the local context. By doing so, it is anticipated that HIV and adverse RH outcomes will be reduced. At the start of the project, the MAP group education curriculum was adapted to address the

specific needs of Tanzanian men and women. A total of 34 MAP workshops were implemented simultaneously between October 2013 and January 2014 using *Engaging Men and Boys in Gender Transformation: The Group Education Manual*, also referred to as the MAP manual. Each group met two to three times per week, following a standardized agenda, for 26 days during the 12-week period. Workshops began first in Ilemela, followed by Mbeya City, Tabora Municipal and the majority of Temeke (Table 1).

Table 1: Implementation of MAP Workshops in Intervention Districts

Intervention District	Start date	Number recruited
Mbeya City Council	14 October	222
Tabora Municipal Council	17 – 19 October	266
Ilemela	7 – 9 October	239
Temeke	11-26 October	253

Focusing on ten of Tanzania's 21 mainland regions[1] with the highest rates of HIV infection, CHAMPION employs an ecological model that acts at different levels to achieve individual, family, community, and social change. The project addresses gender and social norms through promoting partner reduction, reducing high-risk behaviors and creating an enabling environment that promotes positive social norms including fidelity, non-violence and respect for healthy relationships.

1.4 PURPOSE OF THE EVALUATION

The purpose of this evaluation was to establish the effectiveness of the CHAMPION project's MAP approach in Tanzania in reducing HIV risk behaviors, improving RH, and increasing gender equitable norms among urban, adult Tanzanian men and women (aged 25 years and older).

[1]Dar es Salaam, Pwani, Morogoro, Iringa, Mbeya, Tabora, Shinyanga, Mwanza, Lindi, and Mtwara.

1.5 OBJECTIVES OF THE EVALUATION

1.5.1 Broad objective

The broad objective of this evaluation was to assess the relative impact of the MAP group education workshops when implemented alone versus combined with community engagement activities. The evaluation assessed the extent to which the intended project objectives have been achieved and the impact which has been realized as a result of project interventions.

1.5.2 Specific objectives

The evaluation had the following specific objectives:

1) To determine change in gender equitable attitudes and beliefs measured by the Gender Equitable Men's (GEM) Scale
2) To determine change in men's perpetration of intimate partner violence measured by the adapted WHO Multi-country Study Tool on Domestic Violence Against Women
3) To determine change in risky sexual behavior measured by number of multiple concurrent sexual partners
4) To determine change in risky sexual behavior measured by condom use at last sex with casual partner
5) To determine change in utilization of HIV and RH services – for example, number of men accompanying partners to receive antenatal care (ANC) services (including PMTCT), number of ANC partners tested for HIV, or number of participants receiving voluntary counseling and testing
6) To document testimony from primary sexual female partners supporting self-reported changes in their partner's behavior

METHODOLOGY

1.6 Evaluation design

The evaluation design was quasi-experimental where data was collected at two points: at the baseline (Pre-test) for both the control and intervention groups and at the end of the project (post-test conducted six months after pre-test). While the baseline data was collected to determine the needs of the community and status quo; post-test (post-intervention) data was collected to assess the sustained effects of the program. At each of these data collection points, data was collected from the three study arms as described below.

1. A *comprehensive intervention* arm of MAP group education workshops and community outreach activities
2. A *modified intervention* arm of MAP group education workshops only
3. A *control* arm with no intervention.

Table 2:Data collection per arm at different times

Group	Baseline (Pre-test)	End Post-test
Intervention:		
Comprehensive	X	X
Modified	X	X
Control (Comparison)	X	X

"X" represents data collected at that time point.

1.7 Evaluation area

Four urban districts were chosen for the evaluation: Mbeya City Council; Tabora Municipal Council; Ilemela and Temeke Municipals. The control group consisted of Bukoba Municipal and Songea Municipal (Table 3). In each district, two wards were assigned.

Table 3: Districts and wards selected for the evaluation by study arm

Study Arm	Comprehensive Intervention		Modified Intervention		Control	
District	Mbeya City Council	Tabora Municipal Council	Ilemela	Temeke	Bukoba Municipal	Songea Municipal
Wards	Isanga Iganzo	Ndevelwa Ifucha	Bugogwa Buswelu	Azimio Chamazi	Hamugembe Rwamishenye	Mjini Bombambili
No. of MAP Workshops	9	8	9	8	-	-
Community Outreach	Yes	Yes	-	-	-	-

The four intervention districts were purposively selected by CHAMPION among the 14 ~~"k~~key districts" where the project operates. The criteria used for selection were: (1) the number and capacity of MAP field facilitators to organize and facilitate high quality MAP workshops; (2) the capacity of community action teams (CATs) to organize and implement high quality gender-transformative community outreach activities, and (3) the capacity of CHAMPION lead NGOs (LNGOs) to manage and oversee the implementation of gender-transformative interventions in these districts. Eligible control districts were matched to intervention regions, districts, and wards (where data were available) based on the selected demographic, economic, and RH indicators from the 2012 Population and Housing Census (PHC), the 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS), and 2010 Tanzania Demographic and Health Survey (TDHS). Among the eligible urban districts, Bukoba Municipal matched most closely to the MAP evaluation intervention districts on the selected indicators, followed by Sumbawanga Municipal in Rukwa and Songea Municipal in Ruvuma. Sumbawanga Municipal was not chosen as a control district because of the similar and extensive gender work conducted by the Swedish Association for Sexuality Education (RFSU) in Rukwa under their Young Men as Equal Partners (YMEP) project.[2]

[2] http://www.rfsu.se/en/Engelska/International-Programmes/Implemented-Projects/YMEP-Tanzania-Kenya-Uganda-and-Zambia/

The unit of intervention for this evaluation was at the ward level. Thus, two wards within each of the six districts were selected by CHAMPION for the evaluation (Table2). The 2012 PHC was used to determine the number, names, and population of wards within each district. In all intervention districts, wards were purposively selected in collaboration with LNGOs and MAP field facilitators among those where CHAMPION has not implemented any activities to date – i.e., has not conducted a MAP workshop and/or community or workplace outreach activity.

1.8 Study population

Adult (aged 25 to 50 years) men and women were recruited across the selected sites.

1.9 Sample size estimation

A total of 1,620 adult men and women were recruited on equal allocation per arm; that is, 540 individuals per study arm. This sample size was calculated for a quasi experimental design in order to detect at least a 10 percent difference between study arms with 80 percent power, a 95 percent confidence interval, and accounting for a 10 percent loss to follow-up. Although the main focus is men, a ratio of one woman to 2 men per site was used in order to gather information related to women.

1.10 Sampling procedure

1.10.1 Sampling for the four intervention districts

In each district two wards were selected. Five (5) streets were selected from one ward and four (4) from the other. The CHAMPION aimed at recruiting a minimum of 30 men and women (in a ratio of 2:1) but not exceeding 35 participants per street (Figure 1). Purposive selection of participants was based on pre-set criteria that included: aged between 25 -50 years, resident (at least one year) of the street visited, literate in Kiswahili and willing to participate in workshops without receiving monetary compensation (~~"v~~olunteerism spirit"). In each district, a random selection of nine (9) streets was done making a total of 270 participants per district.

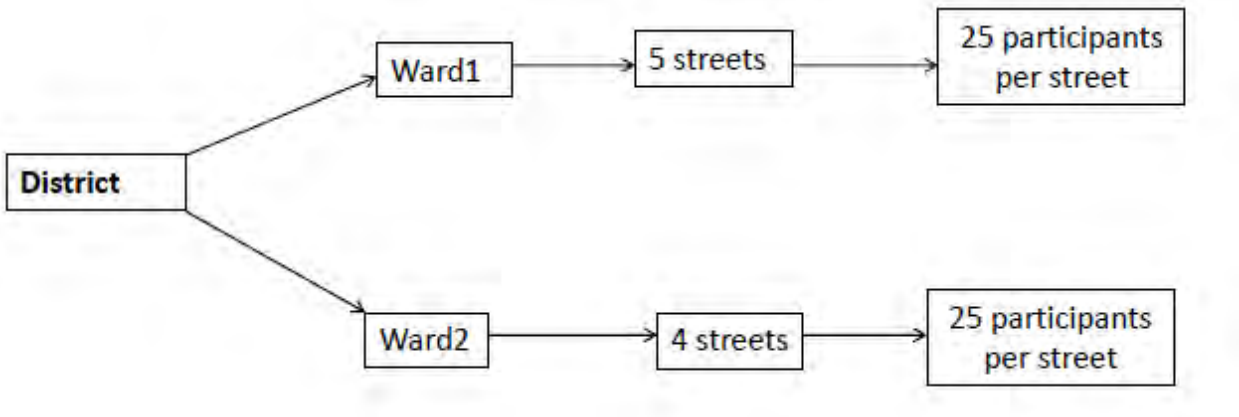

Figure 1: Sampling process

1.11 Sampling for participants in the control districts

Two stage sampling procedure was employed to select wards in the control districts. The first stage included a systematic selection of streets per ward (based on a sampling frame of available streets in a ward) also as indicated in figure 2. The second stage was a random selection of households per street. In each of the selected household, one adult (aged 25 to 50 years) was selected at random. However, this selection was by alternating from left to right of the street following the ratio of two men and one woman (Man-Left, Man-Right, Woman-Left, Woman-Right, Man-Left, etc) until 25 participants per street were enrolled.

1.12 Data collection

The evaluation process used a combination of methods to collect information that was relevant to the evaluation objectives and questions outlined in the Scope of Work for the MAP Project. The collected information was both quantitative and qualitative in nature.

1.12.1 Quantitative data

The team developed a questionnaire targeting adult men and women (25 to 50 years) to determine changes in knowledge, attitudes and practices related to HIV and gender norms. The questions were adapted from standard tools such as TDHS 2010, THMIS 2011/12 and PEPFAR Gender Equitable Men‘s (GEM) Scale. The reliability and validity of this tool have been tested in the PEPFAR Gender Equitable Men‘s (GEM) Scale, TDHS 2010 and THMIS 2011/12.

1.13 Qualitative data

Interviews with female partners of MAP participants were 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 participating in the questionnaire survey to allow their partners to be interviewed. Only those females who consent took part in the in depth interviews. Outcomes of the reviews from documents, key informant interviews and observations were translated, transcribed and subjected to quality checks and cross-checked among the Evaluation Team members to determine patterns of responses, consistency and accuracy. The information was categorized into the evaluation 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).

1.14 Data processing

The quantitative data was entered into Epi Info (the software is capable to control quality through in-built check-sub-program) centrally at MUHAS by trained data entry entrants. No unique identifiers in the database that could be linked to a participant. Data analysis was performed by the evaluation team in consultation with M&E Evaluation Officers at EngenderHealth. Preliminary data analysis was conducted immediately following data collection so that prompt feedback can be provided to the stakeholders (USAID and EngenderHealth).

1.15 Data analysis

Although the unit of intervention was at ward level, the unit of analysis was individuals in the respective wards. Therefore, all outcomes were summarized (by average or proportion) to form a collective measure in the ward. The outcome variables included (a) condom use at last sex with casual partner, (b) proportion of men accompanying partners to receive antenatal care (ANC) services (including PMTCT), (c) proportion of ANC partners tested for HIV and (d) proportion of participants receiving voluntary counseling and testing. However because the evaluation targets men being partners, a combined indicator for (b) through (d) was used. Using the generated variable, comparisons between arms were used to assess the effectiveness of the interventions as follow;

First, the basic data analysis included reporting descriptive statistics (frequencies and percents, means and medians) on the main variables of interest. Charts and diagrams were used to display data. Tables were created to illustrate distributions of characteristics associated with indicators in each specific objective. Statistical methods such as tabular analyses (cross-tabulations), trend analysis across the study arms and analyses of ratings (for variables measured on scales) were used. In order to examine difference within and between study-arms for quantitative variables (for example number of sexual partners), analysis of variance was used.

Second, since the evaluation used multiple comparisons based on study arms, that is, selected outcomes by the intervention and a modified intervention groups, the intervention and control group and between modified intervention and the control groups, we applied Bonferroni adjustments in order to minimize the relative family-wise error (FEW).

FINDINGS AND DISCUSSION

1.16 Quantitative results

1.16.1 Implementation of MAP Workshops

Implementation of MAP workshops began at different dates for each site from mid October 2013 through to January 2014. The number of participants and completion rates are indicated in table 4. These participants were recruited to participate in the evaluation of the intervention at baseline and end line

Table 4: Implementation of MAP Workshops in Intervention Districts

Intervention District	Workshop Implementation		Participant Completion		
	Start Date (2013)	End Date	No. Recruited	No. Complet-ed	% Complet-ion
Mbeya City Council	14 October	3-7 Jan 2014	222	190	86%
Tabora Municipal Council	17-19 October	7-11 Jan 2014	266	243	91%
Ilemela	7-9 October	30 Dec 2013-4 Jan 2014	239	177	74%
Temeke	11-26 October	6-22 Jan 2014	253	186	74%

1.16.2 Description of the study population

Participants in the evaluation study were 1,383 at baseline and 838 (60.6%) at end-line. Loss-to-follow-up was due to economic activities (farming and business), sickness and exit from the study area before or during end-line survey. Almost three quarters of the participants were married or dating someone (74.1%) at baseline and (76.8%) at end-line. More than 95% had at attained at least primary education.

1.16.3 Change in risk sexual behaviours

Change in risk sexual behaviours was measured by assessing the number of current (within the past one month) sexual partners a respondent had. Furthermore, this change was measured by condom use at last sex with casual partner.

Table 5:Distribution of study participants at baseline and end line by study arm and sex

Time line and Sex	Study Arm		
	Comprehensive Number (%)	Modified Number (%)	Control Number (%)
Baseline:			
Male	301 (63.2)	248 (61.5)	336 (66.8)
Female	175 (36.8)	155 (38.5)	167 (33.2)
Total	476 (100.0)	403 (100.0)	503 (100.0)
End-line:			
Male	226 (58.4)	165 (59.6)	160 (58.4)
Female	161 (41.6)	112 (40.4)	114 (41.6)
Total	377 (100.0)	227 (100.0)	274 (100.0)

1.16.4 Number of concurrent sexual partners

Although both, comprehensive and modified, study arms reported a decreased proportion of having multiple concurrent sexual partners from baseline to end line, the difference between these two arms number was not statistically significant. Nevertheless, there was a reported increase of respondents reporting having concurrent multiple sexual partners in the control group by almost more than 65% as compared to the baseline (Table 6). This increase is almost three times as compared to participants in the comprehensive or modified study arms suggesting a positive effect of the intervention.

Table 6: Percent of study participants reporting currently having multiple sexual

Study arm	Baseline	End-line	Absolute % change
Comprehensive	17.7	14.1	3.6
Modified	13.0	9.6	3.4
Control	15.5	25.6	-10.1

1.16.5 Condom use at last sex with casual partners

Participants were asked about use of condom during the most recent sex with casual partners. Results of respondents reporting condom use at baseline and at end-line study periods by type of study arm are presented in Figure 2.

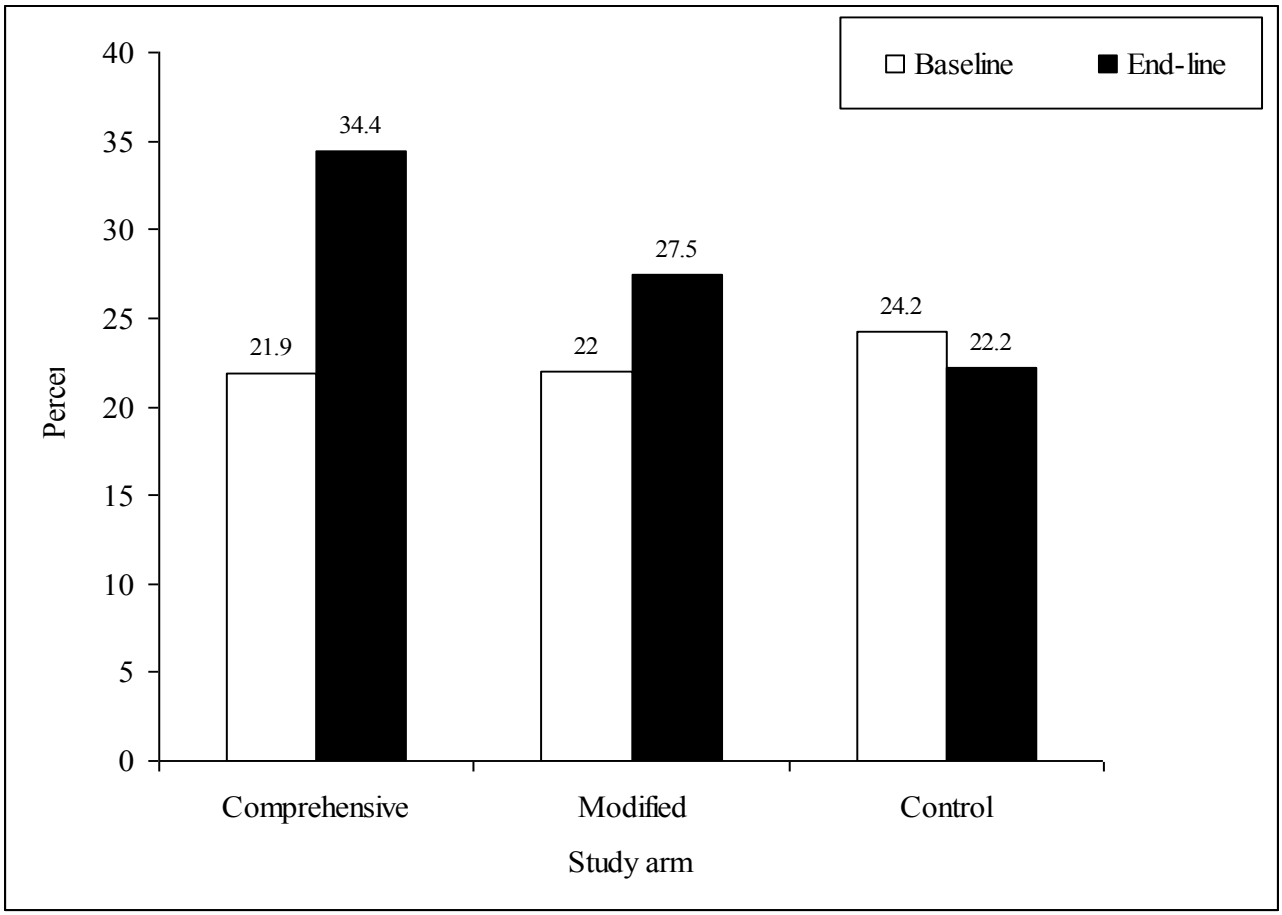

Figure 2: Percent of participants reporting condom use with casual partner at most recent sexual act

Reported condom use by study participants with casual partners increased significantly ($p<0.01$) from 21.9% at baseline to 34.4% at end-line in the comprehensive study arm. Although there is an increase of condom use in the modified study arm, such increase was not significant. Reported condom use with casual partners decreased in the control study arm between the two study periods.

1.16.6 Change in utilization of HIV and RH services among men

Utilization of HIV and reproductive health services among men was assessed by looking at number of men accompanying partners to receive antenatal care and number received voluntary counseling and testing (VCT) services.

1.16.7 Men accompanying partners for ANC services

Table 7: Number and percent of men accompanying partners to receive antenatal care (ANC) services

Study arm	Baseline	End-line	p-value
Comprehensive	199 (78.3)	182 (91.0)	< 0.01
Modified	112 (54.9)	97 (68.3)	0.018
Control	150 (54.2)	66 (51.6)	0.627

While there is a significant ($p< 0.05$) reported increase of the proportion of men accompanying partners to receive antenatal care services between baseline and end-line study periods for both comprehensive and modified study arms, there was a reverse in the control study arm. However, such a reported increase is almost the same (13%) in the comprehensive and modified study arms.

1.16.8 Men receiving PMTCT services when accompanying partners during ANC visits

Table 8: Number and percent of men receiving PMTCT services during antenatal care visits

Study arm	Baseline	End-line	p-value
Comprehensive	136 (51.7)	157 (82.2)	< 0.01
Modified	68 (34.5)	75 (52.8)	< 0.01
Control	110 (40.0)	52 (39.4)	0.907

The proportion of men reporting utilizing PMTCT services during ANC visits with partners increased significantly ($p<0.05$) between baseline and end-line study periods in the

comprehensive and modified study arms. The increase was almost twice in the comprehensive study arm as compared to the modified study arm (Table 8).

1.16.9 Men utilizing VCT services during ANC visits

Table 9: Number and percent of men utilizing VCT services during ANC visits

Study arm	Baseline	End-line	p-value
Comprehensive	195 (65.0)	216 (95.6)	< 0.01
Modified	158 (64.0)	146 (88.5)	<0.01
Control	212 (63.1)	108 (67.5)	0.338

The proportion of men reporting utilizing VCT services during ANC visits with partners increased significantly ($p<0.05$) between baseline and end-line study periods in the comprehensive and modified study arms. No significant increase was reported in the control study arm (Table 9).

The proportion of men reporting testing for HIV when accompanying partners during ANC visits, increased significantly ($p<0.05$) between baseline and end-line study periods only in the comprehensive study arm. Although there was such an increase between the study periods in the modified study arm, this increase was not statistically significant (Table 10).

Table 10: Number and percent of men tested for HIV during antenatal care visits

Study arm	Baseline	End-line	p-value
Comprehensive	250 (83.3)	216 (95.6)	< 0.01
Modified	180 (72.9)	133 (80.6)	0.072
Control	271 (80.7)	129 (80.6)	0.994

1.16.10 Men's Perpetration of Intimate Partner Violence against Women

We assessed men's as perpetrators of intimate violence against partners using the WHO Multi-country Study Tool on Domestic Violence. In this section, violence is classified into emotional, physical and sexual.

The proportion of women reporting emotional and physical violence decreased significantly in the comprehensive study arm. Although there are decreased reported emotional and physical violence in the other study arms, the decrease is not statistically significant. The proportion of women reporting sexual violence did not decrease significantly in any of the study arms (Table 12).

Table 11: Number and percent of women reporting violence by study arm and period

Type of violence and Study arm	Baseline	End-line	p-value
Emotional Violence			
Comprehensive	76 (43.4)	48 (29.8)	0.01
Modified	83 (53.5)	47 (42.0)	0.061
Control	89 (53.3)	49 (43.0)	0.090
Physical violence			
Comprehensive	75 (42.9)	50 (31.1)	0.025
Modified	69 (44.5)	43 (38.4)	0.317
Control	69 (41.3)	38 (33.3)	0.176
Sexual violence			
Comprehensive	51 (29.1)	33 (20.5)	0.067
Modified	50 (32.3)	28 (25.0)	0.198
Control	44 (26.3)	26 (22.8)	0.500
Physical **or** sexual			
Comprehensive	108 (61.7)	75 (46.6)	0.005
Modified	105 (67.7)	62 (55.4)	0.039
Control	107 (64.1)	65 (57.0)	0.233

1.16.11 Gender equitable attitudes and beliefs

We assessed gender equitable and beliefs using the Gender Equitable Men‘s (GEM) Scale. We analyzed data for all 24 items of the GEM scale at baseline and end-line (Table 13a).

Table 12a: Percent distribution of study participants towards equitable gender norms

Equitable Gender Norms	Baseline			End-line		
	Agree	Partially agree	Disagree	Agree	Partially agree	Disagree
1. Giving the kids a bath and feeding the kids are the mother‘s responsibility	55.4	7.8	36.8	31.2	5.3	63.4
2. A woman‘s most important role is to take care of her home and cook for her family	68.1	6.5	25.4	41.9	6.2	51.9
3. A man should have the final word on decisions in his home	67.1	7.1	25.8	40.2	4.7	55.1
4. It is a woman‘s responsibility to avoid getting pregnant	44.3	9.2	46.5	26.2	5.7	68.1
5. If someone insults a man he should defend his reputation with force if he has to	33.2	7.5	59.3	19.6	4.1	76.3
6. You don‘t talk about sex, you just do it	10.3	3.2	**86.4**	5.2	2.1	**92.6**
7. Women who carry condoms on them are easy	25.7	4.3	70.0	10.7	3.1	86.2
8. If a woman cheats on a man, it is ok for him to hit her	55.8	4.1	40.1	37.4	3.7	61.5
9. Men need sex more than women do	48.9	7.8	43.3	33.4	6.8	59.8
10. Men are always ready to have sex	51.7	4.7	43.7	36.3	4.3	59.4
11. There are times a woman deserves to be beaten	34.7	6.2	59.1	20.0	4.6	75.4
12. A man needs other women, even if things with his wife are fine	41.7	3.8	54.5	25.4	2.9	71.7
13. A woman should tolerate violence in order to keep her family together	35.8	6.9	57.2	22.8	4.5	72.7
14. A man should be outraged if his wife asks him to use a condom	45.1	13.4	41.5	27.3	10.9	61.8
15. It is okay for a man to hit his wife if she refuses to have sex with him	22.0	3.6	74.4	12.3	1.8	85.9

Table 13b: Percent distribution of study participants towards equitable gender norms

Equitable Gender Norms	Baseline			End-line		
	Agree	Partially agree	Disagree	Agree	Partially agree	Disagree
16. Real men do not immediately go to a doctor when they are sick	35.0	6.0	59.0	21.4	7.2	71.4
17. A man using violence against his wife is a private matter that shouldn't be discussed outside the couple	37.3	6.5	56.2	21.2	4.1	74.7
18. A man should not take his child to the clinic without the child's mother	24.1	3.9	72.0	11.6	1.7	86.7
19. A woman should not initiate sex	23.3	3.9	72.7	13.7	3.6	82.7
20. A woman should obey her husband in all things	66.1	6.6	27.3	38.2	6.3	55.5
21. It is the man who decides when to have sex with a partner	33.7	4.4	61.9	19.1	3.5	77.4
22. Only when a wife has a child she becomes a real woman	42.8	3.3	53.9	25.4	2.7	72.0
23. A real man produces a male child	13.3	1.6	**85.1**	7.6	1.1	**91.4**
24. Employed women do not make good wives	7.8	2.2	**89.9**	4.2	1.8	**94.0**
Mean (Standard deviation):	51.88 (SD = 11.57)			60.0 (SD = 12.09)		
Cronbach's Alpha:	0.895			0.930		

Items in the GEM scale used during the baseline and at the end-line surveys indicated the very internal consistency ($\alpha > 0.6$) and none of the items indicated a weak contribution to the equitable gender norms. During both, baseline and end-line surveys, items whose participants had the most favourable responses include "Employed women do not make good wives", "You don't talk about sex, you just do it" and "A real man produces a male child". A statement "A man should have the final word on decisions in his home" had a largest positive attitude change (29.3%) suggesting understanding of equitable gender norms (Table 13a and Table 13b).

1.16.12 Attitude towards Gender Equitable Norms

We created a new variable by summing up scores for the 24-items of the GEM scores. The possible minimum and maximum scores were 24 and 72 respectively. The expected minimum and maximum possible sum scores are 24 and 72 respectively. High scores would suggest positive attitudes towards gender equitable norms and low scores, negative gender equitable norms (Figure 4).

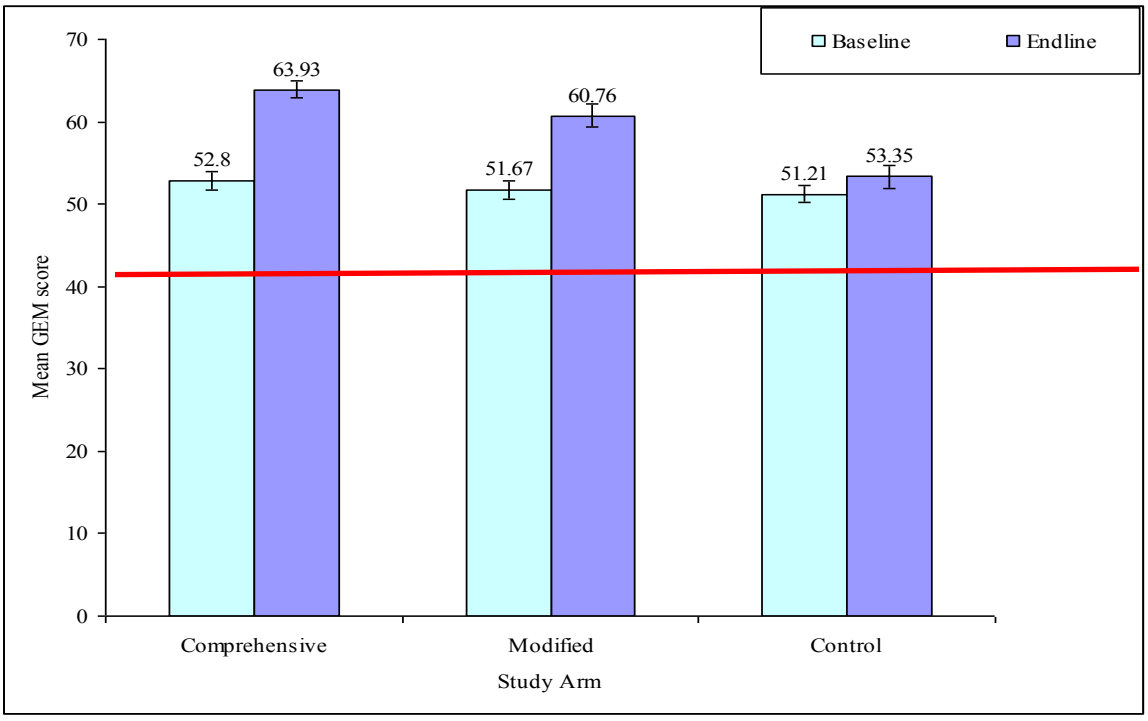

Figure 3: Mean GEM score by study arm and study period

All study participants had positive (above 48 mean scores) attitude towards gender equitable norms, regardless of the study intervention (comprehensive, modified or control) and of study

period (baseline or end-line). However, there were no differences of mean GEM scores between study arms at baseline. At end-line, participants in the comprehensive and modified study arms scored significantly higher points as compared to the control arm. There was no significant difference in mean GEM score between participants in the comprehensive and modified study arms at end-line (Figure 4).

1.16.13 Predictors of Gender Equitable Norms

A multivariate linear regression model was set using the sum GEM score as a dependent variable. Selected explanatory variables included:

(1) Study period (0=Baseline, 1=End-line)

(2) Sex (0=Female, 1=Male)

(3) Education status (0= Below primary education, 1=Primary, 2=Above primary education)

(4) Marital status (0=Single, 1=Married/Cohabiting, 2=Previously married)

(5) Occupation (0=Peasant, 1=Employed, 2=Business, 3= Artisan, 4=Other).

(6) Study arm (0=Control, 1=Modified, 2=Comprehensive)

(7) Study period (0=Baseline, 1=End-line)

Table 14: Multivariate linear regression analysis on gender equitable norms

	Estimated		95% CI of β	
Predictor	Coefficient (β)	p-value	Lower	Upper
Sex	7.147	< 0.01	6.206	8.088
Age	-0.053	0.034	-0.102	-0.004
Education level	5,889	< 0.01	4.957	6.821
Occupation	0.354	0.07	-0.030	0.738
Marital status	-0.164	0.751	-1.178	0.849
Study period	8.523	< 0.01	7.612	9.433
Study arm	2,979	< 0.01	2.420	3.538
Constant	1.315	< 0.01	35.635	40.793

$R^2 = 0.292$; Adjusted $R^2 = 0.289$

Out of the seven selected independent variables, only sex, age, education level, study period and study arm came out to be significant predictors of equitable gender norms. A set of these independent variables explain slightly less than 30% of the variance in the GEM score. Age and marital status have a negative correlation with equitable gender norms; suggesting young study participants to have positive attitude towards equitable gender norms as compared to old participants. Similarly, single participants have positive attitudes as compared to married or previous married (divorced or widow) participants (Table 13), lead to information bias especially during the end-line evaluation when participants may have been responding to impress the interviewers.

1.17 Qualitative results

1.17.1 Testimonies from primary sexual female partners

Analysis of indepth interviews identified six (6) thematic areas (see box 1) describing different aspects in the relationships among male and partners. However, we will mainly focus on specific aspects that highlight and illustrate impact of intervention on behaviour

Box 1 List of main themes

- ***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***

1.17.2 Awareness of CHAMPION's MAP project

We first sought to determine if female partners were aware of the MAP project. Most of the participants interviewed appeared to be aware of the MAP project. Many were able to describe (in their own words) some of the objectives or activities of the project. Some mentioned that MAP project was dealing with HIV counselling, testing and prevention, gender equality, equal participation of men and women in various issues concerning their family, how men should treat their wives and marriage issues in general. Study participants also mentioned that MAP project

educated men on the importance of involving their spouses (wives) in decision making pertaining to family welfare/wellbeing at household level. Partcipants who were aware of the project acknowledged to have been informed by their partners (who participated in the MAP workshops/trainings implemented by CHAMPION project in their respective localities).

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 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)*

Another one remarked;

> *I have heard about champion, my husband told me about it, he said they are educated on the issues of marriage, family planning, gender equality (usawa wa kijinsia) and how to live as husband and wife in the family (IDI Temeke)*

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

> *I heard about the project when they were passing and enrolling my husband, since i was in the kitchen cooking i did not get a chance to hear most of the things, what i remember is that they asked my husband some questions and he was enrolled* (IDI Mwanza)

1.17.3 Method of HIV prevention used with a partner

Findings suggest that condom use might be low among 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 short period immediately after giving birth in order to prevent unwanted/unplanned pregnancies. While these female partners rely on faithfulness in marriage, they were not sure about their husbands‘s faithfulness particularly when the husband is away from home.

One participant was quoted saying;

We never use any means of preventing HIV/AIDS, we are faithfull to each other so we never use anything so if i introduce a subject about using condom he will not be happy (IDI, Mbeya)

Another one said;

No, we never use condom but i don't know if he uses condoms when he is doing it (sex) elsewhere (IDI, Mwanza)

On the contrary, for some discordant partners the motivation for condom use was reportedly to prevent infecting their (uninfected) partner and unwanted pregnancies

We use condom.....we have agreed to use condom because....in 2000 i got tested and was found to be positive.....so i had also to take my children to get tested but all of them were negative so the issue was how can i tell my husband so i had to get courage to tell my husband and i thank God i was then able to tell my husband and he was also tested and once he was found to be negative and it is when we decided to use condom so that i dont infect my husband(IDI Temeke)

1.17.4 Attitudes towards condom use

With regard to the attitude towards condom use, findings reveal that married couple tended to associate condom with extramarital sexual relationships. Some said condoms were used when someone was cheating (*kutoka nje ya ndoa*) or when a woman was brestfeeding. In addition, others went further and thought it was absurd for a woman to ask her husband to use condom.

"To be honest if i tell him about it, he will be suprised because i have never asked him to use it even once. So he might feel bad and think probably i have cheated on him" (IDI Temeke)

"He always tell me to use condom when i go out but for me it is not easy to cheat him may be that is what he does behind my back" (IDI Mwanza)

1.17.5 Male partner involvement in health care

We investigated male partner willingness to acompany 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 are highly motivated to have their first babies, and this motivation dwindled in

subsequent pregnancies. Indeed some reported to have been accompanied by their partners for not only for HIV testing and counseling but also occasionally taking the children for ANC.

One participant was quoted saying;

My husband always escorts me to clinic… we get counseled together but if it happens that he is busy at work i will go on my own. Sometimes he takes the child to clinic but all in all whenever he is free he never refuses to acompany me (IDI Mbeya)

1.17.6 Attitudes of health workers toward men attending health facilities with their partners

Attitude of the health care workers towards attendance of male partners at the clinic with their female partner was reported to be positive. Health workers encouraged men to attend by using different strategies. Some of the strategies mentioned included giving the couples the first priority and using the couples as role models for other clients who attend health facilities without their partners. It was also reported that sometimes male partners shunned accompanying their partners because occasionally men don't get places to sit. Some men were reported to use such events as excuses for not attending.

> *"Health care workers advise us to visit clinic with our partners and they really enjoy seeing us together, and when you go with your partner you get first priority…the environment is friendly for men to attend" (IDI, Mbeya)*

In other contexts, the environment was reportedly not very conducive as one was quoted saying;

> *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*)

1.17.7 Testimonies of gender transformation

Study participants described events and actions observed in their partners to substantiate their claims. Testimonies suggest that male partners have began to exhibit behaviours and attitudes that are suggestive of change in gender norms in specific aspects of life particularly with regard to; increased knowledge/skills in gender issues, increased role in child care, negotiating/discussion 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.

In several interviews from different study sites, participants were quoted saying;

1.17.8 Gender knowledge/skill

Men have learnt alot 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 short he has changed a lot and i must give much credit to this [MAP]project (IDI, Mbeya)

*They way i see him it's like he has changed, because now he can advise and share with me things he has learnt in the training…in general he has changed and we are living in peace now (*IDI, Mwanza)

1.17.9 Household chores/division of labour

He is changed…I can tell him I don't feel like having sex and he understands me very well. He can help me with household chores… and a few minutes ago he was helping me to cook for the kids (IDI, Temeke)

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 a very small thing becomes 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)

My husband has started helping me things like fetching water and other small actvities here at home and when i am sick he helps me a lot with the entire activities (IDIs, Tabora)

1.17.10 Sex life/negotiaton

Findings suggest there is some discussion among partners about sex 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 relationships. Among those who discussed sex life with their partner, some were quoted as saying;

...yes with regard to sex…before it was like… even when i was not ready or not feeling to have sex he used to force me to do it ...sometimes even when i was sick… but nowadays he would ask me if i was ready for that… and also sometimes he buys some gifts for me when he comes back from town (IDI, Temeke)

Yes we do discuss about side effects of condom use, we never use condom you know! (IDI Mbeya)

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 with activities like cooking and fetching water... things which are all new...I haven't seen this before (IDI Tabora)

1.17.11 Child care

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

Box 2: summary of some aspects of behavior change and gender transformation

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

1.18 Limitations of the study

The evaluation has some limitations. First, assessing gender equitable norms may be multi-factorial and, although we used a GEM scale that has been used and internally validated earlier,

even in one sub-Saharan country (Ethiopia), it is not certain how precise is the scale to Sub-Saharan African culture. Further attempts should be made to assess use of the scale relative to the culture and societies‘ norms. Second, the evaluation was based on self-reporting that use purposeful selection of female partners (to provide testimonies of behavior change in their partners), which may potentially lead to bias in the opinions and experienced shared. Most of the women interviewed were in a way stakeholders in the project and some of their partners might have been involved in implementing the project. The information collected from them could be influenced by the nature and extent of their involvement. The team prepared a semi structured interview guide (with possibilities for probing questions) to ensure the information collected was consistent. Since some of the questions required recounting of events that happended back in time, some information from respondents may be affected by recall bias, which may have affected the accuracy of recollection of some of the daily life or project events in terms of specific dates, people, places, and contexts. Respondents may have shaped their responses so as to influence the continuation of the project or to please the interviewers. Some respondents had participated in CHAMPION- sponsored trainings; they may have given response to meet expectations, rather than saying what they actually believed. However, a triangulation of methods used in this evaluation ensured that the information obtained was counter-checked with other methods**.**

CONCLUSION AND RECOMMENDATIONS

One of the major findings in this evaluation is the observed change among men in the utilization of reproductive health services being the result of the MAP intervention. Positive changes have also been observed in risk sexual behaviours after the intervention. Furthermore, additional change was observed in reduced reported violence among women. Our evaluation also demonstrated a higher change towards positive attitude in gender equitable norms.

Furthermore, female partner testimonies suggest that men who participated in the MAP workshops have exhibited behavour change in specific aspects. This change is mainly illustrated/observed in men‘s increased participation/responsibility in household and family activities, willingness to engage in joint decision making and dialogue/negotiation on sexual matters as well as increased awareness of gender issues in generaly .However, there appears to be concerns/challenges with regard to condom use and sexual fidelity/faithfulness particularly

when the partners/husbands were away from home. Perhaps these requires increased attention taking into account that majority of intervention participants reported to be in some form of sexual relationship (married or cohabiting)

Therefore, it is recommended:

(1) To extend MAP training in other areas where similar impact could be realized.

(2) To promote the comprehensive intervention and ignore modified intervention as it does not produce significant changes in expected output; compared to comprehensive training. There is also a need to conduct a cost-effectiveness analysis of these two approaches to assess the comparative advantage of each.

(3) Young study participants have a more positive attitude to gender equitable norms. Since this may be due to possibility in acquiring modern facilities and access to education, a possible avenue to address the gap among older participants is by promoting access to education via both formal and informal means of IEC.

(4) We found males having a more positive attitude towards gender equitable norms than females. We recommend increased interventions to promote greater understanding of gender equitable norms among females; to let them understand their rights and responsibilities in changing gender sterotypes that fuel various forms of inequities affecting health spread.

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APPENDICES

1.19 DATA COLLECTION TOOLS

1.19.1 MAP QUESTIONNAIRE

INTRODUCTION TO THE HOUSEHOLD TO BE INTERVIEWED

Hello, My name is .....…. The U.S. Agency for International Development (USAID) has commissioned an impact evaluation of CHAMPION's Men as Partners® (MAP) interventions .We are conducting a baseline survey for MAP evaluation in six districts in Tanzania.. Specifically, the evaluation will assess whether and to what extent two different modes of implementing the MAP approach to gender norms transformation are successful in reducing HIV risk, improving reproductive health (RH) outcomes, and increasing gender-equitable norms and behaviors among project participants. This evaluation is being conducted by a team of four consultants from the Muhimbili University of Health and Allied Sciences (MUHAS). CHAMPION is responsible for conducting the interventions to be evaluated. This operational plan outlines how and when CHAMPION will implement the interventions.

This interview is a part of this baseline study, and I would like to ask you some questions about yourself. There is no possible risk if you agree to participate in this study; rather, it will benefit you by helping the government of Tanzania do better job in meeting and improving services and needs of all Tanzanians.

All the information that you give to me will be kept strictly confidential; your name will not be used and you will not be identified in any way. This interview should take approximately one hour to complete. Your participation is absolutely voluntary and there is no penalty for refusing to take part. You are free to ask any questions; you may refuse to be in this study; you may refuse to answer any question in the interview; and you may stop the interview at any point. Do you have any questions? Do I have your agreement to participate?

If the respondent agrees, then you may begin the interview.

MAP INDIVIDUAL QUESTIONNAIRE (ENGLISH VERSION)

SECTION A-1: IDENTIFICATION

REGION: ----------

DISTRICT | | | | ----------

WARD | | | | ----------

VILLAGE | | | | ----------

MTAA NAME | | | | ----------

HOUSEHOLD ID | | | | ----------

SECTION A-2: SURVEY STAFF DETAILS

NAME OF ENUMERATOR: ----------

TIME INTERVIEW START: ----------

DATE OF INTERVIEW: ----------

NAME OF DATA ENTRY CLERK: ----------

DATE OF DATA ENTRY: ----------

OBSERVATIONS ON THE INTERVIEW: 'Record general notes about the interview and record any special information that will be helpful for supervisors and the analysis of this questionnaire.'

SECTION B: Socio demographic Characteristics (Pleases circle)

QCODE	QUESTION	RESPONSES AND CODING
B1	District name	Temeke .....1 Tabora .....2 Mbeya.....3 Mwanza.....4 Songea .....5 Bukoba.....6
B2	Sex of respondent	Male .....1 Female 2
B3	How old are you?	[.....] years
B4	Marital status	Married .....1 Single .....2 Divorced .....3 Cohabiting 4
B5	What is your education level?	Pre primary.....1 Primary. .....2 Post primary training.....3 Secondary O level.....4 Secondary A level.....5 Post secondary O level training.....6 Post secondary A level training.....7 University.....8
B6	What is your occupation?	Civil servants.....1 Businessman/Trader .....2 Peasant .....3 Other specify.....4

SECTION C: KNOWLEDGE, ATTITUDE AND PRACTICES ON HIV AND AIDS

C 1: Knowledge (Please circle)

QCODE	QUESTION	RESPONSES AND CODING
C11	Can a person get HIV/AIDS from: Bites from mosquitoes or other insects that have bitten someone with HIV/AIDS?	Yes .....1 No .....2 Don‘t know……3
C12	Do you agree or disagree that people are infected with HIV as a punishment from God?	Agree----------…..1 Disagree…….2 Don‘t know……..3
C13	Can a baby get HIV from his/her mother who has HIV/AIDS?	Yes .....1 No .....2 Don‘t know…….3
C14	Do you have any relatives, friends or colleagues who have HIV or who have died of AIDS?	Yes .....1 No 2
C15	Are there special drugs that a doctor or a nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmission to the baby	Yes .....1 No .....2 Don‘t know.....3
C16	How much protection do you think male circumcision can provide against HIV infection: complete, partial, or none at all?	Compete.....1 Partial.....2 Not at all.....3

C2: PRACTICES

QCODE	QUESTION	RESPONSES AND CODING
C21	I do not want to know the results of your test, but have you ever been tested for HIV/AIDS?	Yes No
C22	Would you say that a woman's risk of being infected with the AIDS virus is greater, the same, or less during pregnancy?	Yes No
C23	How likely do you think that you will get tested for HIV in the next six months?	Yes No
C24	Have you ever given gifts, money, or favors to 1st partner in exchange for not using a condom during sexual intercourse?	Yes No
C25	In the past 6 months, how frequently did you yell at your 1st partner when she did not want to have sex?	Once More than once None
C26	In the past 12 months, how frequently did you use a condom when you had sex with your 1st partner	Once More than once None
C27	Did you use a condom the last time you had sex with your 1st partner?	Yes No
C28	In the past 6 months, how frequently did you speak to your 2nd partner about using a condom	Once More than once None
C29	Have you ever tried to force a partner to get an abortion through use or threat of physical violence or abandonment?	Yes No
C210	Who have you talked with about HIV/AIDS? (Please tick)	Female friend Doctor Nurse Family member Other
	Have you ever talked with any one about your sexual needs? (Please tick)	Yes No
C211	Who have you talked with about your sexual needs? (Please tick)	Female friend Doctor Nurse Family member Other

C3: GENDER EQUITABLE MEN'S ATTITUDE QUESTIONS

INSTRUCTIONS TO INTERVIEWER: Individuals are asked if they –Agree," –Partially agree," or –Disagree" with each of the 24 GEM Scale statements. Each response is scored on a 3-point scale where 1 = Agree, 2 = Partially agree, and 3 = Disagree

S/N	QUESTION	RESPONSES
C31	Giving the kids a bath and feeding the kids are the mother's responsibility	Agree.....1 Partially agree.....2 Disagree.....3
C32	A woman's most important role is to take care of her home and cook for her family	Agree.....1 Partially agree.....2 Disagree.....3
C33	A man should have the final word on decisions in his home	Agree.....1 Partially agree.....2 Disagree.....3
C34	It is a woman's responsibility to avoid getting pregnant	Agree.....1 Partially agree.....2 Disagree.....3
C35	If someone insults a man he should defend his reputation with force if he has to	Agree.....1 Partially agree.....2 Disagree.....3
C36	You don't talk about sex, you just do it	Agree.....1 Partially agree.....2 Disagree.....3
C37	Women who carry condoms on them are easy	Agree.....1 Partially agree.....2 Disagree.....3
C38	If a woman cheats on a man, it is ok for him to hit her	Agree.....1 Partially agree.....2 Disagree.....3
C39	Men need sex more than women do	Agree.....1 Partially agree.....2 Disagree.....3
C310	Men are always ready to have sex	Agree.....1 Partially agree.....2 Disagree.....3
C311	There are times a woman deserves to be beaten	Agree.....1 Partially agree.....2 Disagree.....3
C312	A man needs other women, even if things with his wife are fine	Agree.....1 Partially agree.....2 Disagree.....3
C313	A woman should tolerate violence in order to keep her family together	Agree.....1 Partially agree.....2 Disagree.....3

C314	A man should be outraged if his wife asks him to use a condom	Agree.....1 Partially agree.....2 Disagree.....3
C315	It is okay for a man to hit his wife if she refuses to have sex with him	Agree.....1 Partially agree.....2 Disagree.....3
C316	Real men do not immediately go to a doctor when they are sick	Agree.....1 Partially agree.....2 Disagree.....3
C317	A man using violence against his wife is a private matter that shouldn‘t be discussed outside the couple	Agree.....1 Partially agree.....2 Disagree.....3
C318	A man should not take his child to the clinic without the child‘s mother	Agree.....1 Partially agree.....2 Disagree.....3
C319	A woman should not initiate sex	Agree.....1 Partially agree.....2 Disagree.....3
C320	A woman should obey her husband in all things	Agree.....1 Partially agree.....2 Disagree.....3
C321	It is the man who decides when to have sex with a partner	Agree.....1 Partially agree.....2 Disagree.....3
C322	Only when a wife has a child she becomes a real woman	Agree.....1 Partially agree.....2 Disagree.....3
C323	A real man produces a male child	Agree.....1 Partially agree.....2 Disagree.....3
C324	Employed women do not make good wives	Agree.....1 Partially agree.....2 Disagree.....3

D: REPRODUCTIVE HEALTH (Please TICK)

	QUESTION	Responses
D1	How important do you think it is that men do the following to help prevent children from becoming infected with HIV	Very important
		Somewhat important
		Not at all important
D2	Reduce number of sexual partners	Very important
		Somewhat important
		Not at all important
D3	Get tested alone for the AIDS virus	Very important
		Somewhat important
		Not at all important
D4	Use condoms with their pregnant partner	Very important
		Somewhat important
		Not at all important
D5	How comfortable would you feel going to a health facility in this community as a family planning client	Very comfortable
		Somewhat comfortable
		Not at all comfortable
D6	How important do you think it is that men do the following to help prevent children from becoming infected with HIV	Very important
		Somewhat important
		Not at all important
D7	Do you feel that health facilities in this community welcome men to be counseled on family planning together with their partners?	Yes
		No
D8	How comfortable would you feel being counseling on family planning together with your partner?	Very comfortable
		Somewhat comfortable
		Not at all comfortable
D9	How important do you think men should participate in family planning counseling with their partner?	Very important
		Somewhat important
		Not at all important

INTERVIEW GUIDE FOR FEMALE PARTNERS OF MAP BENEFICIARIES

Hello, my name is .....…...We would like to thank you for participating in this interview. The U.S. Agency for International Development (USAID) has commissioned an impact evaluation of CHAMPION's Men as Partners® (MAP) interventions. The interview is part of the MAP evaluation for the CHAMPION project, a USAID-funded project and implemented by EngenderHealth. We are conducting a baseline survey for MAP evaluation in six districts in Tanzania. Specifically, the evaluation will assess whether and to what extent two different modes of implementing the MAP approach to gender norms transformation are successful in reducing HIV risk, improving reproductive health (RH) outcomes, and increasing gender-equitable norms and behaviors among project participants. This evaluation is being conducted by a team of four consultants from the Muhimbili University of Health and Allied Sciences (MUHAS). CHAMPION is responsible for conducting the interventions to be evaluated.

This interview is a part of this baseline study, and I would like to ask you some questions about the project. The interview should take approximately one hour. There is no possible risk if you agree to participate in this study; rather, it will benefit you by helping the government of Tanzania to do better job in meeting and improving health services of all Tanzanians.

All the information that you give to me will be kept strictly confidential; your name will not be used and you will not be identified in any way. Your participation is absolutely voluntary and there is no penalty for refusing to take part. You are free to ask any questions; you may refuse to be in this study; you may refuse to answer any question in the interview; and you may stop the interview at any point. Do you have any questions? Do I have your agreement to participate?

If the respondent agrees, then you may begin the interview.

1. Have you ever heard about CHAMPION'S MAP project? (PROBE: what did she know about it, objectives/activities)
2. How long have you been with your current partner?(PROBE; for type of relationship, duration of relationship, children, if any)
3. Can you briefly describe a typical day with your partner
4. What methods of HIV prevention do you and your partner use?(PROBE for condom use, purpose of using, consistency, partner willingness to use, decisions making process in condom use, attitudes towards condom use)
5. How does your partner participate in attending health facilities?
6. What can you say about the attitudes of health workers toward men attending health facilities with their partners (PROBE: is the facility environment welcoming to males?

7. What changes /arrangements have you witnessed that support male involvement in family health? Do you consider your partner as being gender transformed? (PROBE: for specific examples of behaviours representing support for gender equity vs. Social adherence to traditional views of manhood
8. Have you or your partner tested for HIV? (PROBE: I do not want to know the results of your test; did any one of you share results with their partner? Was this test done voluntarily or for some reason/pregnancy related)
9. Have you ever received gifts, money, or favors to in exchange for not using a condom during sexual intercourse?
10. In your relationship with your current partner, what do you discuss in relation to :sexual life, sexual decision making, condom use
11. Have your partner ever tried to force to have sex/ through use or threat of physical violence or abandonment(PROBE: for reason/context and her reaction)
12. Finally, can you describe one important and memorable action that your partner has done in recent times that has made you happy?

Is there anything else that you would like us to discuss?

THANK YOU FOR YOUR TIME!

1.19.2 INTERVIEW GUIDE FOR FEMALE PARTNERS OF MAP BENEFICIARIES (SWAHILI VERSION)

1. Je umewahi kusikia mradi unaojulikana kama CHAMPION MAP? (DADISI kufahamu anajua nini kama vile malengo na shughuli zake, nk.)
2. Kwa muda gani umekuwa na mwenza wako wa sasa (DADISI kujua aina ya mahusiano, idadi ya watoto kama wanao na wamekuwa pamoja kwa muda gani)
3. Unaweza kunieleza siku yako ya kawaida ukiwa na mwenza wako inakuwaje?
4. Wewe na mwenzi wako huyu mnatumia njia gani kujikinga msipatate VVU (DADISI matumizi ya kondom, sababu za kutumia kondom, matumizi ya mara kwa mara au mara moja, utayari wa mwenzi wako kutumia kondomu, maamuzi (ubishi) wakati wa kutumia kondomu pamoja na mtazamo wake kuhusu matumizi ya kondomu)
5. Mwenza wako anashiriki kwa namna gani mahudhurio kwenye kituo cha afya?
6. Unazungumziaje mtazamo wa wahaudumu wa kitu cha afya kuhusu wanaume kuhudhuria pamoja na wenza wao (DADISI: Mazingira ya kituo yanafaa kwa wanaume?)
7. Ni mabadiriko au mipango gani umeiona inayoboresha wanaume kushiriki katika afya ya familia? Unafikiri mwenzi wako amebadirika katika masuala ya jinsia? (DADISI: upate mifano kadhaa ya mtazamo na matendo yanayoashiria kukubali usawa wa kijinsia kulinganisha na itikadi za jadi kuhusu _uwanaume"
8. Je, wewe au mwenza wako ume/amewahi kupima VVU? (DADISI: Sihitaji kujua majibu yako au yake, baada ya kupima kuna aliyeshiriki katika kuambizana matokeo ya kipimo? Was this test done voluntarily or for some reason/pregnancy related)
9. Je, umewahi kupewa zawadi, pesa au upendeleo wowote ili ufanye ngono bila kutumia kondomu?
10. Katika mahusiano wa mwenza wako wa sasa, huwa manshauriana nini kuhusu ujinsia, maamuzi yoyote kufanya ngono na matumizi ya kondomu?
11. Je, huyu mwenza wako amewahi kukulazimisha kwa nguvu au akitumia vitisho au kukutelekeza ili mfanye ngono bila ridhaa yako) DADISI: kujua sababu na katika mazingira gani na ulifanya/amua nini)
12. Mwisho, unaweza kunisimulia kitu kimoja cha kukufurahisha na hutokisahau maishani alichokifanya huyu mwenza wako?

Kuna lolote zaidi ungependa tuongelee?

NAKUSHUKURU KUWA PAMOJA NA KWA MAONGEZI!

1.19.3 OBSERVATION GUIDE/CHECKLIST FOR HEALTH FAIR, STREET DIALOGUE (BODABODA EVENTS)

Observation number……

Region…….

District…….

Ward …….

Type of event……

Date of interview…….....

Name of observer/researcher……

STARTING TIME: ……

ISSUES TO OBSERVE

1. Record IEC materials used
   ……
   ……
   ……
2. Audience description
   Participation……
   ……
   ……

   Gender composition
   ……
   ……

   Record any other important demographic variable/info……
   …….
3. Facilitators;

   Facilitation style

   Were participants allowed to ask questions?.....

4. Venue/place:

   Accessibility/other features to facilitate/hinder learning/information exchange

   ……
   ……
   ……

5. Topics/issues discussed
   ……
   ……
   …….

6. Commentaries from people

   ……
   ……
   ……

7. Is it worthy of further investigation Yes/No_____

FINISH TIME: …….

Summary of key issues from observation
……
……
……
……

1.20 LIST OF THE INDICATORS USED TO MATCH CONTROL DISTRICTS TO INTERVENTION DISTRICTS.

Below are demographic and reproductive health indicators used to match control and intervention areas

2012 Population and Housing Census

District-level indicators:

- Total population
- Average household size
- Sex ratio

Ward-level indicators:

- Total population
- Average household size
- Sex ratio

2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey

Regional-level indicators:

- Wealth (quintiles)
- Education (mean years completed)
- Unemployment (percentage employed in the 12 months preceding survey)
- Marital status (zero co-wives)
- Comprehensive knowledge of HIV[3]
- Accepting attitudes towards those living with HIV[4]
- Recent sexual activity (percentage who had sex within the past 4 weeks)
- Multiple sexual partners (percentage who had 2+ partners in the past 12 months)
- Condom use at last paid sex (men only)
- HIV testing (tested for HIV in past 12 months and received results)
- Men circumcised
- Sexually transmitted infections (percentage who had an STI in past 12 months)
- HIV prevalence

2010 Tanzania Demographic and Health Survey

Regional-level indicators:

- Contraceptive use (percentage of women using any modern method)
- Gender-based violence (percentage of women who have ever experienced sexual violence)

[3] Comprehensive knowledge of HIV is measured as the percentage of people who know that consistent use of a condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, know that a healthy-looking person can have the AIDS virus, and reject the two most common local misconceptions about transmission or prevention of HIV/AIDS.

[4] Accepting attitudes towards those living with HIV is measured as the percentage of people who said yes to all four statements: are willing to care for a family member with the AIDS virus in the respondent's home, would buy fresh vegetables from a shopkeeper who has the AIDS virus, say that a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching, and would not want to keep secret that a family member got infected with the AIDS virus.

1.21 RECRUITMENT PROCESS AND PARTICIPANT SELECTION CRITERIA FOR THE MAP WORKSHOPS

Pre-recruitment steps: Each lead NGO (LNGO) will write a letter to the Ward Executive Officer (WEO) from the evaluation wards to: 1) introduce the CHAMPION project and MAP group education workshops; 2) provide an overview of the MAP evaluation and criteria for participation; 3) request permission to conduct MAP workshops in their ward; and 4) request the support of a Community Develop Officer (CDO), *Mitaa* Executive Officer (MEO), or other local influential leader to assist with the identification and recruitment of participants. CHAMPION will provide the LNGO with language for this letter. In evaluation districts where an LNGO is not present, CHAMPION will write the letter to the WEO.

Before recruitment begins, CHAMPION in collaboration with the respective LNGO will assign two or three MAP field facilitators (FFs) to each evaluation ward to oversee the MAP process. MAP FFs will be responsible for recruiting participants and implementing the MAP workshops in their assigned wards. As the project has done in the past, CHAMPION staff will be in-district to support the entire recruitment process.

Time needed for recruitment: 8 days or less (see table below for additional details)

Step 1. MAP FFs meet with the WEO, present introduction letter, and obtain permission to conduct MAP workshops.

- MAP FFs will schedule and meet with the WEO from their assigned evaluation ward to present the introduction letter and obtain permission to conduct the MAP workshops in their wards. The MAP FF will also discuss the criteria for selecting participants.
- The WEO will assign a CDO, MEO, or other local influential leader to support the identification and recruitment of community members and give the MAP FFs his/her contact information.
- The MAP FFs and WEO will discuss a tentative date and venue for the sensitization meetings[5] for MAP workshop participants (see Step 7).

Step 2. MAP FFs meet with the CDO/MEO/local influential leader, present introduction letter, and schedule the location and datesfor door-to-door recruitment of participants.

[5] After the identification and recruitment of participants for the MAP workshops, the MAP FFs will conduct a sensitization meeting for workshop participants and local leaders at the ward level including religious leaders, local government authorities, and opinions leaders. The purpose of this meeting is to introduce the CHAMPION Project and its activities and to present why and how the MAP workshops will be implemented. These sensitization meetings are also meant to create a sense of project ownership among local leaders at the ward level and improve the sustainability of the project‘s work.

- MAP FFs will schedule and meet with the CDO/MEO/local influential leader assigned by the WEO to present a copy of the introduction letter and explain the support needed to recruit participants.
- The MAP FFs and CDO/MEO/local influential leader will agree on: 1) which streets (*mitaa*) to recruit participants; and 2) the dates/times for door-to-door recruitment.

  Notes: Door-to-door recruitment should begin immediately after meeting with the CDO/MEO/local influential leader. Recruitment should take no more than three days. At least two streets should be visited to recruit participants for one workshop.

Step 3. MAP FFs notify select Community Action Team (CAT) members to participate in door-to-door recruitment.

- After the MAP FFs and CDO/MEO/local influential leader agree on the streets and dates/times for door-to-door recruitment, the MAP FFs will identify and request 2-3 CAT members to assist them with the door-to-door recruitment in their assigned evaluation ward.

Step 4. MAP FFs organize the venue, date, and time for sensitization meetings.

- After the dates for recruitment are determined, MAP FFs will organize the venue, date, and time for the sensitization meetings for MAP workshop participants. The sensitization meetings should take place within two days after recruitment ends.
- One sensitization meeting will be conducted for each group of workshop participants, i.e., 30 participants per meeting.
- MAP FFs will organize the sensitization meeting(s) for the group(s) they will facilitate.

Step 5.Door-to-door recruitment of MAP workshop participants is undertaken.

- The MAP FFs, select CAT members, and CDO/MEO/local influential leader will meet at one of the recruitment streets. The team will then walk door-to-door to recruit 30 participants for each workshop. At least two streets should be visited to recruit participants for each workshop.
- Depending on the ward, 4-5 groups will be recruited.
- The team will recruit participants based on the selection criteria below. Groups will include both men and women; however, each group should be composed of roughly 2/3 men and 1/3 women.[6]

  To participate in the workshop, participants must be:
  - 25 years or older
  - Residents of the street visited

[6] As the project has done in the past, CHAMPION will recruit more men than women for the workshops since the workshops were originally designed to target men.

- Literate in Kiswahili
- Willing to participate in workshops without receiving monetary compensation (~~–v~~olunteerism spirit")
- Able to attend workshop sessions up to three times per week for 12 weeks
- Willing to participate in the evaluation
- Mentally healthy and able to consent to participation.

To participate in the workshop, participants cannot be:

- A CHAMPION community or workplace volunteer (past or present)
- A previous participant of a MAP workshop or CHAMPION training
- The partner of a previous MAP workshop participant
- In a relationship with another person also attending the workshops, i.e., married couples or partners cannot attend the MAP intervention together or in different workshop groups.

❖ **Important Note:**Each participant must attend 80% of all workshops in order for them to be considered as having completed the intervention.

- The MAP FFs or CAT members will: 1) register any individual who meets all of the above criteria and agrees to participate on a registration form provided by CHAMPION; and 2) notify the individuals of the upcoming sensitization meetings. The MAP FFs or CAT members will call each registered participant to confirm the location and time of their sensitization meeting.
- A CHAMPION staff and LNGO Program Coordinator will be onsite to observe and support the recruitment process and to ensure all procedures are being followed.

Step 6: Registered participants and FFs are assigned to workshop groups and each participant is notified of when/where their sensitization meeting will take place.

- The CHAMPION staff in-district, MAP FFs, and LNGO Program Coordinator will compile the registered participants into one list.
- The team will then assign participants to workshops. The first 30 participants on the list will be assigned to Workshop A, the next 30 participants will be assigned to Workshop B, and so on.
- The CHAMPION staff and LNGO Program Coordinator will assign the MAP FFs to the workshop groups that they will facilitate.
- Once the participants and MAP FFs are assigned to workshop groups, the team will decide the day, time, and venue for each group's sensitization meeting. The team will then call each registered participant to confirm the location, date, and time of their sensitization meeting.

- Before the sensitization meeting takes place, groups will be assigned to prepare the tentative 12-week workshop schedule for each group.

Step 7: Sensitization meeting for each group of participants is conducted.

- The MAP FFs will conduct a sensitization meeting for each group of workshop participants and local leaders at the ward level identified by the WEO.The meeting will: 1) introduce the CHAMPION project and MAP program; 2) present the workshop schedule; and 3) discuss workshop logistics.
- The MAP FFs will be responsible for sensitizing the participants in the workshop they will facilitate. CHAMPION will prepare standard talking notes on the CHAMPION Project, the MAP workshops, and the MAP evaluation in Kiswahili for the MAP FFs.
- The WEO, CDO/MEO/local influential leader, LNGO Program Coordinator, and CHAMPION staff will all be invited to participate in the sensitization meetings.

1.22 CONSENT FORM FOR MAP EVALUATION QUESTIONNAIRE; ENGLISH VERSION

Greetings! My name is.....from MUHAS; We are part of a team carrying out an evaluation to assess the implementation of MAP project in six selected districts of urban Tanzania.

Purpose of the evaluation

We would like to thank you for participating in this discussion. The discussion part of an evaluation to establish the efficacy of the CHAMPION project's MAP approach in Tanzania in reducing HIV risk behaviors, improving RH, and increasing gender equitable norms among urban, adult Tanzanian men and women (aged 25 years and older). The evaluation will also assess the relative impact of the MAP group education workshops when implemented alone versus combined with community engagement activities. The evaluation will assess the extent to which the intended project objectives have been achieved and the impact which has been realized as a result of project interventions.

The reason for inviting you for the interview/discussion is to understand your (as an implementer or beneficiary of MAP project) perspectives of the role/contribution of the project in reducing HIV risk behaviors, improving RH, and increasing gender equitable norms among urban, adult Tanzanian men and women. In this evaluation we will administer a questionnaire, conduct individual interviews and focus group discussions with selected groups who participated in the implementation or benefited directly or indirectly from the intervention/project. Finally, we are also interested to document your recommendations for future direction of the programme

The questionnaire/discussion will take approximately 60 minutes. If you feel that there are related issues that are relevant and important, you are mostly welcome to raise these issues during the conversation. Please feel free to give your opinion and your responses will be treated with highest degree of confidentiality.

What participation involved

If you agree to participate in this study, you will be required to answer questions on various issues that will be asked. Participation is on voluntary bases, no any payment or medicine that will be issued to you upon participation. But you will be compensated for the travel costs incurred to come to the discussion

Confidentiality

All information we collect on forms will be entered into computer with only the study identification number and that the information will be strictly confidential.

Rights to Withdraw and Alternatives

Taking part in this study is completely your choice. If you choose not to respond to any question asked you won‘t be penalized. You can stop participating in this study any time even if you have already given your consent. Refusal to participate or withdraw from the study will not involve penalty or loss of any benefits to which you are otherwise entitled

Benefits

Your participation in this study will make you aware of your contribution to CHAMPION project implementation thus contributing to promoting health for yourself and members of community .We hope that the information we learn from this evaluation will benefit you and others indirectly through influencing policy changes in improving both curative and preventive services.

Potential Risks

There are no potential risks to your participation.

Who to Contact

If you ever have questions about this study, you should contact the Director of Research & Publications, MUHAS, Prof. M.Moshi via telephone number 255 22 2150473 or the evaluation Team leader Dr. Mangi Job Ezekiel, from Muhimbili University of Health & Allied Sciences (MUHAS) . His mobile number is: 0772 228811 OR 0713788811.

Signature:

Do you agree?

Participant agrees.....Participants does NOT agree.....

I .....have read the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of participant.....

Signature of research assistant.....

……..

Date of Signed consent.....

1.23 FOMU YA RIDHAA KUSHIRIKI KWENYE UTAFITI/TATHMINI (DODOSO): SWAHILI VERSION

FOMU YA RIDHAA

Kuridhia Kushiriki Katika tathmini ya mradi wa MAP/Wanaume kama wenza unaotekelezwa na CHAMPION/ENGENDERHEALTH

Salaam! Mimi naitwa……natokea MUHAS, tunafanya tathimini kuangalia utekelezaji wa mradi wa CHAMPION kwenye baadhi ya wilaya hapa Tanzania

Lengo la tathmini

Tungependa kukushukuru kwea kukubali kushiriki kwenye majadiliano haya, haya ni majadiliano yanayofanyika kwa ajili ya kuutathimini mradi wa **Wanaume kama Wenza** (MAP) unaotekelezwa na CHAMPION/ENGEDER HEALTH. Tathmini hii inalenga utendaji wa mradi wa CHAMPION katika kipindi cha miaka mitano ya utekelezaji wake.

Sababu ya kukushirikisha kwenye tathmini hii ni kutaka kujua uzoefu wako (kama mshiriki an mlengwa wa mradi wa MAP/*Wanaume kama Wenza*) juu ya mchango na athari za utekelezaji wa mradi huu katika kuleta mabadiliko endelevu kwa wanaume na wavulana katika masuala ya jinsia na mabadiliko ya tabia. Katika tathmini hii tutafanya mahojinao kwa kutumia dodoso maalumu na pia usaili wa kina kwa mtu mmoja mmoja na majadiliano ya vikundi kwa vikundi vitakavyochaguliwa ambao walishiriki katika utekelezaji wa mradi au walinufaika kwa namna moja ua nyingine kutokana na mradi huu.

Mwisho tungependa kuandika mapendekezo yako kwaajili ya matumizi ya baadae ya mradi.

Mahojiano kwa kutumia na usaili wa kina yatachukua takribani dakika 60. Kama utahisi kwamba kuna vitu vinavyohusiana na ni vya muhimu karibu sana kuzizungumza wakati wa majadiliano. Tafadhali kuwa huru kutoa maoni yako na majibu yako yatatunza kwa usiri wa hali ya juu.

Ushiriki gani unaohitajika toka kwako

Ukiridhia kushiriki katika tathmini hiiutatakiwa kujibu maswali yatakayoulizwa kuhusiana na maswala mbalimbali. Kushiriki ni kwa hiari, hakutakuwa na malipo yatakayotolewa kwa kushiriki lakini tutarudishiwaa gharama ulizotumia kusafiri kufika hapa kwenye majadiliano

Usiri

Taarifa zote tutakazokusanya kwenye madodoso na fomu zingine zitaingizwa kwenye tarakilishi tukiandika namba yako ya utambulisho tu, na taarifa hizo zitatunzwa kwa usiri mkubwa

Haki ya Kujitoa katika tathmini

Kushiriki kwenye hii tathmini ni chaguo lako mwenyewe. Kama utachagua kutojibu swali lolote utakaloulizwa hautapewa adhabu. Unaweza kuacha kushiriki kwenye hii tathmini saa yeyote hata baada ya kukubali kushiriki kwa ridhaa yako. Kukataa kushiriki au kujitoa kwenye ushiriki wa tathmini hii hakutahusisha adhabu au kupoteza faida ambazo ulitakiwa kuzipata

Faida

Ushiriki wako katika tathmini hii utakuwezesha kujua ni kwanamna gani umechangia kwenye utekelezaji wa mradi huu wa CHAMPION na kwanamna gani umechangia kwenye kuboresha afya yako na wanajamii wengine katika jamii hii. Tunaamini kwamba taarifa tutakazozipata kutoka kwenye tathmini hii zitakusaidia na wengine kwa kusaidia mabadiliko ya sera yatakayoboresha matibabu na uzuiaji wa magonjwa

Hatari/athari zinazoweza kutokea

Hakuna madhara yeyote katika kushiriki tathmini hii**.**

Mawasiliano

Kama utakuwa na swali au maswali kuhusiana na tathmini hii, wasiliana na Mkurugenzi wa Utafiti na Machapisho MUHAS, Prof. M.Moshi kwa simu namba 255 22 2150473 au mkuu wa timu ya tathmini Dr. Mangi Job Ezekiel kutoka Muhimbili University. Namba yake ya simu ya mkononi ni 0772228811 au 0713788811.

Sahihi:

Unakubali?

Mshiriki anakubali.....Mshiriki hakubali.....

Mimi .....nimesoma yaliyomo katika hati hii.Maswali yangu yote yamejibiwa vizuri.Nakubali kushiriki katika tathmini hii.

Sahihi ya Mshiriki.....

Sahihi ya mtafiti msaidizi.....

Tarehe.....

CONSENT FORM FOR INDEPTH INTERVIEW: ENGLISH VERSION

Greetings! My name is.....from MUHAS; We are part of a team carrying out an evaluation to assess the implementation of MAP project in six selected districts of urban Tanzania.

Purpose of the evaluation

We would like to thank you for participating in this discussion. The discussion part of an evaluation to establish the efficacy of the CHAMPION project's MAP approach in Tanzania in reducing HIV risk behaviors, improving RH, and increasing gender equitable norms among urban, adult Tanzanian men and women (aged 25 years and older). The evaluation will also assess the relative impact of the MAP group education workshops when implemented alone versus combined with community engagement activities. The evaluation will assess the extent to which the intended project objectives have been achieved and the impact which has been realized as a result of project interventions.

The reason for inviting you for the interview/discussion is to understand your (as an implementer or beneficiary of MAP project) perspectives of the role/contribution of the project in reducing HIV risk behaviors, improving RH, and increasing gender equitable norms among urban, adult Tanzanian men and women. In this evaluation we will administer a questionnaire, conduct individual interviews and focus group discussions with selected groups who participated in the implementation or benefited directly or indirectly from the intervention/project. Finally, we are also interested to document your recommendations for future direction of the programme

The questionnaire/discussion will take approximately 60 minutes. If you feel that there are related issues that are relevant and important, you are mostly welcome to raise these issues during the conversation. Please feel free to give your opinion and your responses will be treated with highest degree of confidentiality.

What participation involved

If you agree to participate in this study, you will be required to answer questions on various issues that will be asked. Participation is on voluntary bases, no any payment or medicine that will be issued to you upon participation. But you will be compensated for the travel costs incurred to come to the discussion

Confidentiality

All information we collect on forms will be entered into computer with only the study identification number and that the information will be strictly confidential.

Rights to Withdraw and Alternatives

Taking part in this study is completely your choice. If you choose not to respond to any question asked you won't be penalized. You can stop participating in this study any time even if you have

already given your consent. Refusal to participate or withdraw from the study will not involve penalty or loss of any benefits to which you are otherwise entitled

Benefits

Your participation in this study will make you aware of your contribution to CHAMPION project implementation thus contributing to promoting health for yourself and members of community .We hope that the information we learn from this evaluation will benefit you and others indirectly through influencing policy changes in improving both curative and preventive services.

Potential Risks

There are no potential risks to your participation.

Who to Contact

If you ever have questions about this study, you should contact the Director of Research & Publications, MUHAS, Prof. M.Moshi via telephone number 255 22 2150473 or the evaluation Team leader Dr. Mangi Job Ezekiel, from Muhimbili University of Health & Allied Sciences (MUHAS) . His mobile number is: 0772 228811 OR 0713788811.

Signature:

Do you agree?

Participant agrees.....Participants does NOT agree.....

I .....have read the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of participant.....

Signature of research assistant.....

……..

Date of Signed consent.....

FOMU YA RIDHAA KUSHIRIKI KWENYE USAILI

FOMU YA RIDHAA

Kuridhia Kushiriki Katika tathmini ya mradi wa MAP/Wanaume kama wenza unaotekelezwa na CHAMPION/ENGENDERHEALTH

Salaam! Mimi naitwa……natokea MUHAS, tunafanya tathimini kuangalia utekelezaji wa mradi wa CHAMPION kwenye baadhi ya wilaya hapa Tanzania

Lengo la tathmini

Tungependa kukushukuru kwea kukubali kushiriki kwenye majadiliano haya, haya ni majadiliano yanayofanyika kwa ajili ya kuutathimini mradi wa **Wanaume kama Wenza** (MAP) unaotekelezwa na CHAMPION/ENGEDER HEALTH. Tathmini hii inalenga utendaji wa mradi wa CHAMPION katika kipindi cha miaka mitano ya utekelezaji wake.

Sababu ya kukushirikisha kwenye tathmini hii ni kutaka kujua uzoefu wako (kama mshiriki an mlengwa wa mradi wa MAP/*Wanaume kama Wenza*) juu ya mchango na athari za utekelezaji wa mradi huu katika kuleta mabadiliko endelevu kwa wanaume na wavulana katika masuala ya jinsia na mabadiliko ya tabia. Katika tathmini hii tutafanya mahojinao kwa kutumia dodoso maalumu na pia usaili wa kina kwa mtu mmoja mmoja na majadiliano ya vikundi kwa vikundi vitakavyochaguliwa ambao walishiriki katika utekelezaji wa mradi au walinufaika kwa namna moja ua nyingine kutokana na mradi huu.

Mwisho tungependa kuandika mapendekezo yako kwaajili ya matumizi ya baadae ya mradi.

Mahojiano kwa kutumia na usaili wa kina yatachukua takribani dakika 60. Kama utahisi kwamba kuna vitu vinavyohusiana na ni vya muhimu karibu sana kuzizungumza wakati wa majadiliano. Tafadhali kuwa huru kutoa maoni yako na majibu yako yatatunza kwa usiri wa hali ya juu.

Ushiriki gani unaohitajika toka kwako

Ukiridhia kushiriki katika tathmini hiiutatakiwa kujibu maswali yatakayoulizwa kuhusiana na maswala mbalimbali. Kushiriki ni kwa hiari, hakutakuwa na malipo yatakayotolewa kwa kushiriki lakini tutarudishiwaa gharama ulizotumia kusafiri kufika hapa kwenye majadiliano

Usiri

Taarifa zote tutakazokusanya kwenye madodoso na fomu zingine zitaingizwa kwenye tarakilishi tukiandika namba yako ya utambulisho tu, na taarifa hizo zitatunzwa kwa usiri mkubwa

Haki ya Kujitoa katika tathmini

Kushiriki kwenye hii tathmini ni chaguo lako mwenyewe. Kama utachagua kutojibu swali lolote utakaloulizwa hautapewa adhabu. Unaweza kuacha kushiriki kwenye hii tathmini saa yeyote hata baada ya kukubali kushiriki kwa ridhaa yako. Kukataa kushiriki au kujitoa kwenye ushiriki wa tathmini hii hakutahusisha adhabu au kupoteza faida ambazo ulitakiwa kuzipata

Faida

Ushiriki wako katika tathmini hii utakuwezesha kujua ni kwanamna gani umechangia kwenye utekelezaji wa mradi huu wa CHAMPION na kwanamna gani umechangia kwenye kuboresha afya yako na wanajamii wengine katika jamii hii. Tunaamini kwamba taarifa tutakazozipata kutoka kwenye tathmini hii zitakusaidia na wengine kwa kusaidia mabadiliko ya sera yatakayoboresha matibabu na uzuiaji wa magonjwa

Hatari/athari zinazoweza kutokea

Hakuna madhara yeyote katika kushiriki tathmini hii**.**

Mawasiliano

Kama utakuwa na swali au maswali kuhusiana na tathmini hii, wasiliana na Mkurugenzi wa Utafiti na Machapisho MUHAS, Prof. M.Moshi kwa simu namba 255 22 2150473 au mkuu wa timu ya tathmini hii Dr. Mangi Job Ezekiel kutoka Muhimbili University. Namba yake ya simu ya mkononi ni 0772228811 au 0713788811.

Sahihi:

Unakubali?

Mshiriki anakubali.....Mshiriki hakubali.....

Mimi .....nimesoma yaliyomo katika hati hii.Maswali yangu yote yamejibiwa vizuri.Nakubali kushiriki katika tathmini hii.

Sahihi ya Mshiriki.....

Sahihi ya mtafiti msaidizi.....

Tarehe.....

DODOSO (SWAHILI VERSION)

DODOSO LA MAP LA UKUSANYAJI TAKWIMU ZA AWALI

UTAMBULISHO KWA KAYA ITAKAYOHOJIWA

Habari, Jina langu ni …….. …… Shirika la Kimataifa la Maendeleo la Kimarekani (USAID) linafanya tathmini ya CHAMPION's ya mradi/program ya Wanaume kama wenza ® (MAP). Tunafanya utafiti wa awali wa tathmini ya MAP katika wilaya sita za Tanzania. Tathmini hii italenga kuangalia ni kwa kiasi gani na kuona kama aina tofauti za kutekeleza mpango huu wa MAP katika mambo ya ufanisi wa mabadiliko ya tamaduni za jinsia katika kupunguza hatari za maambukizi ya UKIMWI, uboreshaji wa matokeo ya afya ya uzazi (RH), na kuongeza tamaduni za usawa katika jinsia na tabia miongoni mwa washiriki. Tathmini hii inafanywa na timu ya wataalam wanne kutoka Chuo Kikuu cha Afya cha Muhimbili (MUHAS). CHAMPION inahusika na kuendesha programuzitakazofanyiwa tathmini.Huu mpango ulioandaliwa unaonyesha ni jinsi gani na ni lini CHAMPION itafanya hizo interventions

Mahojiano haya ni sehemu ya utafiti wa awali na ningependa kukuuliza baadhi ya maswali kuhusu wewe mwenyewe. Hakuna madhara yoyote kama utakubali kushiriki katika utafiti huu: bali, utatunufaisha kwa kuisaidia serikali ya Tanzania kufanya kazi nzuri katika kuboresha, na kutoa mahitaji na huduma kwa watanzania wote.

Maelezo yote ambayo utatoa kwangu yatahifadhiwa kwa usiri mkubwa: jina lako halitatumika na hutatambulika kwa namna yoyote ile. Mahojiano haya yatachukua takribani saa moja kumalizika.Ushiriki wako ni wa hiyari na hakutakuwa na madhara ukiamua kutoshiriki. Uko huru kuuliza maswali; unaweza kukataa kushiriki katika utafiti huu; unaweza kukataa kujibu swali lolote katika mahojianao haya; na unaweza kuacha kufanya mahojiano haya muda wowote. Je una swali lolote?Nimepata ridhaa yako ya kushiriki?

Kama mshiriki amekubali, unaweza kuanza mahojiano.

SEHEMU A-1: UTAMBULISHO

MKOA: | | | | ----------

WILAYA ----------

KATA | | | | | | | ----------

JINA LA MTAA | | | | ----------

ID YA KAYA | | | | ----------

SEHEMU A-2: DODOSO LA MAELEZO YA WAFANYAKAZI

JINA LA ANAYEHOJI: ----------

MUDA WA KUANZA MAHOJIANO: ----------

TAREHE YA MAHOJIANO: ----------

JINA LA KARANI MUINGIZAJI TAKWIMU ----------

TAREHE YA KUINGIZA TAKWIMU: ----------

ANGALIZO KWA MAHOJIANO: 'Andika maelezo ya jumla kuhusu mahojiano na andika maelezo yoyote maalum ambayo yatakuwa muhimu kwa wasimamizi na uchambuzi wa hili dodoso'

QCODE	QUESTION	MAJIBU NA CODING
B1	Jina la Wilaya	Temeke .....1 Tabora .....2 Mbeya.....3 Mwanza.....4 Songea .....5 Bukoba.....6
B2	Jinsi ya anayehojiwa	Me .....1 Ke 2
B3	Una umri gani?	[.....] miaka
B4	Hali yako ya ndoa	Ameolewa/oa .....1 Hajaolewa/oa.....2 Ametalikiana…….....3 Wanaishi pamoja kinyumba.4
B5	Una kiwango gani cha elimu?	Elimu kabla ya msingi…….....1 Elimu ya Msingi…..... .....2 Elimu baada ya msingi…… ……3 Sekondari O level..... .....4 Sekondari A level.....5 mafunzo baada ya sekondari O level.....6 Mfunzo baada ya sekondari A level.....7 Chuo Kikuu.....8
B6	Kazi yako ni ipi?	Mwajiriwa wa Serikali …….....1 Mfanya biashara…. .....2 Mkulima .....3 Ingine (Taja).....4

SEHEMU C: UFAHAMU, MTIZAMO NA MATENDO KUHUSU UKIMWI NA VVU

C 1: Maarifa (Tafadhali zungushia)

QCODE	SWALI	MAJIBU
C11	Je mtu anaweza kupata UKIMWI/VVU kwa: Kung'atwa na mbu ama wadudu ambao wamemng'ata mtu mwenye UKIMWI/VVU?	Ndiyo .....1 Hapana .....2 Sijui ……3
C12	Je unakubali au unakataa kwamba watu wanaambukizwa UKIMWI kama adhabu toka kwa Mungu?	Nakubali----------…..1 Nakataa…… …… ……..2 Sijui ……..…… ……..3
C13	Je, mtoto anaweza kupata UKIMWI kutoka wka mama yake ambaye ana UKIMWI/VVU?	Ndiyo .....1 Hapana..... .....2 Sijui …….3
C14	Una ndugu, marafiki ama wenzako ambao wana VVU au waliokufa kwa UKIMWI?	Ndiyo .....1 Hapana.....2
C15	Je kuna dawa zozote ambazo daktari ama nesi anaweza kumpa mama mjamzito aliyeambukizwa VVU ili kupunguza hatari za kumwambukiza mtoto?	Ndiyo .....1 Hapana .....2 Sijui.....3
C16	Je unafikiria ni kwa ni kwa kiasi gani kutahiriwa kwa mwanamume kunaweza kutoa kinga dhidi ya maambukizi ya VVU?	Inazuia kabisa.....1 Kidogo tu.....2 Haizuii kabisa.....3

C2: MATENDO

QCODE	SWALI	MAJIBU NA CODING
C21	Sitaki kujua majibu yako, je ulishawahi kupima VVU?	1, Ndiyo
		2. Hapana
C22	Unaweza kusema kwamba hatari ya mwanamke kuambukizwa VVU ni kubwa zaidi, ni sawa, ama ndogo wakati wa ujauzito?	1, Kubwa zaidi 2, Ni sawa 3, Ndogo
C23	Je kuna uwezekano gani wa wewe kupima VVU kwa miezi sita ijayo?	1. Sawa
		2, Siwezi
C24	Je uslishawahi kutoa zawadi, pesa ama upendeleo wowote kwa mwenza wako wa kwanza ili msitumie kondomu wakati wa kufanya mapenzi?	1, Ndiyo
		2. Hapana
C25	Katika kipindi cha miezi 6, ni mara ngapi ulimfokea mwenza wako wa kwanza wakati alivyokataa kufanya mapenzi na wewe?	1. Mara moja
		2. Zaidi ya mara moja
		3. Sijawahi
C26	Katika kipindi cha miezi 12 iliyopita, ni mara ngapi ulitumia kondomu ulivyofanya mapenzi na mwenza wako wa kwanza?	1. Mara moja
		2, Zaidi ya mara moja
		3. Sijawahi
C27	Je ulitumia kondomu mara ya mwisho ulipofanya mapenzi na mwenza wako wa kwanza?	1. Ndiyo
		2. Hapana
C28	Katika kipindi cha miezi 6 iliyopita, ni mara ngapi uliongea na mwenza wako wa pili kuhusu kutumia kondomu?	1. Mara moja
		2. Zaidi ya mara moja
		3. Sijawahi
C29	Je ulishawahi kumlazimisha mwenza wako kutoa mimba kwa kutumia vitisho ama kumpiga ama kumwacha?	1. Ndiyo
		2. Hakuna
C210	Umeshaongea na nani kuhusu UKIMWI/VVU? (Tafadhali weka vema)	1. Rafiki wa kike 2. Daktari 3. Nesi 4. Mtu wa familia yako 5. Wengine :Taja
	Je ulishawahi kuongea na mtu yoyote kuhusu mahitaji yako ya ngono?	1. Ndiyo 2. Hapana
C211	Ulishaongea na nani kuhusu mahitaji yako ya ngono? (Tafadhali weka alama ya vema)	1. Rafiki wa kike 2. Daktari 3. Nesi 4. Mtu wa familia yako 5. Wengine :Taja

C3: MTAZAMO WA WANAUME KUHUSU USAWA WA KIJINSIA

MAELEKEZO KWA ANAYEHOJI: watu wanaulizwa kama –Wanakubali", –Wanakubali kidogo", ama –Wanakataa" kwa kila 24 GEM sentensi mizania . Kila jibu linapata alama kwenye 3-point scale ambapo 1 = Anakubali, 2 = Anakubali kidogo and 3 = Anakataa

S/N	SWALI	JIBU
C31	Kuogesha na kulisha watoto ni jukumu la mama	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C32	Kazi muhimu ya mama ni kuangalia nyumba na kuipikia familia yake	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C33	Mwanamme anakuwa ni muamuzi wa mwisho katika maamuzi nyumbani kwake	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C34	Ni jukumu la mwanamke kukwepa kupata mimba	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C35	Kama mtu akimtukana mwanaume, mwanaume huyo lazima alinde heshima yake kwa kutumia nguvu kama itamlazimu	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C36	Huwezi kuongea na mwenza kuhusu kufanya mapenzi, unafanya tuu.	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C37	Wanawake wanaobeba kondomu ni malaya	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C38	Kama mwanamke akiwa na mpenzi mwingine, mume wake akimpiga ni sawa tu	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C39	Wanaume wanahitaji ngono zaidi ya wanawake	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C310	Wanaume wako tayari muda wote kufanya ngono	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C311	Kuna kipindi mwanamke anastahili kupigwa	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C312	Mwanaume anahita wanawake wengine, hata kama hana ugomvi na mke wake	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C313	Mwanamke lazima avumilie vipigo ili akae na kuiweka familia yake pamoja	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3

C314	Mwanaume atakasirika kama mke wake akimwambia watumie kondomu	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C315	Ni sawa kwa mwanume akimpiga mke wake kama akikataa kufanya mapenzi	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C316	Wanaume wa kweli hawaendi kwa daktari mara moja wanapohisi wanaumwa	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C317	Mwanaume kuleta vurugu kwa mke wake ni jambo binafsi haitakiwi kujadiliwa nje ya wanafamilia hao wawili	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C318	Mwanaume hapaswi kumpeleke mtoto wake kliniki bila ya mama yake huyo mtoto	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C319	Mwanamke hatakiwi kuwa wa kwanza katika kuanza kufanya mapenzi	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C320	Mwanamke ni lazima amtii mume wake katika vitu vyote	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C321	Mwanaume ndiye anatakiwa kuamua ni wakati gani kufanya mapenzi na mwenza wake	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C322	Mwanamke anapopata mtoto ndio anakuwa mwanamke wa kweli	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C323	Mwanaume wa ukweli huwa anazaa watoto wa kiume	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3
C324	Wanawake walioajiriwa siyo wake wazuri	Nakubali.....1 Nakubali kidogo.....2 Nakataa.....3

D: AFYA YA UZAZI (Tafadhali weka vema)

	SWALI Je unafikiri ni muhimu kiasi gani kwa wanaume kufanya yafuatayo:	**Jibu**
D1	Kusaidia kuzuia watoto kuambukizwa virusi vya UKIMWI?	1
		2
		…….....3
D2	Kupunguza idadi ya wapenzi	Muhimu sana……..1
		Muhimu kidogo ……2
		Siyo muhimu kabisa ……..3
D3	Kupimwa wenyewe VVU	Muhimu sana……..1
		Muhimu kidogo ……2
		Siyo muhimu kabisa ……..3
D4	Kutumia kondomu na wenza wao wajawazito	Muhimu sana……..1
		Muhimu kidogo ……2
		Siyo muhimu kabisa ……..3
D5	Utajisikia vizuri kwa kiasi gani kwenda kwenye kituo cha afya katika jamii hii kama mteja wa uzazi wa mpango?	Muhimu sana……..1
		Muhimu kidogo ……2
		Siyo muhimu kabisa ……..3
D6	Je unafikiri ni muhimu kiasi gani kwa wanaume kufanya yafuatayo kusaidia kuzuia watoto kuambukizwa virusi vya UKIMWI?	Muhimu sana……..1
		Muhimu kidogo ……2
		Siyo muhimu kabisa ……..3
D7	Je unafikiri kwamba hospitali katika jumuiya hii zinakaribisha wanaume kupewa ushauri juu ya uzazi wa mpango pamoja na wenza wao?	1. Ndiyo
		2. Hapana

D8	Utajisikia vizuri kiasi gani kupata ushauri nasaha juu ya uzazi wa mpango pamoja na mwenza wako?	1. Nitajisikia vizuro kabisa
		2. Nitajisikia vizuri kidogo
		3. Sitajisikia vizuri hata kidogo
D9	Je unafikiri ni muhimu kiasi gani wanaume wanatakiwa kushiriki katika kupata ushauri nasaha juu ya uzazi wa mpango na wenza wao?	1. Muhimu sana
		2. Muhimu kidogo
		3. Siyo muhimu Kabisa

MWONGOZO WA MASWALI KWA MAAFISA WA SERIKALI

KUMBUKA: Maswali yataulizwa na utofauti wa sehemu/idara
Utangulizi

Habari, Jina langu ni,.....….. Tungependa kukushukuru kwa kushiriki kwako katika mahojianao haya. Shirika la Kimatafaila la Maendeleo la Marekani (USAID) linafanya tathmini ya CHAMPION's ya mradi/program ya Wanaume kama wenza ® (MAP).Haya mahojianoni sehemu ya tathmini ya MAP kwa mradi wa CHAMPION, mradi ambao unafadhiliwa na USAID na kutekelezwa na Engenderhealth.Tunafanya utafiti wa awali kwa wa kuifanyia tathmini MAP katika wilaya sita Tanzania. Hii tathmini haswa itachambua kama na ni kwa kiwango gani njia mbili za utekelezaji wa MAP katika mabadiliko ya tamaduni za jinsia zimefanikiwa katika kupunguza hatari ya kuambukizwa UKIMWI, kuboresha matokeo ya afya ya uzazi(RH) na kuongezeka kwa usawa wa tabia na tamaduni za jinsia miongoni mwa washiriki katika maradi. Tathmnini hii inafanywa na timu ya wataalam kutoka Chuo Kikuu cha Afya cha Muhimbili (MUHAS). CHAMPION inahusika katika kuendesha program ambazo zinafanyiwa tathmini. Mahojiano haya ni sehemu ya huu utafiti wa awali, na ningependa kukuuliza baadhi ya maswali kuhusu huu mradi.Mahojiano haya yatachukua takribani saa moja. Hakutakuwa na uwezekanao wa madhara kama utakubali kushiriki katika huu utafiti; bali, utafaidika kwa kuisaidia serikali ya Tanzaniakufanya kazi nzuri zaidi katika kufikia na kuboresha huduma za afya kwa Watanzania wote.

Maelezo yote utakayonipa yatahifadhiwa kwa usiri mkubwa; jina lako halitatumika na hautatambulika kwa namna yoyote ile. Ushiriki wako ni wa hiari kabisa na hakutakuwa na adhabu kwa kukataa kushiriki katika utafiti huu. Uko huru kuuliza swali lolote; unaweza kukataa kushiriki katika utafiti huu;unaweza kukataa kujibu swali lolote katika mahojiano haya; na unaweza kuacha kuhojiwa kwa muda wowote ule. Je u na swali lolote? Nimepata ridhaa yako ya kushiriki?.

Kama mhojiwa amekubali, unaweza kuanza mahojiano.

KII namba…….…….

Mkoa…….

Wilaya…….

Wizara/Idara……

Tarehe ya mahojiano ……......

1. Je umefanya kazi yako ya sasa katika idara/wizara/wilaya hii kwa miaka mingapi sasa?
2. Ulisikia wapi kwa mara ya kwanza kuhusu CHAMPION's MAP project?
3. Serikali inafanya kazi gani ambayo unaiwakilisha kila siku katika MAP projekti?
4. Ni kwa kiasi gani malengo ya mradi muhimu katika lengo kuu la wizara/idara/wilaya (tafadhali unaweza kutoa mifano*?)*
5. Ni kiwa jinsi gani idara yako ilihusika/inahusika Katika utekelezaji wa mradi wa MAP?
6. Ni vitu gani, miongozo, mada (kwenye matumizi ya nguvu ya jinsia, ushiriki wa wanaume, afya ya uzazi) ambazo mradi wa CHAMPION na wizara yako zilichangia katika maendeleo yao (Je mradi wa CHAMPION ulishiriki katika mapitio ya sera ya UKIMWI/AIDS, NMSF ya UKIMWI , na sheria yoyote, sera?)

   Je unadhani ni yapi mazuri ya mradi wa MAP?
7. Ni kwa vipi na ni kwa kiasi gani huu mradi uliborehsa mambo ya afya (katika ngazi ya kitaifa, mkoa, wilaya) kutatua mambo yanayohusiana na migoro ya utumiaji nguvu dhidi ya jinsia? Afya ya familai, kuzuia maambukizi ya UKIMWI?
8. *(Dodosa: Unaweza kutoa mifano maalumu? Unaweza kuelezea ni kwa namna gani huu mradi ulichangia kwa haya mabadiliko?*
9. *Kwa maoni yako,shughuli za mradi wa CHAMPION ulichangia katika kuhimiza mabadiliko ya jinsia katika mkoa huu?*
10. Tafdahali elezea maoni yako kuhusu vipindi vya elimu inayotolewa na kikundi cha MAP.Je unadhani ilikuwa na ufanisi /kina ufanisis wowote?
11. Je una mpango gani kuendelea na shughuli za MAP na kwa VIPI? (Unaweza kunipa mifano maalumu?

    Je kuna kitu kingine chochote ambacho unadhani unahitaji kujua kuhusu mradi huu ambacho hatujakijadili?

TUNAKUSHUKURU KWA MUDA WAKO!