



Project Results from Masculinities, Faith, and Peace in Nigeria

Nigeria is the most populous country in Africa, with an estimated population of 201 million as of 2020 which is almost evenly split between Christians and Muslims.¹ Inter-religious conflict between Muslim and Christian communities has led to violence, degraded social cohesion, and disrupted health service delivery. Conflict at the inter-personal, family, and community level is driven in part by social and gender norms.

Virility and fertility have become key determinants of social status and characteristics of masculinity and femininity, respectively. These social norms and ascribed gender roles endorse high fertility rates and low family planning use.² Communities assign more social status to larger families and expect newlyweds to start a family immediately. Due to the important role of these social norms, when women are seen opposing their assigned gender role (to support their husbands through bearing and raising children), society sanctions the use of gender-based violence.

About the Intervention

Combined, these three issue areas – social cohesion, family planning use, and gender-based violence – form the central pillar of the [Masculinities, Faith, and Peace \(MFP\) intervention](#). MFP is an adaptation of Tearfund’s evidence-based “[Transforming Masculinities](#)” (TM) program and draws on a previous adaptation called Masculinities, Family, and Faith, funded by USAID through the Passages consortium. MFP is a faith-based approach to transforming harmful concepts of gender and masculinities to promote gender equality, drawing on religious texts and positive role models. This adaptation integrates a focus on fertility awareness-based methods of family planning, an Islamic interpretation of a previously Christian-focused curriculum, and new project activities to link family planning services to program participants and to foster interfaith dialogues and social cohesion.

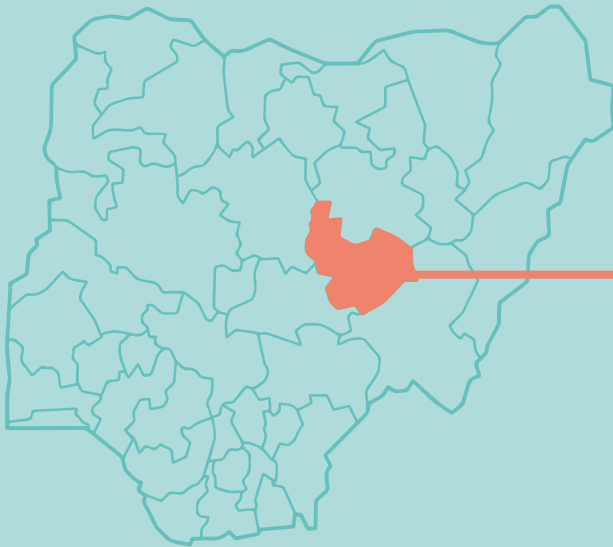
Masculinities, Faith, and Peace (MFP) has sought to challenge harmful social norms by elevating and reframing values inherent to local religious beliefs. Working with religious leaders and Gender Champions (see below) in the community, the MFP process has promoted recognition of the dignity of fellow community members and women as equal and valuable members of society through faith-based reflections on gender equality, family planning, and interfaith dialogue. MFP has enabled local communities across the faith divide to co-create pathways for the transformation of harmful social norms.

MFP is a research-led project implemented by Georgetown University’s Institute for Reproductive Health and Tearfund in partnership with two local partners, the Faith Alive Foundation and Team Community Integrated Health Development Advancement (TEAM-CIHDA), through a three-year award from the John Templeton Foundation. From 2018 to 2021, MFP was conducted in churches and mosques in five peri-urban and rural communities in Plateau State, Nigeria.

1. USAID, 2020. IDEA Country Dashboard Nigeria. Retrieved from: <https://idea.usaid.gov/cd/nigeria?comparisonGroup=region>

2. Izugbara, C.O., & Ezeh, A.C., 2010. Women and high fertility in Islamic northern Nigeria. *Studies in Family Planning*, 41(3), 193–204.

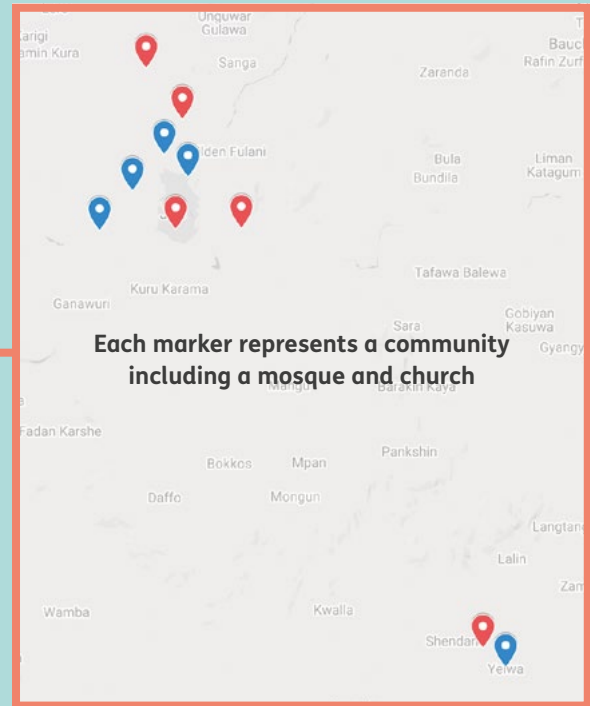
Where MFP was implemented Jos, Plateau State, Nigeria



Control



Experimental



MFP is designed to engage religious leaders, young couples, and their wider Christian and Muslim congregations to foster greater gender equality, promote positive masculinities, enable family planning use by young couples, and improve interfaith relationships.

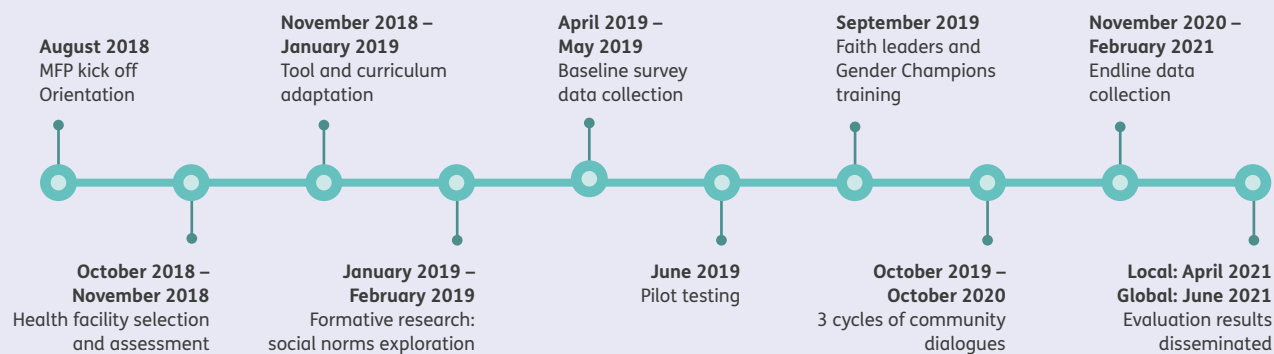
The intervention uses workshops and structured small-group discussions called “community dialogues”. They draw on scriptural reflections on gender equality, gender-based violence (GBV), positive masculinities, family planning, and interfaith relationships.

These community dialogues work alongside other key activities such as:

- Religious leaders, from the local to national level, are trained on the MFP curriculum and engage in personal reflection. They are also trained to provide leadership and support for the MFP intervention.
- Religious leaders then select key members of their congregations to be trained as facilitators of community dialogues, called Gender Champions.
- Once trained, Gender Champions facilitate guided two-hour small-group discussions, called community dialogues, with young couples in their communities. Men and women meet separately for the first five sessions and rejoin their partner for sessions 6–9.

- After the final community dialogue session, a family planning provider conducts a Health Talk including modern family planning methods, their side effects, and common myths and misconceptions. All family planning providers received the same contraceptive methods update training and received supportive supervision for quality assurance. Participants receive a referral card to access further counseling and family planning methods, if desired, from local health centers.
- To bring about a wider change beyond the couples, MFP themes are diffused to all congregation members through sermons and small groups led by faith leaders, couples sharing their testimonies at congregational meetings, and community mobilization events in the wider community.
- To foster improved inter-religious relationships between Christians and Muslims, MFP facilitates a joint celebration at the end of each community dialogue cycle with the participating mosque and church in each community.
- Religious leaders also participate in peacebuilding training to then facilitate interfaith conversations. Community mobilization events are held jointly by the participating mosque and church in each community to promote MFP messages to the wider congregations.

MFP Events Timeline



Key Results

Implementation Results

Following an 18-month intervention period, according to survey respondents, 92.3% of respondents in MFP congregations reported that they attended at least one community dialogue, 82.9% heard at least one couple testimonial, 65.2% participated in community celebrations with both Muslims and Christians, 96.6% attended at least one religious gathering focused on MFP messaging, 86.3% attended at least one Health Talk, 36.2% reported that they had received a referral card, and 56.7% visited a health facility to obtain a modern method of family planning, and of those, 90.4% obtained and were able to use their desired method of family planning.

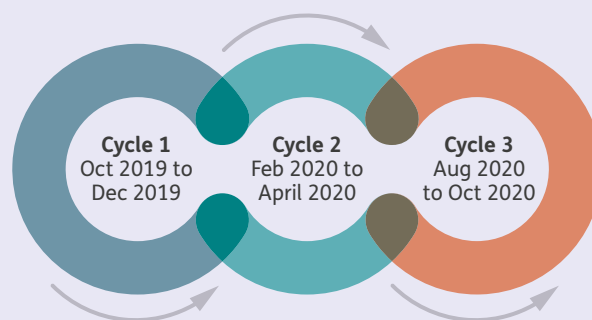
Family Planning Results

In MFP congregations, use of a method of modern family planning among non-pregnant couples increased by 14.9% from 44.6% at baseline and 59.5% at endline. However, we also saw a 14.7% increase in control congregations, and the difference in change comparing MFP and control congregations was not significant. Proportions of respondents noting that they were highly likely to use a method of family planning as a couple in the near future also increased by 23.9% from 43.0%. This was a marginally statistically significant ($p < 0.10$) increase compared to a 17.8% increase in control congregations. At endline, the majority of family planning users were currently using a short-acting method (41.4% of respondents), followed by a long-acting reversible contraception method (13.7%), or a fertility-awareness method (4.4%).

While we did not see a statistically significant increase in modern family planning use comparing MFP to control congregations, we did see significant improvements in several intermediate outcomes leading to increased uptake of modern family planning.

For example, we saw marked improvements for perceptions of access (adequate availability, transportation, information, etc.), individual attitudes, self-efficacy in using modern family planning, injunctive norms (perceptions of acceptability by key reference groups, including faith leaders), and couple communication about family planning.

3 Cycles of Community Dialogues



722
men and women

completed MFP community dialogues

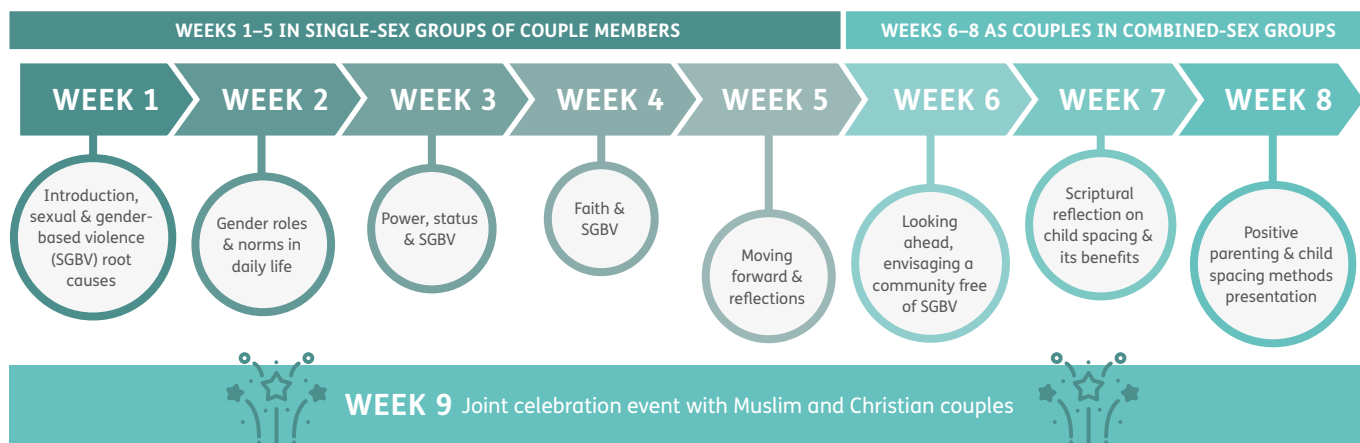
489
men and women

referred and visited local health facilities in intervention and control congregations

235
women

visited health facilities with their partners from intervention and control congregations

Community Dialogue Structure and Session Topic



From qualitative findings, respondents generally saw modern family planning methods as safe and acceptable, and some even suggested that couples that used family planning were higher status (“modern” vs. “traditional”). Many respondents noted positive effects of using modern family planning, including for the health of mothers and children as well as economic health of the household. However, many women noted that their husbands were still opposed and feared their husbands would be violent if they mentioned wanting to obtain a method of family planning, especially if the woman has not had any prior children. Women without children were often perceived as being thought of as “barren” or “less of a woman.” Moreover, a number of respondents believed that using modern family planning would lead to future difficulties in becoming pregnant.

Gender Equity & Roles Results

In MFP congregations, we saw a 7.1% increase in respondents reporting that the husband of the couple regularly contributed to household work (74.1% to 81.2%) and a 9.2% increase for the husband regularly contributing to childcare from baseline to endline (79.5% to 88.7%). This was a statistically significantly ($p < 0.01$) higher change in MFP congregations compared to control congregations for a husband’s contribution to household work (+7.2% vs. -5.0%), but not for a husband’s contribution to childcare (+9.2% vs. +13.4%).

Related to this improvement, we saw several positive shifts over time and relative to control populations for personal attitudes toward male engagement in both childcare and household work, and descriptive norms (perceptions of these behaviors being typical in the respondents’ communities) and injunctive norms (toward a husband contributing to household work in the respondents’ faith communities).

From qualitative findings, respondents were more supportive of husbands being involved in childcare and household work responsibilities after participation in the MFP intervention. However, many husbands still noted that men who helped their wives out in traditionally female roles were seen as being under a spell of witchcraft or he was a “woman wrapper,” controlled by his wife.

Intimate Partner Violence

Intimate partner violence (IPV) was disaggregated into emotional IPV (i.e., yelling, threatening), physical IPV (i.e., pushing, slapping, hitting), sexual IPV (forced sex even if partner did not want), and violence used specifically to discourage family planning use. In MFP congregations, reported perpetration (if male) or experience (if female) of emotional IPV in the previous 12 months reduced by 22.2% from (61.0% to 38.8%) in MFP congregations. This reduction was statistically significantly ($p < 0.05$) larger compared to the 8.7% reduction in control congregations. Other forms of IPV were less commonly reported in MFP congregations: 18.3% physical violence, 21.4% sexual violence, and 8.6% violence to discourage family planning use. Reductions were higher in MFP congregations for physical IPV (-8.2% vs. -3.2%), sexual IPV (-12.1% vs. -6.9%), and violence specifically to discourage family planning use, but only this last difference was marginally statistically significant ($p < 0.10$). At baseline, 40.8% of survey respondents in MFP congregations reported that they strongly agreed that they would use a form of non-violent conflict resolution to avoid violence in their relationship if they knew of one. At endline, the proportion increased by 25.8% to 66.6%. This was statistically significantly higher ($p < 0.01$) compared to an increase of only 11.3% among respondents in control congregations.

Related to these reductions of IPV in MFP congregations, we saw several positive shifts over time and relative to control populations for personal attitudes toward a husband using violence to discipline his wife, justifications for a husband using violence to discipline his wife, and injunctive norms (perceptions of acceptability by key reference groups) particularly among faith leaders and fellow congregants. In one example, the proportion of respondents in MFP congregations who thought a husband disciplining his wife with violence was acceptable in any one of six different scenarios (e.g., wife goes out without telling him, etc.) declined by 14.3% from baseline (43.3%) to endline (29.0%). This shift was statistically significant ($p < 0.01$) compared to a 1.7% increase in respondents in control congregations justifying use of violence in any of these six scenarios from baseline to endline.

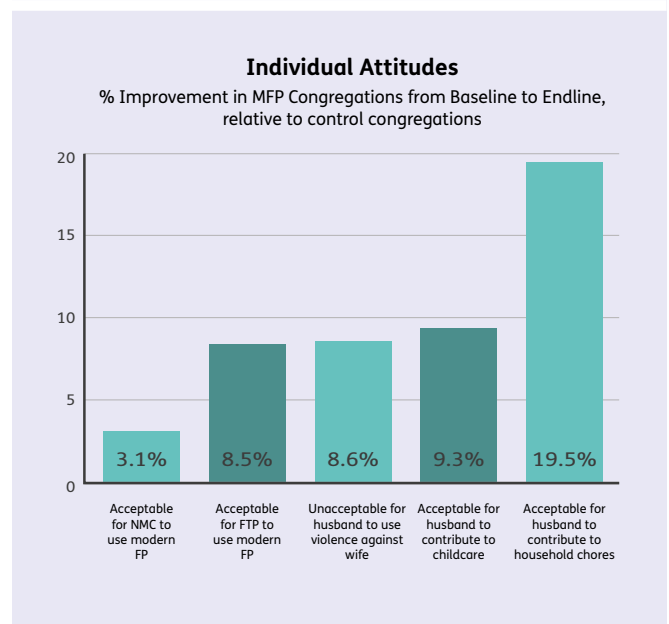
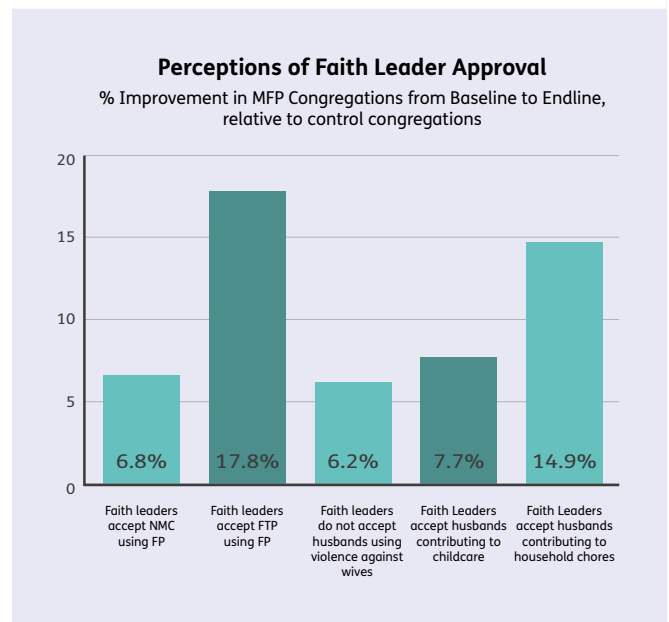
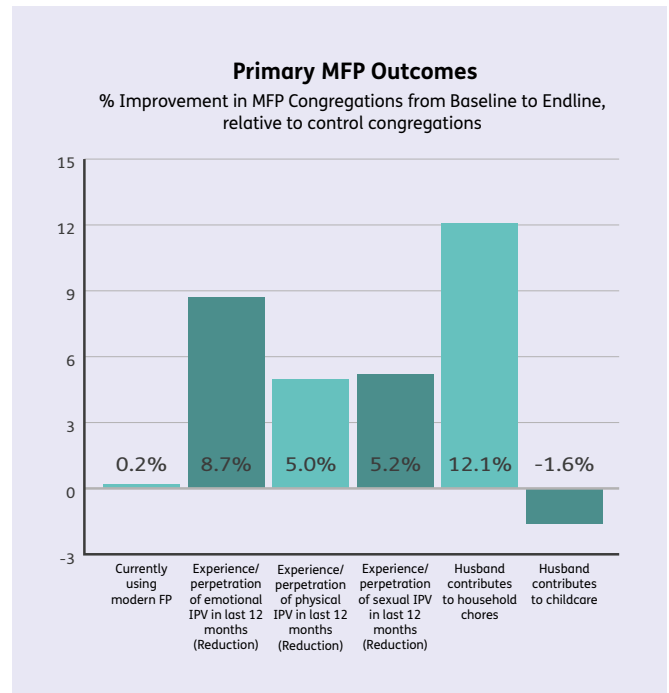
Intimate Partner Violence (continued)

In the qualitative work, using violence against a wife was generally seen as unacceptable to most respondents, particularly physical violence. However, these same respondents often tacitly endorsed IPV under specific scenarios (e.g., she neglects the children or burns the food).

Social Cohesion & Interfaith Dialogue

In MFP congregations, there were large reductions from baseline to endline in the proportion of respondents perceiving that conflict (-18.7%; 46.4% to 27.7%) and mistrust (-18.7%; 46.4% to 27.7%) between Muslims and Christians was common in their community (-20.1%; 49.8% to 29.7%). These shifts were statistically significant ($p < 0.01$) compared to reductions of only 1.8% for perceptions of interfaith conflict and 1.2% for perceptions of mistrust between the faiths in their community. In addition, we saw a statistically significant ($p < 0.05$) shift in the proportion of respondents in MFP congregations agreeing that Christian and Muslim faith leaders work together to solve community problems (+4.8%; 89.1% to 93.9%) from baseline to endline compared to a 2.4% reduction of respondents in control congregations agreeing with the statement, and this shift was statistically significant ($p < 0.05$). Personal attitudes and social norms were highly supportive of faith leaders working together to solve community problems in both MFP and control congregations.

Evidence from the qualitative interviews suggest that the MFP project has enhanced the proactive engagement of faith leaders in promoting ethno-religious conflict resolution and tolerance across faith communities. For example, participants noted that faith leaders have been taking greater leadership in interfaith activities, including playing football, sharing meals, and joining in religious celebrations. According to respondents, these activities have created an avenue for bonding and strengthening social cohesion in the community.





Lessons Learned

The MFP project has brought about a range of learnings in various categories, including social cohesion, IPV and child spacing, as well as learning on effective implementation processes. The evaluation demonstrates that MFP project activities are leading to improved individual attitudes and confidence, communication between husbands and wives, and community visibility and acceptance supporting increased family planning use, males taking part in childcare and household work, and reduced violence within relationships. In an 18-month intervention period, we are already seeing significant behavioral impact, particularly for prevalence of emotional violence in relationships and male engagement in household work. In addition, the novel and enhanced focus on social cohesion and interfaith dialogue within the MFP project are clearly leading to faith communities working together to solve problems and consequently, participants perceiving less conflict and more trust in their communities.

Fertility Awareness-Based Methods of Family Planning and Family Planning Service Linkages

Churches and mosques responded positively to hosting family planning talks from health providers. Participants who attended the talks were more likely to visit health facilities for child spacing methods and were seeking support. However, financial barriers remained a challenge when participants sought to access services. Some of the health facilities charged for non-natural methods, which were unaffordable for the participants. Future programming

should consider this when selecting health facilities, and should ensure that any financial costs are explained to participants during the health talks. Similarly, the purpose of referral cards should be made explicit, and it should be made clear to participants that referral cards are not vouchers for service.

Faith leaders and Gender Champions need high quality training and ongoing input so that they are able to communicate effectively with their congregations and communities on the topic of family planning, as well as other topics. The faith leaders and Gender Champions played a key role in disseminating messaging and addressing misconceptions and myths about many of the topics covered. Faith leaders were approached by members of the congregation, and therefore needed a strong understanding of family planning methods in order to effectively redress any misconceptions. High quality training is especially significant for unmarried Gender Champions who initially faced criticism that they would not be able to understand the content owing to their marital status. Careful consideration should be given to the selection of Gender Champions, ensuring that they are able to effectively facilitate and lead on the specific topics.

Fostering Interfaith Dialogue and Social Cohesion

Following the MFP project, faith leaders are now seen as change agents for peaceful coexistence and the development of harmonious relationships. Continuation of community mobilization, especially the social activities such as eating together, home visits, and the football match, was strongly suggested by the faith leaders and the community stakeholders. These events brought about significant excitement among both faiths and it has enabled greater togetherness, with many participants expressing that they would like more time for the social activities. Future programming should consider how to integrate this more, especially finding sustainable, low-cost or self-funded activities which can be easily continued beyond the project. Other organic activities should also be encouraged, such as the formation of the interfaith COVID-19 Committee which included members of both faiths to work harmoniously to address a common issue, and home exchange visits during religious festivals.

The Technical Advisory Group (TAG), composed of health professionals, lawyers and both Christian and Muslim scholars, was a significant support alongside the faith leaders for the effectiveness of this norms-shifting intervention. Muslim TAG members made an essential contribution to the Islamic adaptation of the training manuals, as neither Tearfund nor its implementing partners had expertise in Muslim texts. The Technical Advisory Group ensured that the project had legitimacy with both



faiths, owing to the mixture of Christian and Muslim members in the group, and were able to respond to concerns raised that the project was aiming to manipulate members of the mosque into Christianity, or to reduce the Muslim population.

The TAG group played a key role in additional expertise and access to a range of spaces and organizations to advocate for the program. They also supported SGBV linkages, provided an additional layer of protection for SGBV-specific issues, and strengthened the program's awareness of Nigerian law. In future scale-up opportunities, a TAG group will need to be inclusive of the geographic areas covered, and be as representative as possible in order to retain legitimacy and to provide ongoing direction.

The Way Forward

Demonstrated by the results above, the Masculinities, Faith, and Peace project has seen positive results on all three key components of the intervention. Findings have also confirmed local partners' ability to scale up the intervention in the Nigerian context.

Additional short-term funding (one year) has been secured to scale up the MFP intervention and improve implementation. New strategies will be developed to strengthen the interfaith elements of the intervention and advocate for the integration of fertility awareness-based methods in national procurement systems. Scale-up will focus on both vertical and horizontal approaches, simultaneously continuing coverage for additional participants in current sites and expanding geographic coverage across the region. Further, the focus on advocacy at the national level will take a systematic approach to increasing accessibility of these key family planning methods.

Resources for implementing a program like MFP remain available for further expansion of this intervention in other contexts. Please contact Tearfund's Gender and Protection Unit: gender-and-protection@tearfund.org or visit www.tearfund.org/sexualviolence to access key resources.