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PROGRAMMING FOR MALE INVOLVEMENT IN REPRODUCTIVE HEALTH

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CONTENTS

Page

RESOURCE PERSONS v

BACKGROUND vii

1. OVERALL RECOMMENDATIONS 1

2. PRESENTATIONS 7

2.1 Programmes for men on prevention and care of sexually transmitted infections (STIs)/HIV 7

2.1.1 Interventions to prevent STI/HIV infection in heterosexual men—a systematic review *(Dr Sarah Hawkes)* 7

2.1.2 Male involvement in prevention of pregnancy and HIV infection *(Dr Edith Pantelides)* 15

2.2 Programming for men in family planning 29

2.2.1 Counselling and communicating with men to promote family planning in Kenya and Zimbabwe *(Dr Young Mi Kim)* 29

2.2.2 Communicating with men to promote family planning: lessons learned and suggestions for programming *(Ms Manisha Mehta)* 42

2.3 Programming for men in promoting safe motherhood 54

2.3.1 Involving men in safe motherhood: the issues *(Dr Alexis Ntabona)* 54

2.3.2 Male involvement in a reproductive health programme: where we stand today *(Dr M.E. Khan)* 58

2.3.3 Field experiences in involving men in safe motherhood *(Dr Imtiaz Kamal)* 63

2.4 Targeting men for improving the reproductive health of both partners 85

2.4.1 Opportunities and challenges for men's involvement: the regional reproductive health strategy *(Dr Andrew Kosia)* 85

2.4.2 The sexual health of men in India and Bangladesh: what are men’s concerns? *(Dr Sarah Hawkes)* 88

Page

2.4.3 Male participation in reproductive health—a Caribbean imperative *(Dr Hugh Wynter)* 104

2.4.4 Capacity building in reproductive health programmes focusing on male involvement: a South-to-South framework *(Dr Badrud Duza)* 115

2.5 Present lessons and future programmatic directions 132

2.5.1 Men's roles with multiple partners: challenges and opportunities *(Dr Amy Ratcliffe)* 132

2.5.2 Research on men and its implications for policy and programme development in reproductive health *(Dr Charles Nzioka)* 143

2.5.3 Addressing gender imbalances to improve reproductive health *(Ms Judith Helzner)* 153

2.5.4 Lessons and future programmatic directions for involving men in reproductive health *(Dr Margaret Greene)* 159

3. ANNEXES 166

3.1 Meeting Agenda 166

RESOURCE PERSONS

WHO Regional Offices

Dr Andrew Kosia	Regional Office for Africa (AFRO)
Dr Maria Teresa Cerqueira	Regional Office for the Americas (AMRO)
Dr Ernest Pate	Regional Office for the Americas (AMRO)
Dr Virginia Camacho	Regional Office for the Americas (AMRO)
Dr Matilde Maddaleno	Regional Office for the Americas (AMRO)
Ms Marijke Velzeboer-Salcedo	Regional Office for the Americas (AMRO)
Ms Kathleen Taylor	Regional Office for the Americas (AMRO)
Dr Jose L. Diaz Rosello	Regional Office for the Americas (AMRO)
Dr Ricardo Fescina	Regional Office for the Americas (AMRO)
Dr Ramez Mahaini	Regional Office for the Eastern Mediterranean (EMRO)
Dr Assia Brandrup-Lukanow	Regional Office for Europe (EURO)
Dr Rusdi Aliudin	Regional Office for South-East Asia (SEARO)
Dr Pang Ruyan	Regional Office for the Western Pacific (WPRO)

WHO/HQ/RHR/Secretariat

Dr Michael T. Mbizvo *(chair)*	Senior Scientist, Office of the Director
Dr Heli Bathija	Area Manager, Africa and Eastern Mediterranean region
Dr Enrique Ezcurra	Area Manager, Americas region
Dr Peter S. Fajans	Scientist, Technical Cooperation with Countries
Dr Alexis Ntabona	TAP/RH Specialist and Coordinator, Technical Cooperation with Countries
Dr Wang Yi-fei	Area Manager, Asia and the Pacific region

WHO Temporary Advisers

Dr Imtiaz Kamal	National Committee on Maternal Health, Karachi, Pakistan
Dr Charles Nzioka	Department of Sociology, University of Nairobi, Kenya
Dr Edith Pantelides	Centro de Estudios de Población (CENEP), Buenos Aires, Argentina
Dr Amy A. Ratcliffe *(rapporteur)*	Medical Research Council Laboratories, Banjul, Gambia
Dr Hugh Wynter	Advanced Training & Research in Fertility Management, Department of Obstetrics and Gynaecology, The University of the West Indies, Kingston, Jamaica

Collaborating Agencies

Ms Manisha Mehta	EngenderHealth, New York, United States of America
Dr Roberto Rivera	Family Health International, North Carolina, United States of America
Dr William Conn	Family Health International, North Carolina, United States of America
Ms Victoria Jennings	Georgetown University, Washington DC, United States of America
Ms Judith Frye Helzner	IPPF/Western Hemisphere Region, New York, United States of America
Ms Vera M. Zlidar *(rapporteur)*	Johns Hopkins School of Public Health, Baltimore, United States of America
Dr Young-Mi Kim	Johns Hopkins University, Baltimore MD, United States of America
Dr Badrud Duza	Partners in Population and Development (PPD), Dhaka, Bangladesh
Dr Margaret E. Greene	Population Action International, Washington DC, United States of America
Dr Sam Clark	Program for Appropriate Technology in Health (PATH), Washington DC, United States of America
Dr Elaine Murphy	Program for Appropriate Technology in Health (PATH), Washington DC, United States of America
Dr Karin Ringheim	Program for Appropriate Technology in Health (PATH), Washington DC, United States of America
Dr Suellen Miller	The Population Council, New York, United States of America
Dr M.E. Khan	The Population Council/Bangladesh, Dhaka, Bangladesh
Dr Sarah Hawkes	The Population Council/India, New Delhi, India
Ms Sylvie Cohen	UNFPA, New York, United States of America
Ms Marguerite Farrell	USAID, Latin America and the Caribbean Bureau, Washington DC, United States of America
Mr Jeffrey Spieler	USAID, Washington DC, United States of America

BACKGROUND

Traditionally, health care providers and researchers in the field of reproductive health have focused almost exclusively on women when planning programmes and services, especially with regard to family planning, prevention of unwanted pregnancy and of unsafe abortion, and promotion of safe motherhood. In recent years, efforts have been made in many countries to broaden men's responsibility for their own reproductive health as well as that of their partners. Measures are also being taken to improve gender relations by promoting men's understanding of their familial and social roles in family planning and sexual and reproductive health issues.

The Cairo International Conference on Population and Development (ICPD) Programme of Action (1994), urged that:

> "… special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour including family planning; prenatal, maternal child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children". (paragraph 4.27)

The above challenge calls for more intense efforts to foster partnerships between men and women which help men identify with the magnitude and range of reproductive illnesses which affect women. The philosophy embodied in the Programme of Action combines a primary health care approach with a human rights dimension.

Research has shed some light on the gaps in our knowledge of reproductive health issues as they relate to men, but we have little information about programmatic issues and how such research could improve programme operation and service delivery. WHO Country Offices are often consulted by programme managers and policy-makers for advice on strategies for including men in the delivery of reproductive health services.

It was proposed that the meeting of WHO Regional Advisers and Directors of Reproductive Health for 2001 focus on the design, success stories, lessons learned and research recommendations for programmes that aim to include men in reproductive health. Regional experiences, case studies, systematic reviews, research highlights and model projects representing a variety of regions were presented at the meeting by a select group of experts working in the field, Regional Offices, collaborating agencies, programme managers, and researcher institutions. Among these were several experts and individuals who had participated in RHR-funded studies at the global or the regional level.

The meeting's goal was:

To review and recommend strategies for the involvement of men in programmes aimed at improving reproductive health

The specific objectives were:

1. To review the current situation with regard to the role of men and their responsibility in the areas of family planning, maternal health, prevention of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), and the prevention of violence against women.

2. To review current knowledge and experience with regard to interventions for increasing the involvement of men in promoting reproductive health.

3. To recommend strategies for integrating men into programmes aimed at improving reproductive health outcomes for women.

4. To recommend strategies for instilling in men a sense of responsibility for improving their own reproductive health.

Outcomes

Based on lessons learned, as well as research and programme experiences, the meeting outlined a framework for programme managers, suggesting strategies for increasing male responsibilities in reproductive health. Inputs included the following:

- Participants received presentations on gender-sensitive, innovative approaches which strive to involve men positively in reproductive health.

- Research findings, systematic reviews, and lessons learned from existing male involvement initiatives were shared and summarized as a means of providing better information and of strengthening programme planning.

- On the basis of theoretical and operational knowledge already accumulated, basic concepts and key elements were defined for the design of programmes aimed at building partnerships and reinforcing gender equity in reproductive health-care delivery.

- Gaps in information on male involvement were identified: the international reproductive health community must be aware of these gaps when designing and implementing reproductive health programmes for men and women.

- Approaches were outlined that programmes can take to successfully involve men in reproductive health.

The following key messages and suggestions for cross-cutting programmatic issues were adopted by the participants:

- Governments, nongovernmental organizations (NGOs), donor agencies and relevant stakeholders should ensure availability, accessibility and sustained advocacy for use of condoms for dual protection against unwanted pregnancy and STIs/HIV.
- STI/HIV prevention programmes should target men within their specific reproductive age groups, with messages expressed in such a way so as to ensure that male adolescents are made aware of the need for lifelong protection for themselves and their partners. Such programmes should be developed specifically for youths attending schools, those not attending schools, men at the workplace, the partners of women presenting for antenatal care and at social events attended by men potentially at risk.

To achieve the above goals the meeting:

- Called for the collection and dissemination of the best practices for increasing male involvement.
- Recognized the need for measures to increase male involvement that are adaptable to diverse local and cultural settings.
- Identified the need for global information-sharing and capacity-building networks in order to achieve optimum male-involvement programmes.
- Called for the development of national policy frameworks on male involvement in countries where such frameworks are lacking.
- Recognized the need to enlist the support of programmes outside the health sector as sources of information and education on men's and women's health issues: communities, media, policymakers, and providers must all take part in promoting male involvement.
- Recognized that male programming cannot be accomplished at the expense of existing women's health services, and that the development of cost-effective programmes is possible.
- Identified the need for a spectrum of male involvement programmes that address men's needs throughout their sexual and reproductive health life cycles, from youth to old age.
- Called for the development of information guidelines and tools addressing male involvement.
- Recommended that a greater degree of monitoring and more rigorous evaluation of programmes targeting men be carried out and that they include process as well as outcome indicators.
- Urged that more advocacy programmes for involving men in reproductive health at the local, national, and international levels be launched.
- Identified the need to promote the concept of dual protection among men.
- Recommended specific targeting of adolescent males.

- Identified the need for research focusing not only on behavioural outcomes but also on epidemiological and health outcomes.
- Recognized that male involvement means providing reproductive health services for men and women, as individuals as well as partners, in a way that best serves their needs as men, women, and couples.
- Recommended that regional programmes of action be developed for involving men in reproductive health that include local organizations, communities, the private sector, traditional healers, and nongovernmental organizations (NGOs).

1. OVERALL RECOMMENDATIONS

The overall recommendations below summarize the salient issues reported in the presented papers, comments by individual paper discussants and remarks made during the discussions which followed the plenary presentations. The meeting provided an opportunity for brainstorming. Recommendations from scientific papers were discussed and reviewed in the context of their application in diverse regional settings. Recommendations for each thematic area took the form of lessons learned (based on case studies or research outcomes) and their implications for further research and programme development. It is the opinion of the authors that these recommendations can contribute to the elaboration of research questions as a basis for the development of programmes and should assist in identifying gaps and provide information which is vital to the design of strategies for involving men within the defined areas. Such strategies may include the prevention of reproductive ill-health and innovative messages for risk reduction which build on past experience and provide insight into ways in which appropriate care can be provided.

1.1 STIs

1.1.1 Lessons learned

- With regard to STI-control in heterosexual men, repeated reinforcement of the message has been the key to successful interventions.
- Effective interventions have included: mass media campaigns, individual and group counselling, skills-based interventions (including decision-making skills and partner communication), and interventions which reach men in their own communities.
- Few studies on the prevention of STIs have targeted mainstream heterosexual men.
- More emphasis has been placed on behavioural and sociopsychological outcomes, and far less on morbidity outcomes.
- Because of men's limited access to public-sector health care and the stigma attached to STIs, they tend to turn to the private sector and traditional medicine for treatment of STIs.
- Men decide whether or not to use protection according to their perception of risk with individual partners.
- Syndromic management works well in men with symptoms of urethral discharge and genital ulcer disease.

1.1.2 Research implications

- There is a need for more studies on heterosexual men that test the effectiveness of interventions suggested by formative research for STI/HIV prevention.
- There is a need for more information on methodology, identifying appropriate entry points and providing financial support to test interventions in diverse settings.
- Research should provide dose-response information, e.g. what works, on what scale, and at what moment a point of saturation is reached (if ever)?
- More studies are required on morbidity outcomes and STI sequelae in diverse settings.
- There is a need for more substantial studies on behavioural antecedents associated with infection.
- Cost-effectiveness criteria must be considered to enable advocacy for policy change: What are the costs of averting infections? Of targeting men? What are the cost-effective implications of *not* involving men?

- Does including men bring more infected women into the treatment framework or more importantly, demonstrate that doing so is effective in reducing infection in both men and women?

1.1.3 Programme implications

- There is a need to improve men's knowledge, access to and use of effective reproductive health care services.
- Programmes should be designed to raise awareness of men about risk, benefits of protection and the consequences of delayed and inadequate treatment of STIs.
- Programme managers should attempt to plan and implement a variety of interventions to involve men and monitor the impacts of these interventions.
- Research findings should be incorporated into programme planning.
- Couple counselling sessions may not be the ideal situation for the discussion of STI risk.
- With respect to the control of genital discharge syndromes, syndromic management for symptomatic men is more effective than for women in some epidemiological settings.
- Epidemiological evidence suggests that the effectiveness of STI control is likely to be greater if programmes focus on identifying infected men, as well as women.

1.2 Family planning

1.2.1 Lessons learned

- Communication campaigns to promote family planning for men should complement those that are designed for women, with messages which men can relate to in support of family planning by their partners and themselves.
- Communication campaigns directed at men need to be explicit about shared and co-operative decision-making.
- Men are more likely to be active participants in the counselling sessions (asking questions, interacting) while women are more likely to be passive (answering questions, not elaborating).
- Integrating men into existing family planning services improves sustainability.
- When men are involved, more women adopt and continue family planning methods.
- The role of men, their involvement with other partners and their fertility choices and preferences must be must be taken into consideration when counselling them on family planning.

1.2.2 Research implications

- Messages incorporating a gender-sensitive perspective and conveying the need to promote gender relations should be identified.
- There is a need to assess the needs of men and identify strategies for their involvement based on a situation analysis approach.
- Research should provide a better understanding of gender dynamics and interaction in family planning counselling sessions.

- More data are needed on the successes and failures of vasectomy programmes, including culture-specific data on motivation and misconceptions surrounding vasectomy which could be used for counselling potential clients.

1.2.3 Programme implications

- There exists a need for appropriately trained counsellors to interact with men.
- A broader range of topics needs to be dealt with when men are included, such as prevention of gender violence, awareness of the consequences of female genital mutilation and promotion of supportive, positive behaviour on the part of men in general.
- The diverse needs of men must be recognized and addressed.
- A choice of counselling sessions for individuals and couples needs to be offered in order to protect clients' private interests.
- Programme managers may need to accept that there is no "special formula" for involving men and that different service delivery models and approaches are required which are culturally acceptable, appropriate, and have the potential to work.
- Programmes need to be developed which promote male methods more effectively, including vasectomy.
- The sexual and reproductive needs of men need to be considered holistically—not simply from a family planning perspective—if efforts to reach men are to be successful.

1.3 Safe motherhood

1.3.1 Lessons learned

- Men have a unique role to play in promoting safe motherhood—they should not be viewed as passive onlookers or mere obstacles.
- Men could be as greatly affected by the social, cultural and economic complexities of safe motherhood as women—they needed to be adequately informed and involved.
- Men are adversely affected by the deaths of their wives and female relatives—they need support to recognize factors which contribute to maternal deaths.
- Men receive little support to encourage their involvement in and knowledge of pregnancy and delivery of care.
- In some settings, men are receptive and eager to participate in safe motherhood campaigns and to be active partners for their wives during pregnancy and child birth.
- Women want men to be involved as partners or advocates for greater access to care and a better understanding of their needs during and following pregnancy.
- In most countries the public sector may provide routine support, but male involvement programmes have not been regarded as a public sector issue.

1.3.2 Research implications

- There is a need to outline a set of interventions for men that can be tested.
- Research should provide a basis for the development of policies for male involvement.
- Support should be provided for operations research at the country level to test relevant intervention programmes.
- Society should mobilize support to put as much pressure on men as on women—research should identify the constraints on mobilizing men.
- More research is needed on the socioeconomic impact of maternal deaths, in particular in young mothers.

- Studies should identify relevant and acceptable roles for men in service-delivery settings.
- Men's failure to support and promote safe motherhood should be addressed, particularly where there might be constraints within the health system.

1.3.3 Programme implications

- Men's contributions can include:
  - ensuring and facilitating access to and the use of antenatal care, delivery and post-partum care;
  - ensuring and facilitating access to and the use of obstetric care and emergency transport; increasing awareness of risks in pregnancy, child birth and the postnatal period, and participating in the development of a birthing plan.
- Programme managers need to do more to promote men's involvement at various levels.
- NGOs and researchers can give models of positive men's roles and involvement, but governments must apply them on a large scale.
- Health providers need to be educated on how to involve men in addition to women.
- Men and women can be addressed separately as part of the same campaign to increase support and acceptability.
- Work should be carried out through existing leaders and channels within the community.
- Men will accept information from women about women, but want information on their own health from men.
- An optimal model of an integrated gender-sensitive programme and a long-term strategy for its implementation is lacking and needs to be developed.
- Service providers should address the specific information needs of men and ensure that service programmes provide quality of care and the correct attitudes to women and men.
- Campaigns should raise the question: 'Where are the fathers in safe motherhood?' and should carry the message: Ensuring safe motherhood is responsible fatherhood.

1.4 General messages

1.4.1 Lessons learned

- Most countries have no official policy on male involvement in reproductive health generally.
- There is a need to prioritize interventions for men—with regard to sexually transmitted infections, family planning, safe motherhood and prevention of gender violence.
- The many roles of men as fathers, husbands, brothers, etc., need to be taken into consideration in programme development.
- Men are often policy and decision-makers, opinion leaders and heads of households and should therefore be part of the process of providing optimal reproductive health services.
- Men often do not have access to information on reproductive health issues and on their role in promoting reproductive health.
- Men are not adequately included in reproductive health services or programme development.

- Behavioural change among men should be promoted where necessary, and responsible behaviour among adolescent males should be advocated.
- Interventions should be aimed at younger men, as they are more likely to adopt new behaviours and roles.
- Male-only clinics have had so far had only limited success. Incorporating men into existing services should be considered, except when not feasible or acceptable.
- Men are interested in reproductive health for themselves and their partners and want to know how to be involved.
- Often men are subject to similar types of constraints that are embedded in culture and gender as women.
- Men are anxious about performance, sexuality and infertility.
- Gender roles of men and women are mutually reinforcing; both sexes need to be addressed.
- There is no consensus in the field of reproductive health about how to involve men and the rationale for doing so.
- The cultural and social context among men varies greatly, even within a given population, and interventions need to address each situation specifically.
- Women-centred services should remain the primary focus, but in some situations (e.g., sexually transmitted infections), services that include men may be more appropriate and cost-effective.

1.4.2 Research implications

- Operations research is needed to test various interventions derived from formative research.
- Greater scientific rigour and more evaluation with regard to male involvement programmes are required.
- A context-specific understanding of gender dynamics and interaction, men and women’s roles, and the health implications of masculinity is needed.
- Answers need to be found in relevant settings and linked to programme development with regard to:
  - men’s needs for reproductive health care;
  - men’s ideas of rights and responsibilities for themselves and their partners;
  - men’s health-seeking behaviour;
  - men’s preference for contraception methods;
  - men’s role in contraceptive decision-making;
  - men’s understanding of pregnancy, unwanted pregnancy, sexually transmitted infection/HIV and infertility;
  - men’s role in decision-making about abortion;
  - men's understanding/knowledge of their supportive role.

1.4.3 Programme implications

- The integration of men into existing services is likely to be more successful than vertical programmes.
- Messages should be adapted to the different groups of men they are intended to reach.
- The needs of men must be addressed, regardless of sexual orientation.
- Men should be involved in the prevention of harmful social and cultural practices.
- There is a need to move beyond the health sector for a truly intersectoral approach (e.g. education), public service management, etc.

- Programmes should promote healthy male lifestyles as part of a new concept of a supportive role by men for their partners and their own sexual and reproductive health.
- Service providers should use effective promotion to reach men where they are, e.g. at football matches, taxi stands, markets, and the workplace.
- Support for the positive role and involvement of men must involve all sections of the health sector.
- Positive role models for young men and women need to be provided.
- The couple approach does not work in all situations, e.g. STI counselling, multiple partners, covert contraceptive use, domestic/sexual violence.
- There is a need for clarity concerning the objectives of male involvement, e.g. increasing contraceptive use, addressing men's reproductive health concerns and reducing gender inequity.
- There is a need to prepare for the implications of programmes in which men are involved, including the monitoring of gender relationships and health outcomes.
- The integration of male involvement into a broad range of sexual and reproductive health programmes may be a useful approach.

1.4.4 Advocacy and implications for WHO, collaborating agencies and governments

- Research and programme managers, at the country level, should compile and disseminate a package of best practices and successful male involvement programmes.
- WHO should support and encourage the development of regional and country-specific policies and programmes for men and their role in promoting sexual and reproductive health.
- Information on men should be shared through global networking and partnerships of governmental and nongovernmental organizations.
- Countries should promote the establishment of task forces, which identify gaps and coordinate programmes for male involvement.
- WHO and collaborating agencies should continue to monitor, share information on, and provide support to the implementation of best practices and model programmes on male involvement.

REFERENCES

UNFPA, *Population and development, programme of action adopted at the International Conference on Population and Development (ICPD), Cairo, 5–13 September 1994 Volume 1*. New York, United Nations, 1995:paragraph 4.27 (ST/ESA/SER.AS/149).

2. PRESENTATIONS

2.1 Programmes for men towards prevention and care of STIs/HIV

2.1.1 Interventions to prevent STI/HIV infection in heterosexual men: results of a systematic review

Dr Sarah Hawkes (London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, United Kingdom)
Dr A. Rani Elwy, Dr Graham J Hart, Dr Mark Petticrew (MRC Social and Public Sciences Unit, University of Glasgow, 4 Lilybank Gardens, Glasgow G12 8RZ, United Kingdom)

INTRODUCTION

Heterosexual men may be key to controlling the spread of epidemics of sexually transmitted infections (STIs)—including HIV. Despite widespread efforts to prevent the spread of these infections through behavioural and educational interventions and delivery of services aimed at offering free HIV testing and counselling , heterosexual transmission of HIV is increasing globally (UNAIDS, 2000). STIs, including HIV, are more easily transmitted from men to women than women to men (Jones & Wasserheit, 1991). Indeed, women are twice as likely to become infected by a variety of sexually transmitted pathogens as men (Harlap et al. 1991) and the efficiency of male to female transmission of HIV is approximately four times higher than female to male transmission (Aral, 1993). Aside from the increased biological risk of transmission, women may be at high risk of STI and HIV owing to social and cultural norms of behaviour, which mean that women cannot decline sexual intercourse with their partners, or insist upon the use of barrier methods for protection during intercourse (Greene & Biddlecom, 1997). Moreover, these same social and cultural norms often assume that it is acceptable for men to seek sexual pleasure outside of the home, thereby possibly increasing the risk of acquiring STIs, including HIV (Moses et al., 1994).

Nonetheless, there is little information available on the most effective methods for including men in programmes to prevent STIs/HIV. We undertook a systematic review to determine the most effective methods of social and behavioural means of preventing the spread of HIV and other STI in heterosexual men.

Corresponding author: Sarah Hawkes. Email hawkess@who.ch
This paper is a shortened version of Effectiveness of Interventions to Prevent STI/HIV in Heterosexual Men: A Systematic Review by Elwy AR, Hart GJ, Hawkes S, Petticrew M *Archives of Internal Medicine*—forthcoming September 2002.

METHOD

An extensive survey of 22 electronic databases was complemented through additional search criteria, to enquire about other publications they might know about. Studies located by the search strategy were coded for inclusion using a checklist, which was then checked for inter-rater agreement. Inclusion criteria included: study must include heterosexual men 15 years or older, and results for men must be analysed and presented separately; study design is randomized or non-randomized and controlled, or observational and prospective or retrospective; outcomes must include morbidity (new or reinfection with STIs or HIV), behavioural (reported behaviours) and/or social-psychological (e.g. attitudes or intentions). Studies were then assessed for quality and only those of high or moderate quality were included (Deeks et al., 1996; Jadad et al., 1996).

RESULTS

Of the 1157 articles located, 27 studies met the inclusion criteria. Twelve (44%) of the studies were conducted on male-only populations; of the 15 studies which included women, 8 addressed men and women in different groups. Heterosexual men in the 27 studies tended to fall into five well-defined populations: drug users receiving treatment (3/27, 11%); injecting drug users out-of-treatment (2/27, 7%); STD clinic attendees (9/27, 33%); men in the workplace (3/27, 11%); and students (6/27, 22%). Over 60% (17/27; 63%) were conducted in the USA—8 of the studies specifically targeting racial and ethnic minorities in that country. Two studies were undertaken in Brazil, and single studies were conducted in the UK, Australia, India, Kenya, Mozambique, Namibia, Senegal and Thailand.

Eight (30%) studies evaluated morbidity outcomes (new HIV infection, or new or reinfection of STI); 21 (78%) assessed behavioural outcomes (condom use, reduction in number of sex partners, unprotected sex); and 15 (56%) studies assessed social-psychological outcomes (attitudes towards condoms or HIV, intentions to use condoms or change risky behaviour, knowledge of HIV/AIDS, self-efficacy of condom use, communication skills, quality of sexual relationships).

Interventions by Group of Men

Interventions with Drug Users

Three interventions with drug users in treatment programmes were highly successful at changing this group of men's sexual behaviour through the use of educational and motivational aspects, and promotion of negotiating skills (Calsyn et al., 1992; Baker et al., 1994; Malow et al., 1994). The programmes also focused on skills needed to prevent a relapse in both drug use and risky sexual behaviour. One intervention also focused on social-psychological outcomes: Malow et al reported increases in knowledge of HIV, condom use skills, sexual communication skills and response efficacy for using condoms in both the intervention and control groups.

For drug users who are not in treatment programmes, the picture is not as clear: a peer education programme aiming at increasing AIDS education and awareness of personal risk did not report any change in behaviours in men (Cottler et al., 1998). However, an 8-session risk assessment and motivational programme saw condom use increase in one intervention, but the increased use of condoms was reported by men in both the intervention and control groups (Robles et al., 1998).

Interventions with men in the workplace
Work-place interventions found considerable success in reducing STI risk in men. In Kenya, men working in a trucking company were targeted with on-site counselling and HIV testing, and were offered the opportunity to participate in one-on-one sessions which sought to improve skills in condom negotiation and condom use (Jackson et al., 1997). The intervention was successful not only in seeing a change in reported behaviours but also in lowering the incidence of new STI infections. In Senegal, trucking workers participated in a peer education project to increase condom use and increase knowledge about STIs and HIV (Leonard et al., 2000). Over the two-year time frame of the project, there was a confirmed increase in the use of condoms by these men. A second intervention which relied on peer outreach was conducted with port workers in Brazil (Hearst et al., 1999). Over a two-year time frame this intervention was successful in increasing the reported use of condoms and decreasing the reported number of sex partners of these men.

Interventions with men in STI clinics
Eight interventions with men in STI clinics have been evaluated in the United States (Solomon & DeJong, 1989; Cohen et al., 1992; O'Donnell et al., 1995; Boyer et al., 1997; Branson et al., 1998; NIMH, 1998; Kalichman et al., 1999; Wagstaff et al., 1999), and one in India (Bentley et al., 1998). These interventions show conflicting results—programmes which relied upon increasing motivation and skills were successful in reducing the incidence of new STI infections in some clinics but not others. A programme which aimed to change behaviour (and did not attempt to measure changes in STI rates), found that one-to-one counselling sessions seeking to improve condom skills and use was successful in increasing both the use and the consistent use of condoms (Bentley et al., 1998). Other skills-based interventions have reported improvements in communication with sexual partners about risk reduction and use of condoms (Solomon & DeJong, 1989; Kalichman et al., 1999). Video-based education programmes in clinics have been found to be successful in increasing the reported *intention* to use condoms in two sites (Solomon & DeJong, 1989; O'Donnell et al., 1995).

Interventions with Students
Studies among student in the USA (Jemmott et al., 1992; St Lawrence et al., 1995; Sanderson et al., 1999; Wight et al., 2002), Brazil (Antunes et al., 1997) and Namibia (Stanton et al., 1998) aimed to change reported sexual behaviours among these groups of predominantly young men. The results of a number of studies were mixed, with the same type of intervention (behavioural and skills training) showing a positive effect on behaviour change in some settings and not in others. All studies which aimed at increasing students' knowledge succeeded in their objectives.

Interventions with Other Men
A mass national communication campaign (run alongside other interventions to reduce STI incidence) significantly reduced the incidence of STIs among cohorts of men entering the Thai military (Celentano et al., 1998). Other smaller scale interventions concentrated on specific groups of vulnerable or at-risk men—including homeless men (Susser et al., 1998) and men in prisons (Vaz et al., 1996). While knowledge increased in the group of men in prison, social- psychological and behavioural outcomes were more varied in other studies.

DISCUSSION

Until recently, the main focus on heterosexual men's reproductive and sexual health has been on attitudes to contraception and family planning, and men's roles in increasing the risk and vulnerability of their female sexual partners, with relatively little effort concentrated on men's own sexual health concerns (Hawkes & Hart, 2002). Given that in many settings it is the

behaviour of the male partner which places women at increased risk of STI, including HIV, it is imperative to identify strategies and interventions which may work to decrease the burden of risk and disease among heterosexual men and their female partners. Heterosexual men are rarely targeted separately in intervention efforts to prevent the spread of STIs/HIV. We found only 27 studies which met our inclusion criteria for a systematic review of the effectiveness of interventions among this group of men. Most of these studies were concerned with evaluating behavioural and/or social-psychological outcomes rather than morbidity outcomes.

The majority of studies were conducted in the United States, with just under half of these US-based studies conducted on racial and ethnic minority populations. While recognizing the importance of these results for STI/HIV control in the US, the findings cannot easily be transferred to the rest of the world, and especially to those countries currently experiencing the highest burdens of incident and prevalent HIV infection and STI. Several areas of the world are notable by their complete absence from the evidence base that we have reviewed: eastern Europe and central Asia (currently experiencing epidemics of both HIV and other STI); eastern Asia (home to a significant proportion of the world's population, and under increasing threat of an HIV epidemic). In addition, other regions with high burden of STI/HIV disease or potential burden of disease are represented by only one or two study results (e.g. Africa and South Asia).

Despite these and other caveats, we believe that this review has highlighted areas which will serve both the design of future interventions and further research.

Which interventions were effective in reducing the burden of new disease?
There is no single intervention which can be identified as being more effective than others in reducing the incidence of STI/HIV in heterosexual men. This finding is presumably a reflection of the heterogeneity of the groups of men under study, and the wide variety of different contexts in which interventions were being evaluated. Successful interventions ranged from localized to national responses, but all were resource intensive either in their execution or their measurement.

The five successful (but not necessarily high methodological quality) interventions were carried out among men in the workplace (1 study), men in the military (1 study) and men in STI clinics (3 studies). A variety of methods were used in these interventions including an on-site counselling and HIV testing center at a trucking company with individual sessions for participating men; a mass communications (and multi-sectoral) approach to risk reduction in Thailand; and multi-component motivation and skills approaches in STI clinics. In the latter case, two further studies using similar intervention methods reported no decrease in STI incidence.

This result carries important implications for those charged with programme and intervention design—a single 'cookie-cutter' approach is unlikely to be successful in any one setting, and interventions must be targeted to the needs of the local community.

Which interventions were effective in changing men's attitudes and behaviours?
There was no single method which could be identified as being effective in all situations aiming to change behaviours, increase knowledge, or measure an intention to change. However, it is of note that the three interventions targeting heterosexual drug users in treatment reported success in this population often described as 'difficult'. Studies of interventions with men in the workplace all reported significant intervention effects on the men's sexual behaviour and knowledge of HIV and STI - the use of peer educators in interventions of longer duration appear to have been effective in this particular group of men.

For men in other settings, even when similar intervention methods were employed, results were not consistent. Interventions which showed a positive outcome in one setting produced equivocal results elsewhere. A wide variety of approaches were employed throughout these interventions, including one-on-one counselling , group counselling , mixed gender counselling , single gender counselling , repeat and one-off sessions, with no evidence of effect size being related to the form that interventions took.

Summing Up

We believe a degree of caution should be used when interpreting results from this review. It is not possible to be prescriptive on the basis of this review as to the optimum approach to take to reduce the risk of transmission of STI, including HIV, in heterosexual men. We identified relatively few methodologically rigorous studies (and even fewer with a 'gold standard' biological indicator of behaviour as the outcome), and no one, consistently effective approach in reducing incident infections, changing behaviour or changing social-psychological outcomes.

On a more optimistic note, however, it is worth remembering that although there were only four interventions addressing the majority of men in the population (who are not in clinic populations, not in education, or do not have an identifiable 'risk behaviour'), they all showed a positive behavioural intervention effect. These were interventions among men in the workplace, or men joining the military (after a nation-wide mass media and structural intervention to reduce HIV risk in Thailand). This suggests that it is possible to reduce the burden of sexual risk and consequent ill-health for men in the "general population"—the section of men likely to have the largest population attributable risk for the burden of STI and HIV in men *and* women in many settings.

Future Research

The results of this systematic review suggest that the following factors are important for future research agendas to prevent the spread of STI/HIV in heterosexual men:

1. Research needs to focus on morbidity outcomes (e.g. incident infection) rather than only behavioural or social-psychological outcomes.
2. Interventions need to target heterosexual men, or at least ensure that heterosexual men participate in single sex intervention groups, and then evaluations can identify the approaches that are best suited to this population.
3. More research needs to be carried out in regions of the world where rates of STI/HIV are high amongst heterosexual men, such as sub-Saharan Africa, and where they are increasing, such as Asia, eastern Europe and central Asia.
4. Studies other than RCTs can identify promising interventions; the effectiveness of these interventions requires further rigorous evaluation before widespread implementation.
5. Studies should have the statistical power to demonstrate effectiveness, and this should be calculated prior to research being funded and implemented.

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2.1.2 Male involvement in prevention of pregnancy and HIV infection: results from research in four Latin American cities[1]

Dr Edith Alejandra Pantelides

Abstract

Context: In 1999, a survey on reproductive behaviour and beliefs among young men in the metropolitan areas of Buenos Aires (Argentina), Havana (Cuba), La Paz (Bolivia) and Lima (Peru) was undertaken. The aim of the survey was to produce baseline data and to test various hypotheses concerning the relationship between reproductive behaviour and beliefs regarding gender-based ideology on sexuality, as well as the relationship between these beliefs and the sociodemographic characteristics of the individuals, the social stratum in particular. Partial comparative descriptive results of the research are described in this paper.

Methods: *Formal group discussions (FGDs) were held in all cities except Buenos Aires, to detect appropriate language and emergent topics not foreseen by the researchers. This information, together with the results of a pilot survey, was used to design a questionnaire. Although the research was centrally coordinated, the instrument was widely discussed with the four country PIs and a common core questionnaire was agreed upon. The questionnaire was made up of close-ended questions (which were closed after analysing the results of the pilot survey and the focus groups). The questionnaire was administered to random samples ranging from 750 to 850 men aged 20–29.*

Results: *Although the selection of countries was partially based on their cultural, social and political diversity, the preliminary results of the study show similarities with regard to some aspects of reproductive behaviour, knowledge and attitudes between populations of countries assumed to be distant in culture and socioeconomic development, while the expected differences hold with regard to other aspects. Areas of convergence include reasons for use and non-use of preventive measures against pregnancy and STD/HIV infection, and the persons with whom preventive measures would be taken in each case. There is also convergence in the direction of the change between first (initiation) and last (closer to the survey date) sexual intercourse. One of the areas of divergence recorded is with regard to actual use of contraception.*

Conclusions: *We suggest that there is more convergence than expected, given the diversity in the social, cultural and political characteristics of the countries. We also suggest that this is the result of populations of large urban areas being exposed to global inputs, media messages, especially, and that the convergence is greater when the questions asked relate to the ideological aspects (that allow for answers corresponding to what "should be") rather than to actual behaviour.*

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[1] The principal investigators were Rosa Geldstein (Argentina), Franklin García Pimentel (Bolivia), Luisa Álvarez Vázquez (Cuba), and Jesús Chirinos (Peru). For this paper they have kindly provided me with their review of the local literature and the necessary tables. I also profited from the additional literature review made by Graciela Infesta Domínguez for the Argentinian final report.

[2] CONICET and CENEP, Argentina

INTRODUCTION: ABOUT THE RESEARCH

This paper presents partial results of a study into male reproductive attitudes and behaviour as they apply to the decision-making processes with regard to sexual intercourse, adoption of contraception, and prevention of STDs and HIV infection. The study also explores whether and in what way both the objective characteristics of the men and their (culturally grounded) perceptions impinge on their behaviour. These research goals follow the recommendations of the Cairo International Conference of 1994 about the need for promoting greater male responsibility and active participation in sexual and reproductive behaviour (UNFPA, 1995).

The study was conceived as multicountry and comparative because the observation of the same phenomenon in different societies makes it possible both to establish the existence of across-society patterns and, equally importantly, to identify certain phenomena as unique to a given society. This justifies both the comparative component and the choice of countries, bringing together societies with different ethnic compositions, political regimes, health systems, degrees of gender asymmetry, educational levels, family planning ideologies, and availability of family planning services. "If the study of male fertility follows that of female sexuality, then we should expect that the first step is a documentation of patterns in which variety is taken very seriously —variation from society to society, within society among men over the life cycle and under differing historical conditions—and in which men's own explanations of them take a central place" (Guyer, 1995).

The project was carried out in the metropolitan areas of the capital cities of Argentina (Buenos Aires), Cuba (Havana) and Peru (Lima) and the Bolivian city of La Paz. After a few focus groups (except in Argentina, where there was sufficient previous knowledge), designed to cover emergent issues and to refine the language, a survey was conducted among probabilistic samples of men 20–29 years old residing in the above-mentioned cities. The samples ranged in size from 750 to 850.

In this paper we descriptively compare univariate results from the four cities on knowledge of contraception, on some aspects of the negotiation process that led to the adoption of preventive measures (against unplanned pregnancy and STDs/HIV contagion), and on attitudes towards prevention with different kinds of partners. We will end by comparing the men in the study according to their discourse on some myths or popular “knowledge” regarding gender sexual roles. Our purpose is to see whether the convergences and divergences lie in the realm of behaviour, attitudes and discourse.

WHY MEN

To understand how men behave and how they perceive their role in sexuality and reproduction has important implications for various aspects of reproductive health: the timing and characteristics of sexual initiation, contraceptive use, recourse to abortion, prevention and treatment of STDs and HIV, sexual abuse and sexual coercion, among others. Last, but not least, it is important to understand men's behaviour and their point of view because, given the gender asymmetry prevalent in most societies, they still have a dominant role in reproductive health-related decisions and outcomes. Studying men should not be seen as contradictory to studying women: "It shows us the other side of the coin and many mirror images that can enrich the gender analysis" (de Keijzer, 1995).

However, as many authors have already noted, the area of men's sexual and reproductive attitudes and behaviour has only recently interested researchers (Figueroa Perea 1995;

Figueroa Perea & Liendro, 1995; Stycos, 1996; Mundigo, 1998, among others). Interest arose when it became clear that without understanding the male perspective, it would be impossible to change reproductive health-related behaviour that is risky or damaging for both women and men (Mundigo, 1998; Collumbien & Hawkes, 2000; Hawkes & Hart, 2000). Stycos (1996) reviews the existence of the family planning surveys and publications that include men and notes that, although they are still few in number, there has been an significant increase since 1990. Green and Biddlecom (1997) point out that a large part of the growth in research on men consists of studies that examine both men and women. Another indication that, in the area of reproductive health, the interest in men is fairly recent, is given by a compilation by *Family Planning Perspectives* (The Alan Guttmacher Institute, 1996), which reproduces 55 articles dealing with different aspects of men's reproductive health, published in that journal between 1987 and 1995: the majority were published from 1993 onwards.

The past several years have seen an increase in surveys of men focused on the measurement of fertility and contraceptive use and on reproductive preferences. A good example are the 40 Demographic and Health Surveys (DHS) (up from the four of the World Fertility Survey) that collected data from men (or husbands) starting in 1986. The first Latin American country to be included was Brazil in 1991.

In spite of the sizeable increase in interest in men, the sum of knowledge in the area is still scant, both with regard to the more basic measurement of fertility levels and determinants (Coleman, 1995) and with regard to sexual and reproductive perceptions, attitudes, and behaviour. All these aspects have been frequently studied from the female perspective through questions put to women about their experiences with men and about what they believe about what men do and think (Mundigo, 1998). The male partner's characteristics have been generally treated as an attribute of the female: "In methods for interpreting fertility among women, males end up as just another variable, despite their important role in fertility (...). Males appear as a kind of secondary factor and their participation in the reproductive process is undervalued" (Figueroa Perea, 1995). However, "men in the realm of reproductive health also have specific needs that remain under-researched and poorly documented (...)" (Mundigo, 1998).

PRECEDENTS

Our study made use of the Health Belief Model, a theoretical approach that has been used in reproductive health research, especially in that related to the AIDS epidemic (Becker & Maiman, 1983). However, caution had to be exercised, since empirical research suggests that some of the tenets of the Health Belief Model are not supported by evidence: information does not necessarily lead to (adequate) action; perception of risk and of severity of illness does not necessarily change risk-prone behaviour (Klepinger et al., 1993). The study of sexual behaviour from a sociological (rather than psychological or "sexological") point of view is the approach adopted by studies that collect basic data on sexual behaviour (Billy et al., 1993; Laumann et al., 1994; Wellings et al., 1994). This approach was also useful to us.

Regarding empirical results, Ezeh, Seroussi and Raggers (1996) and Hulton and Falkingham (1996), summarize large data sets from the Demographic and Health Surveys (DHS); and Bankole and Singh (1998) and Becker (1999) compare responses from husbands and wives from the same source.

The difficulties related to negotiating over contraception in general, and the use of condoms in particular, within stable relationships (or the converse of the same phenomenon, i.e., the fact that condoms are used more frequently outside stable relationships or with secondary

partners) and the reasons for their use or non-use are documented in many studies (Parker, 1992; Grady et al., 1993; Paiva, 1993; Tanfer et al., 1993; Van Oss Marín, Gómez & Hearst, 1993; Landry & Camelo, 1994; Fachel Leal & Fachel, 1995; Rivera et al., 1995; Gogna, Pantelides & Ramos, 1997, among others).

In the countries included in our study, the majority of previous research on male reproductive behaviour has been carried out among adolescents. However research with adult men is growing. In Peru, Chu (1992), analysed a sample of 10–24 year-old students from evening schools in Lima. Jiménez Ugarte (1996) studied the characteristics of sexual interactions in relation with the type of relationship among 27 men aged 18–23 of the lower strata in Barrios Altos, Lima. Yon Leau (1996) researched the assumption and attribution of responsibility for contraception among male and female contraceptive users 20–35 years of age, from low and middle-class backgrounds who attended family planning services. Cáceres (1998) administered semi-structured interviews and formed focus groups with 20–29 year-old low and middle-class males in Lima. In Cuba, Díaz (n.d) presents the result of a survey with 500 males, ages 15 to 49, visiting medical offices.

Research among young adult males is relatively abundant in Bolivia. However, most of the studies are not relevant to our purpose. Skibiak (1993) explored gender perspectives on reproductive health using a nation-wide survey of 1,500 couples aged 19–59 years old, from seven cities. In Argentina, adult men and women from a poor suburban community were the subject of a study by Gogna, Pantelides and Ramos (1997) regarding factors affecting prevention of sexually transmitted diseases. Using qualitative methods, Villa (1996) explored the incidence of the reproductive life in the processes of health-sickness among urban men (17–45 years old) living in extreme poverty. Zamberlin (2000), also using qualitative methods, explored the social representations concerning fertility control and their incidence in the sexual behaviour and in the adoption of contraceptive practices, among men 15–45 year old men of low economic status. Infesta Domínguez (unpublished) used focus groups and semi-structured interviews with 25–35 and 45–55 year-old men from low and medium-high socioeconomic strata and determined six types of sexual career according to their approach to risk and prevention.

OUR RESULTS

We will start by analysing attitudes that could be construed as grounds for sexual and reproductive behaviour. The first section deals with general attitudes towards sexual gender roles. The purpose was to register opinions about some of the cultural myths that determine gender sexual relations, particularly those that underlie behavioural differences or are indicative of a patriarchal view of gender relations.

The second section centres on attitudes towards prevention of pregnancy and AIDS, specifically those that express possible differential preventive behaviour, depending on the type of bond and the affective distance with the partner.

The third section is devoted to knowledge of contraception, an intervening variable between attitudes and actual behaviour. Lastly, actual adoption/non-adoption of prevention, the process of negotiating it, and its declared motives, are the subject of the last section.

Attitudes towards sexual gender roles

In the interview, men were asked about their agreement or disagreement with the propositions shown in summary form in Table 1.

Table 1:. Percentage of men who hold traditional views about sexual roles among men aged 20–29 years old in Buenos Aires, La Paz, Havana and Lima.*

Propositions	Buenos Aires	Havana	Lima	La Paz
Men need more frequent sexual intercourse	61.9	65.8	21.3	40.8
Women's "no" means "yes"	30.3	31.9	22.6	50.0
Women have less need for sexual intercourse	28.6	35.6	24.0	43.3
Men cannot say "no" to sexual intercourse	21.6	28.8	26.5	54.9
Not having sexual intercourse when excited is harmful for men	20.5	45.7	10.4	31.7
Use of contraception leads to women's infidelity	14.3	19.7	15.2	53.6
Sex is for men's pleasure	9.7	9.4	5.9	10.1
Women are raped because they provoke it	7.1	7.3	8.5	34.1
Men and women have same right to pleasure	1.9	2.1	2.2	4.2

* Traditional views are those expressed by respondents who agree or strongly agree with the first eight propositions and those who disagree or strongly disagree with the last one.

While, as expected, the highest number traditional men is found in La Paz, it is unexpected that the lowest number of traditional men is found in Lima, with very striking differences in some of the items. The highest percentages of traditional responses to most propositions are found in La Paz, while the lowest percentages are found either in Lima or Buenos Aires. The more blatantly sexist sentences such as "sex is for men's pleasure" and "women are raped because they provoke it", and "men and women have the same right to pleasure", generally elicit few traditional responses, except in La Paz in the case of the statement referring to rape, agreed to by more than 1/3 of the men. Residents of La Paz also show a marked difference with those of the other cities regarding the propositions that when women say "no", they mean "yes", that the use of contraception may lead to women's infidelity, and that men cannot refuse sexual intercourse.

In Havana and Buenos Aires, the highest percentage of traditional responses is elicited only by the proposition that men need more frequent sexual intercourse than women, while the opposing idea that women have less need for sexual intercourse than men does not provoke the same reaction. Men in Havana also agree in important numbers with another proposition that asserts the sexual needs of men, the one which states that not having sex when excited is harmful.

Attitudes towards protection against pregnancy and AIDS: With whom or from whom?

Other researchers have documented that the adoption of preventive measures partly depends on the type of bond that links the couple and on who the partner is. Jimenez Ugarte (1996) in his study on Peru found that the characteristics of sexual interactions are constructed on the basis of the type of relationship established with the sexual partner: in the context of strong relationships, risky sexual practices develop; in the context of weak relationships, sexual practices typically assume lower potential risk. Similar results appear in the study by Cáceres (1998). Guevara Ruiseñor (1998) in Mexico also found that the type of relationship and the "degree of love" (our quotation marks), determine differing behaviour in relation to prevention.

In our own project, we proposed to the interviewees a list of "types of persons" and asked them whether they would use protection against AIDS and against pregnancy in each case (Table 2).

Table 2: Persons with whom men aged 20–29 years old would take preventive measures in Buenos Aires, La Paz, Havana and Lima

With whom would take preventive measures *	Buenos Aires		Havana		Lima		La Paz	
	Prevention of AIDS	Prevention of pregnancy	Prevention of AIDS	Prevention of pregnancy	Prevention of AIDS	Prevention of pregnancy	Prevention of AIDS	Prevention of pregnancy
Prostitutes	99.3	89.7	98.5	90.3	99.1	92.9	96.8	69.4
Stranger	98.5	95.8	98.4	92.7	99.6	97.1	96.8	93.9
Not loved	96.8	96.9	96.9	94.4	97.7	96.9	94.9	95.3
Lover	93.7	97.5	94.1	94.2	96.3	97.1	92.8	94.6
Acquaintance	92.5	98.3	95.5	95.0	89.2	97.9	87.8	95.1
Virgin	74.9	94.7	50.5	88.3	57.7	89.9	58.9	80.7
Loved one	64.0	83.2	71.8	78.8	51.6	77.2	67.5	84.5
Fiancée	55.7	91.2	61.8	85.3	56.0	89.6	55.4	90.0
Spouse	12.5	59.3	15.9	40.4	8.5	47.2	21.3	55.1

* The categories "virgin", "a loved one", and "not loved", were suggested to us by reading Guevara Ruiseñor (1998).

Regarding AIDS prevention, the percentage of men who would take preventive measures is generally high, except with spouses. It is clear that the further removed the link between the members of the couple, the more likely the adoption of preventive measures—in all four cities, prostitutes and strangers rank either first or second as the persons with whom the interviewees would use some method of prevention, the respective percentages always being above 96% and approaching 100% in all cities except La Paz. At the other extreme, what we witness is little concern about AIDS prevention when spouses are involved. Other types of partners with whom there is less generalized concern about AIDS prevention are those who are affectively close to the subject—fiancées and loved ones. The reasons are different from those related to the lack of concern with regard to virgins. In the latter case, the deciding factor is not closeness, but rather the fact that there is no worry about risk of getting the disease from the woman. The percentages in the individual cities are strikingly similar. To measure the level of coincidence in the ranking, we calculated a simple rank order correlation (Spearman's r_S) which resulted in coefficients between 0.90 and 0.98. These results suggest that men think about AIDS in terms of their own protection, not that of their partner. They believe that spouses, fiancées, and persons they love pose less of a threat, because they are somebody they "know" and trust; the same belief applies to virgins, because the latter have not had occasion to contract the disease. The opposite is true about prostitutes or persons with whom they may have only casual relationships. It is interesting to relate this finding with that of Yon Leau (1996): the males in her study perceive their responsibility in contracepting, but such responsibility appears removed from the actual use of contraceptives and related to the idea of having an untroubled sexual life.

Prevention of unplanned pregnancies is again less likely with the spouse in all four cities and with a loved one in three of the four. In both these cases, the proportion who would employ preventive measures against pregnancy is significantly larger than those who would prevent

AIDS. These results should be interpreted considering that a proportion of these men are married and trying for pregnancy. In all other cases, the proportion who would prevent is very large, generally close to, or above 90%, though it is difficult to establish a pattern. Agreement between cities is not as high as in the case of AIDS prevention, but it is still considerable, with all Spearman's coefficients being above 0.80, except that of La Paz versus Lima.

Knowledge of contraception

The knowledge of contraception was measured by the usual question that elicits a spontaneous response and an additional question about each of the methods that were not spontaneously mentioned, in order to see if the interviewee recognized them. In Table 3, the methods are ranked according to the total response (spontaneous plus recognition) in Buenos Aires.

The first conclusion is that there is quite widespread knowledge about contraceptive methods, although some are not mentioned spontaneously, but are recognized afterwards, the best example being abstinence in Buenos Aires. The second conclusion is that the level of knowledge is not directly related to the fertility levels prevalent in the cities or to the length of time each population has been contracepting. For example, the most knowledgeable men are in Lima, while the lowest fertility is found in Buenos Aires and Havana, and the earliest fertility transition is that of Buenos Aires. A possible explanation is that in Lima, the issue of contraception has recently been in the media and has sparked a national debate (Magdalena Chu, personal communication), and that sex education was established in schools around 1997. In Buenos Aires, meanwhile, the subject of contraception has not been widely publicized in the context of fertility control (although it is quite frequently mentioned with regard to AIDS prevention).

Table 3: Knowledge of contraceptive methods among men aged 20–29 years old in Buenos Aires, La Paz, Havana and Lima.

	Buenos Aires			Havana			Lima			La Paz		
Methods	Spontaneous	Recognized	Total	Spontaneous	Recognized	Total	Spontaneous	Recognized	Total	Spontaneous	Recognized	Total
Condom	95.4	4.5	99.9	94.4	5.5	99.9	95.3	4.4	99.7	92.0	7.2	99.2
Pills	81.6	15.7	97.3	68.7	25.9	94.6	79.3	18.5	97.8	61.0	31.5	92.5
Withdrawal	14.4	78.9	93.3	15.1	65.2	80.3	32.0	50.0	82.0	45.7	7.2	52.9
IUD	52.1	35.0	87.1	78.4	12.6	91.0	53.2	36.4	89.6	54.3	35.4	89.7
Calendar [a]	12.3	74.2	86.5	13.6	59.7	73.3	48.2	41.2	89.4	46.9	45.7	92.6
Abstinence	4.9	79.9	84.8	4.9	44.3	49.2	8.4	63.3	71.7			
Diaphragm[b]	16.4	55.5	71.9	30.0	31.9	61.9	15.1	51.3	66.4	17.6	41.4	59.0
Female sterl.	4.1	62.3	66.4	11.8	63.2	75.0	22.1	73.1	95.2	6.4	57.5	63.9
Male sterl.	2.1	55.7	57.8	7.7	44.1	51.8	25.6	68.7	94.3	4.3	46.5	50.8
Injections	9.0	45.9	54.9	21.7	40.9	62.6	57.3	38.1	95.4	16.2	50.9	67.1
Spermicides	5.4	42.7	48.1	10.1	39.5	49.6	22.8	56.7	79.5			

[a] La Paz includes abstinence; [b] La Paz includes spermicides

It is immediately clear that the condom is universally known in the four cities and that almost all men spontaneously mentioned it. Almost the same can be said about the contraceptive pill. In the four cities, these two methods rank as the first and second best-known methods (although, in Havana, the pill comes third, after condoms and the IUD, among the methods mentioned spontaneously). Then the differences begin, and some are very important. For example, withdrawal, which ranks third in Buenos Aires where it is known by 93% of those surveyed, is known to only slightly more than half of the men in La Paz (withdrawal was the main method by means of which low fertility was achieved in Argentina). In Buenos Aires, injectables are known to 55% of men and thus rank second-last, but they come third in Lima,

known to 95% of the interviewees. Male sterilization is practically never mentioned in Buenos Aires, but 26% of men in Lima mention it spontaneously.

Comparing the cities in pairs (except La Paz, which has fewer categories), with regard to spontaneous responses, the comparison Buenos Aires-Havana yields a high $r_S = 0.92$, but Buenos Aires-Lima does not show high agreement (0.60), and the same can be said of Lima and Havana (0.69). In “total knowledge" the ordering in Buenos Aires vs. Havana yields an $r_S = 0.70$ and Havana vs. Lima 0.68, while Buenos Aires and Lima agree only at the level of 0.32. The conclusion is that there is high agreement in the level of knowledge of the interviewees regarding condom and pills, but less regarding the remaining methods.

We suggest that both condoms and contraceptive pills are very salient in men’s minds, although for different reasons—the AIDS epidemic for the first method and the frequency of use in the population for the second. This holds true for the four cities. The salience of the other methods depends on the particular contraceptive history of each country—which methods have been more available, which have been promoted or forbidden, and which are culturally more or less acceptable.

Behaviour and the motives behind it: negotiation and the use of preventive methods

The process of negotiating preventive methods (either to avoid pregnancy, infectious diseases or both) occurs within the context of the knowledge and attitudes analysed above. But since it is also the result of an individual couple's experiences and involves both verbal and non-verbal messages, it is difficult to measure by way of a questionnaire. We approached the matter with questions as to whether the persons interviewed spoke about prevention, and if so, who proposed the use of a preventive method. The questions referred to two points in time—first sexual intercourse and most recent. The results are shown in the first panel of Table 4.

Table 4: Negotiation and use of preventive methods in Buenos Aires, La Paz, Havana and Lima among men aged 20–29 years old.

Negotiation of prevention	Buenos Aires		Havana		Lima		La Paz	
	First sexual intercourse	Most recent sexual intercourse	First sexual intercourse	Most recent sexual intercourse	First sexual intercourse	Most recent sexual intercourse	First sexual intercourse	Most recent sexual intercourse
% Spoke about Prevention	50.9	51.8	22.5	51.5	44.7	63.8	31.4	72.8
Who proposed use of methods								
Self	25.5	21.1	24.3	26.6	31.0	25.0	26.1	21.1
Partner	15.2	12.8	30.3	31.3	17.6	9.0	19.1	13.4
Both	53.6	61.3	23.7	36.7	49.7	65.0	43.5	62.8
Nobody	5.7	4.7	21.7	5.4	1.6	1.0	11.3	2.7
Total	100.0	99.9	100.0	100.0	99.9	100.0	100.0	100.0
% Used methods	66.6	79.2	13.8	50.1	47.7	77.5	21.4	60.3
Methods used								
Condom only	93.6	68.7	61.7	54.1	86.5	62.0	65.0	51.8
Hormonal	1.4	15.0	7.8	7.1		20.0		5.6
Other effective And combinations	2.2	9.7	20.9	34.8		8.0		8.3
Traditional	2.7	6.5	9.6	1.5		10.0	26.8	29.8
Other				2.4	13.5		8.3	4.5
Total	99.9	99.9	100.0	99.9	100.0	100.0	100.1	100.0

In Buenos Aires, around half the men reported talking about prevention both in the first and the latest sexual intercourse. Although the percentages with regard to first sexual intercourse were higher than in the other cities, there was no "improvement" with time and experience. That was not the case in the other three cities, where there was less dialogue at first intercourse, but significantly more in the case of the most recent relationship, equalling or greatly surpassing the percentage shown for Buenos Aires. An intriguing feature is that the two more European cultures (Havana and Buenos Aires) show less tendency to dialogue than those with more influence from indigenous cultures, whose members are supposed to be more circumspect and less prone to verbal communication. Some of the men in stable unions said they did not talk because they had already negotiated the issue. However, this factor does not seem to explain the differences found since the highest proportion of men in stable unions is found in Havana, doubling those found in Buenos Aires and in Lima, and much higher than those in La Paz.

With the exception of Havana, the methods were generally proposed jointly by the members of the couple both at first and last sexual intercourse. In all cities, this shared proposition was more prevalent in the most recent episode. The proportion of men alone taking the initiative in this regard ranged between 1/5 and 1/3, and tended to diminish slightly over time. The partner—with few exceptions, a woman—did not feature prominently as initiator of a proposal to use contraception, except in Havana. The latter case is interesting because women there have a more independent role than in the other cities, but the practice of shared responsibility is less prevalent.

We now find a very striking difference: the use of preventive methods during first sexual intercourse is significantly higher in Buenos Aires than in the other cities, and it increases for the most recent intercourse, despite the fact that the dialogue about prevention does not. The men in Havana are the least inclined to prevention although, as in all other cities, things improve over time. Given that fertility levels are lower in Havana than in Lima, it is again curious that contraceptive use is so much higher in the latter. The difficult availability of methods coupled

with the extensive use of abortion in Cuba (Alvarez Vázquez et al., 2001) could explain these findings.

The condom is the method preferred—almost universally in Buenos Aires—by those who elected to prevent during sexual initiation and, although its use diminishes consistently in all cities by the last intercourse, it remains the method most used. A shift towards hormonal methods between the first and last intercourse can be seen in all the cities, a reflection of both the shift from more casual relationships and relative strangers as partners in the first sexual encounter, to more stable relationships with "known" partners (including spouses) in the most recent one, and of the related shift from concern about AIDS to concern about pregnancy. Traditional methods have importance only in La Paz, the use of which does not decrease with time.

Although avoiding pregnancy was the answer given most frequently for both first and last sexual intercourse when the question concerned the reason for using a method, there are important differences between cities that can be summarized by saying that avoiding pregnancy is not as important in Buenos Aires as in the other three cities (Table 5). The opposite case is La Paz, where the prevention of STDs/ HIV is practically absent from the reasons for using preventive methods. These differences are partly, but not totally, reflected in the already-mentioned differential prevalence of condom use in the four areas. It is also notable that the joint prevention of pregnancy and of STDs/HIV gets respectively 30 and 32% of the answers in Buenos Aires, and only between 3 and 14% in the other cities.

Table 5: Reasons for use or non-use of methods in Buenos Aires, La Paz, Havana and Lima among men aged 20–29 years old.

	Buenos Aires		Havana		Lima		La Paz	
Reasons for use or non-use of methods	First sexual intercourse	Most recent sexual intercourse	First sexual intercourse	Most recent sexual intercourse	First sexual intercourse	Most recent sexual intercourse	First sexual intercourse	Most recent sexual intercourse
Reasons for use:								
Avoid								
Pregnancy	34.6	59.2	55.8	60.6	57.0	77.0	87.9	94.9
AIDS/STD	28.8	9.5	27.0	22.2	26.0	9.5	4.5	1.5
Both	31.8	30.1	9.4	14.3	9.0	8.0	4.5	3.3
Other	4.8	1.2	7.8	2.9	8.0	5.5	3.1	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Reasons for non-use								
Did not plan	52.7	34.6	46.4	36.7	48.0	30.0	47.7	39.8
No access	0.0	4.5	2.1	0.7	12.0	0.0	17.4	12.6
Ignorance	27.8	0.0	32.3	0.5	14.0	0.0	17.6	1.6
Knew partner	11.8	22.3	9.2	37.7	7.0	35.0	6.1	15.0
Other[a]	7.8	38.6	10.0	24.4	19.0	35.0	11.2	31.0
Total	100.1	100.0	100.0	100.0	100.0	100.0	100.0	100.0

[a] In Buenos Aires partner pregnant or trying for pregnancy

As has been documented in previous research, the predominant reason for not using any means of prevention during sexual initiation is the fact that it occurred unplanned, followed in order of importance by ignorance (Pantelides, Geldstein & Infesta Domínguez, 1995). This has also been borne out in our current research. The other reason that frequently appears in the literature is "knowing the partner". This reason, as expected, is more prevalent in the most recent sexual encounter, in which stable relationships are more frequent. Also as expected, ignorance of methods was not claimed for the latest intercourse. Accessibility of methods has some importance only in La Paz. The differences between cities are less visible

here, although comparison is made difficult by the importance of the “other” category, which is both large and of different magnitudes in the four cities.

FINAL CONSIDERATIONS

Although differences still exist, we have shown similarities in attitudes and behaviour, unexpected between young urban men of four Latin American countries so different in their political, cultural, economic, and social context and in their approach to fertility limitation. We suggest that in today’s world, large metropolitan areas are more similar to one another than the history and socioeconomics of the countries would lead us to expect. But also, that similarities in discourse are diluted when behaviour is observed. More in-depth analyses of these data are needed to discover and explain the factors underlying the similar outcomes.

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2.2 Programming for men in family planning

2.2.1 Counselling and communicating with men to promote family planning in Kenya and Zimbabwe: findings, lessons learned, and programme suggestions

Dr Young Mi Kim and Adrienne Kols

Abstract

Prior studies from Zimbabwe and Kenya were re-examined to determine whether approaches developed for communicating with women about family planning can be applied to men. Data came from: (1) household surveys of 2,035 men and women in Zimbabwe that evaluated the impact of a multimedia male involvement campaign and (2) audiotaped family planning consultations with 257 men, 325 women, and 105 couples in Kenya. The campaign media and messages most effective in reaching men in Zimbabwe (newspaper and magazine ads and football tournaments) had established male audiences and employed sports imagery. Perhaps because of the macho nature of that imagery, the campaign increased the percentage of men who believed they alone should be responsible for family planning decisions, although the campaign did succeed in increasing male approval of contraceptive use and couple discussion of family planning. In Kenya, male clients participated more actively than women in consultations and raised a wider range of topics, including social, economic, and sexual issues. Compared with individual consultations, couple sessions inhibited women from participating and inhibited men from discussing STIs and HIV/AIDS. Both studies show that the form and content of family planning communication must be adapted to male audiences if it is to be effective. There is also a real danger that messages directed to men may undermine women's control over reproductive health decisions and perpetuate existing, unequal gender roles. Male communication programmes require additional research on male audiences, special training for service providers, and careful consideration of how they will affect women's reproductive rights and roles.

INTRODUCTION

Background and rationale

Because men have a strong influence on women's health and their access to care, reproductive health programmes are increasingly trying to involve men (Drennan, 1998). These programmes promote shared responsibility for family planning, assuming that women will be more likely to adopt and continue using a contraceptive method if they have their partner's active support. Several studies have found that involving men in contraceptive counselling does indeed increase contraceptive adoption, client satisfaction, contraceptive use-effectiveness, and contraceptive continuation (Fisek et al., 1978; Tapsoba et al., 1993; Terefe et al., 1993; Wang et al., 1998). Since male behaviour is critical to preventing the transmission of HIV/AIDS and other STDs, programmes also encourage men to adopt positive behaviours such as consistent condom use and remaining faithful to a single partner.

However, communicating with men poses a challenge for family planning and reproductive health programmes, which historically have focused on serving women. Multimedia campaigns have proven most effective when communication channels and message content are carefully matched with specific audiences. Similarly, good counselling requires health

care providers to respond to the individual needs and concerns of clients. Given gender differences in reproductive health needs and concerns, lifestyle, and media exposure, men presumably require different communication approaches than women.

At the same time, efforts to reach men with reproductive health messages must remain sensitive to the needs of women. Critics worry that involving men in family planning may limit women's control over reproductive health decisions and help perpetuate existing gender roles that place women in a subordinate position (Berer, 1996; Helzner, 1996). Male involvement programmes must promote gender equality along with other messages.

To examine these issues, we draw on data collected and published in prior studies in sub-Saharan Africa. The 1993–1994 Zimbabwe Male Motivation Campaign illustrates some of the challenges involved in reaching male audiences through the mass media and in encouraging them to change their attitudes and behaviour (Kim et al., 1996; Kim & Marangwanda, 1997). Studies of interpersonal communication during family planning consultations in Kenya (Kim et al., 2000) illustrate the advantages and disadvantages of one tactic often used to increase male involvement: counselling couples rather than individuals about family planning (Becker, 1996; Becker & Robinson, 1998).

Key questions

Reaching Men with the Mass Media

- Should multimedia campaigns employ different messages and communication channels to reach men rather than women? If so, what messages and channels are most effective for male audiences?
- Should the expected behavioural outcomes of communication campaigns be the same for men and women or different?

Counselling Male Family Planning Clients

- Should programmes train providers differently to attend to male and female family planning clients? If so, what special communication skills or knowledge do providers need to work with men?
- Should programmes encourage couples to seek joint counselling for family planning services? If so, what special arrangements should be made for counselling couples?

STUDY METHODS AND DATA SOURCES

Zimbabwe Male Motivation Campaign

Household surveys were conducted before and after the campaign to evaluate its impact. A total of 501 men aged 18 to 54 and 518 women aged 15 to 49 were randomly selected and interviewed two months prior to the campaign launch. Two months after the six-month campaign ended, a follow-up survey was conducted with 508 male and 508 female respondents. Interviewers and respondents were matched by gender where possible.

Family Planning Counselling in Kenya

Two data sets from Kenya allow us to compare family planning consultations with couples and individuals. The first data set consists of observation checklists and client exit interviews

from 81 counselling sessions with couples, 216 sessions with men, and 149 sessions with women. The second data set consists of audiotapes of 24 sessions with couples, 41 sessions with men, and 176 sessions with women. The audiotapes were transcribed and coded by researchers. Thus, the data cover both the actual behaviour of providers and clients and the clients' perspectives on what transpired.

FINDINGS AND PROGRAMME IMPLICATIONS

Reaching men with a multimedia campaign in Zimbabwe

Certain types of messages and communication channels were more effective at reaching men than women.

The campaign capitalized on a surge of interest in football (traditionally a male pastime) in Zimbabwe prior to the World Cup. Many campaign messages employed football images and analogies. Wives and other partners were referred to as team-mates, service providers as coaches, and a small family became the goal. Men were asked to "play the game right." Newspaper and magazine advertisements featured football celebrities and appeared near the sports pages.

The two campaign components that proved to be especially effective in reaching men were those tied most closely to the football theme: the newspaper and magazine advertisements and a four-game football tournament (Figure 1 - see Annex). Twice as many men as women (48% vs. 19%, $p<.001$) saw the ads, in part because of the football images and in part because more men than women read newspapers and magazines in Zimbabwe. As for the football matches, men were twice as likely as women to have heard of them (57% vs. 26%, $p<.001$) and six times more likely to have attended them (18% vs. 3%, $p<.001$). Many men who did not attend the matches followed the games on television or radio. The more media to which men were exposed, the more likely they were to use modern contraceptive methods.

Whether male or female, the percentage of respondents using a modern contraceptive method rose steadily (from 30% to 60%, $p<.001$) with increasing exposure to the campaign (Figure 2). To determine whether campaign exposure had an independent effect on contraceptive use, a multiple logistic regression analysis was performed. Results show that respondents were 1.6 times more likely to use a modern family planning method if they were exposed to at least three components of the multimedia campaign, even when controlling for gender, marital status, residence, age, education, and socioeconomic status. While this does not establish the existence or direction of a causal relationship, other studies confirm this finding.

Given this relationship, it is important to note that men were more intensely exposed to the campaign than women: 39% of men were exposed to four or more campaign components, compared with 24% of women ($p<.001$). The communication campaign increased approval of contraceptive use and couple discussion.

Since over 90% of men and women approved of modern contraceptive use prior to the campaign, the campaign focused on improving the image of long-term and permanent methods. According to married women, the proportion of their husbands who approved the use of injectables and the IUD rose significantly after the campaign (from 46% to 60% and from 29% to 45%, respectively) (Figure 3).

Both men and women reported increased discussions with spouses and partners about family planning matters. Among men with partners, the proportion who often talked about family planning with their partner rose from 42% at the baseline to 51% in the follow-up survey ($p<.001$) (Figure 4). The proportion of women who often discussed family planning with their partners rose even more markedly, from 37% to 57% ($p<.001$).

While the campaign increased men's sense of responsibility for family planning, it did not overcome deeply rooted attitudes towards gender-based decision-making.

After the campaign, men were less likely to believe that family planning decisions should be left solely to the female partner. Men were more likely to believe that two key decisions should be made jointly: getting information (56% vs. 65%) and going to a clinic to seek services (36% vs. 44%). At the same time, however, there was a significant increase in the percentage of men who felt that they alone should take responsibility for all three decisions: choosing a method (27% vs. 36%, $p<.001$), getting family planning information (13% vs. 22%), and going to a clinic to seek family planning services (10% to 44%, $p<.001$) (Figure 5).

Counselling men and couples in Kenya

Consultations with men (either alone or as part of a couple) covered a wider variety of topics than sessions with women. Observation data showed that providers encouraged clients to discuss family planning with their partners more often in couple sessions than in sessions with either men or women alone (73% versus 55% and 40%, $p<.001$) (Figure 6). When men were present, there was more likely to be a discussion of the benefits of family planning for men (44% of couple sessions, 40% of men's sessions, and 13% of women's sessions) and of male responsibility for family planning (37%, 34%, and 17%).

A qualitative analysis of the transcripts also found that men sought more detailed information than women and asked a broader range of questions, covering economic, political, and social issues as well as sensitive sexual issues. Women's questions were simpler and more narrowly focused; they generally asked about contraceptive methods and their personal family planning needs.

Counselling sessions were more likely to address STIs and HIV/AIDS in individual sessions with men than in sessions where women were present. According to observation data, STIs and HIV/AIDS were more often discussed in sessions with men—but only when the men were alone, not when their female partners were present. Almost half (46%) of individual sessions with men covered STIs, compared with 23% of couple sessions and 23% of sessions with women ($p<.001$) (Figure 7). HIV/AIDS was addressed in 25% of individual sessions with men, 14% of couple sessions, and 13% of sessions with women ($p<.001$). Men participated more actively than women in consultations.

Approximately two-thirds of the men played an active role in the counselling sessions; that is, they asked questions, raised concerns, and replied at length to the providers' questions so that the lead moved back and forth between client and provider. Few sessions with women followed this pattern. Instead, most female clients spoke little, rarely initiated a topic of conversation, and left providers in control of the conversation. Overall, male clients engaged in active communication 62% of the times they spoke during a consultation, compared with 27% for female clients (Figure 8). For both men and women, the most common way to participate was to answer providers' questions at length, in the process volunteering additional information or voicing their concerns (Figure 9).

Observation data and client exit interviews confirm these gender differences. A larger proportion of male than female clients asked questions without prompting (83% vs. 36%, $p<.001$), expressed concerns (72% vs. 48%, $p<.001$), and sought the provider's opinion (60% vs. 40%, $p<001$) (Figure 10). Men were more likely than women to report that providers encouraged them to participate (96% vs. 83%, $p<.001$) (Figure 11). Despite their higher levels of participation, men were far less satisfied with the consultation than women: 80% of the men interviewed said they wanted to participate more, compared with 43% of women ($p<.001$) (Figure 12).

Qualitative analysis of the transcripts also found that men were equally likely to participate actively in a consultation, regardless of whether they saw a provider alone or together with their partner. In contrast, women behaved differently in the presence of their spouse or partner: they were less likely to participate actively in couple sessions than in individual consultations.

PROGRAMME IMPLICATIONS AND CONCLUSIONS

Lessons learned in Zimbabwe

The success of the Zimbabwe Male Motivation Campaign demonstrates that reaching large male audiences with persuasive messages requires:

- Selecting communication channels that naturally attract male audiences, such as newspapers, sporting events, and broadcast shows that already have established male audiences;
- Using visual images and verbal messages that attract men's attention, hook their emotions, and are readily understood, and
- Employing multiple communication channels so that men are exposed to repetitive, reinforcing messages.

Messages addressed to men also have a unique potential to encourage spousal discussion and support for behaviour change, which may, in turn, increase contraceptive prevalence among women.

However, it is not easy to design messages and materials that men find persuasive, but that also promote gender equality and women's empowerment. In Zimbabwe, many men apparently misinterpreted campaign messages promoting male involvement to mean that decisions should be solely left to men. It is possible that the use of "macho" sports images and analogies reinforced deeply-rooted, traditional gender stereotypes and attitudes towards decision-making. Messages—and the images and metaphors used to communicate them—must be carefully designed so that the idea of joint discussion and decision-making is delivered unambiguously.

Lessons learned in Kenya

As data from Kenya demonstrate, the content and communication style of male family planning clients is somewhat different from that of women so service providers need special preparation to counsel them effectively. Providers need some training so that they are prepared to:

- Answer accurately and confidently when men raise questions about a broad range of social and economic as well as technical issues and when they ask about sensitive sexual matters;
- Respond positively to men's more active communication style, even when men dispute what they say;
- Encourage women to speak during couple sessions and ensure that their concerns are heard and addressed as well as those of the men.

The Kenyan sessions also shed some light on the disadvantages as well as the benefits of counselling couples. Several problems were noted: women participate less actively in the presence of a male partner than they do if they are alone, suggesting that they may lose some control over family planning decisions. Men and women also may not be able to discuss sensitive issues, such as STIs, HIV/AIDS, and domestic abuse, in the presence of their partner. Finally, couple sessions are impossible for women who are hiding their use of contraception from their partners.

Yet couple sessions do offer some advantages. Women may gain more information about important issues when their male partners are present to ask questions and express concerns. Couple sessions also encourage partners to discuss family planning together and consider the man's responsibilities. The hoped-for result is men's practical as well as moral support for contraceptive use. For example, men may help their partners remember instructions, return for appointments, and watch for danger signs.

These findings suggest the best solution may be a combination of individual and couple counselling, designed to reap the benefits of male involvement while protecting women's empowerment. Individual sessions with a woman probably should come first, so she has an opportunity to discuss her own concerns and priorities and to begin forming a decision. Where STIs, including HIV/AIDS, are a problem, individual sessions with men are also indicated.
Follow-up sessions with couples could then promote the further exchange of information and assure men's support for contraceptive decisions.

CONCLUSION

The principles of effective communication for reaching women can be applied to male audiences. However, both the form and content of that communication must be adapted to men's needs, concerns, and situation—without compromising women's control over reproductive health decisions or perpetuating existing, unequal gender roles. For the communication professionals who design male involvement campaigns, this means additional research on male audiences and on existing gender stereotypes to uncover effective messages and communication channels. For the family planning providers who are asked to counsel men and couples, this means training to cover a wider range of topics, to handle a more active client communication style, and to protect women's interests when necessary.

Annex: Figures

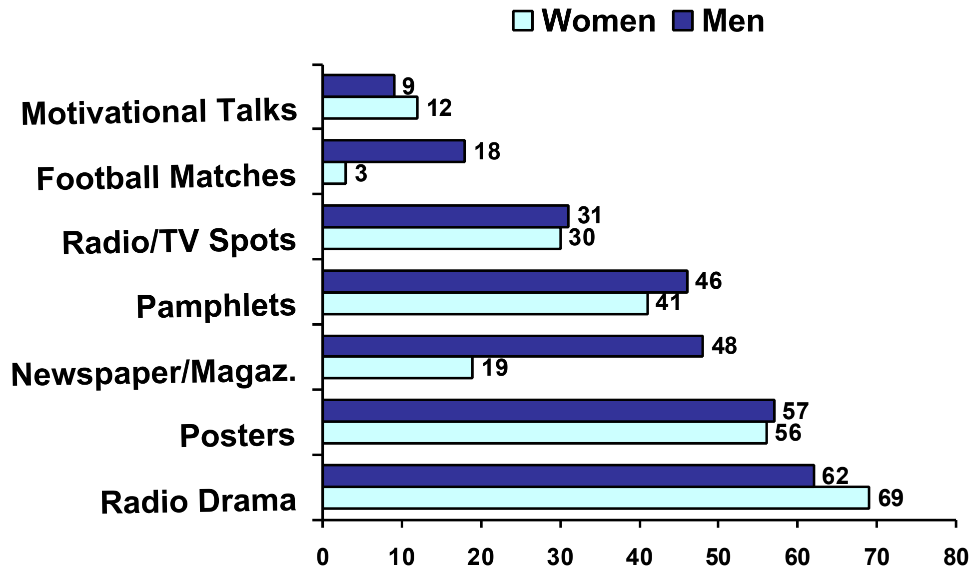

Figure 1. Communication campaign media seen/ heard and events attended: Zimbabwe

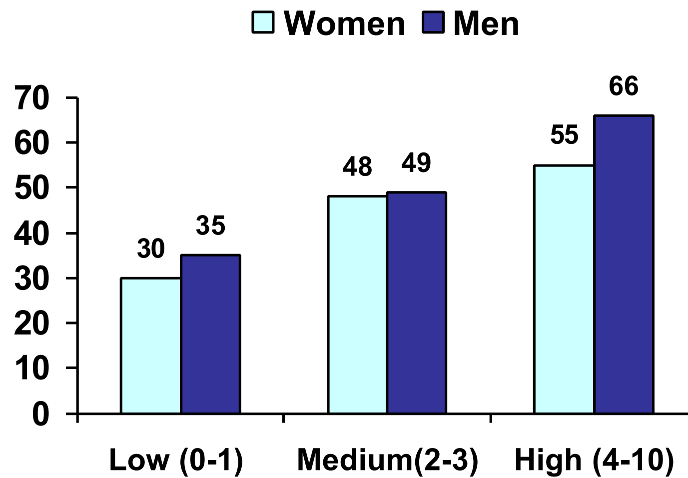

Figure 2. Modern FP method use, by level of campaign exposure: Zimbabwe

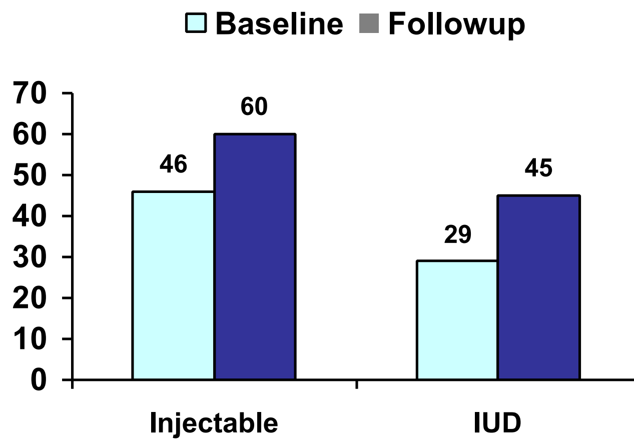

Figure 3. Women reporting that their spouses approve of using various FP methods: Zimbabwe

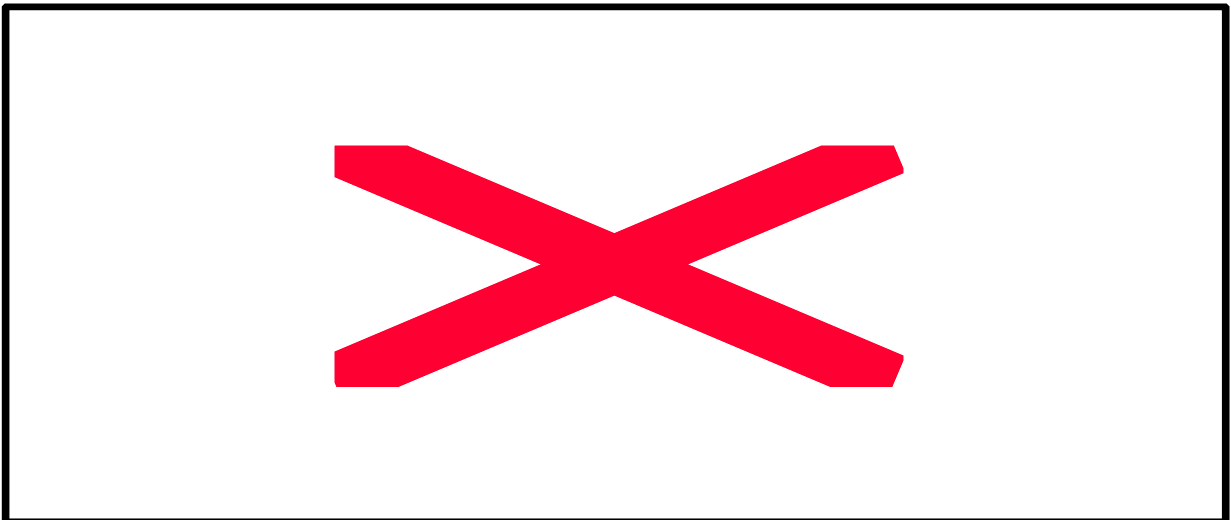

Figure 4. Spousal communication on FP reported by women and men: Zimbabwe

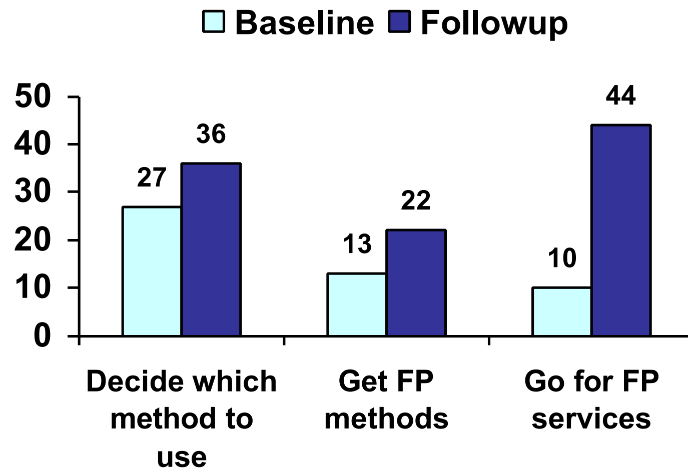

Figure 5. Men reporting that they alone should be responsible for FP actions: Zimbabwe

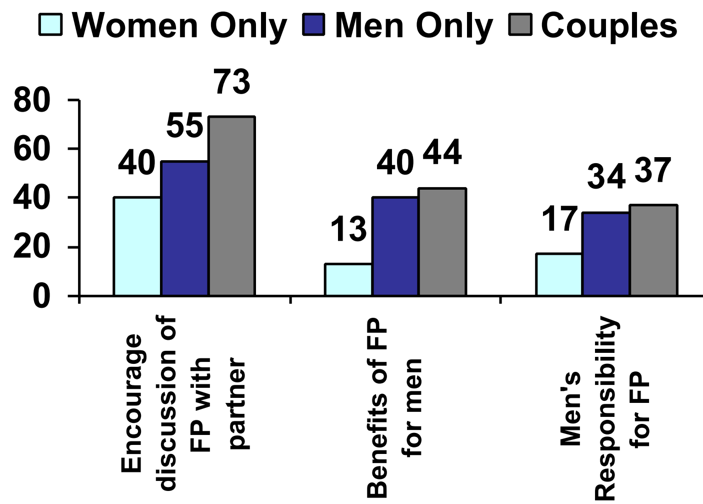

Figure 6. Percent of sessions that covered selected FP topics, observation data: Kenya

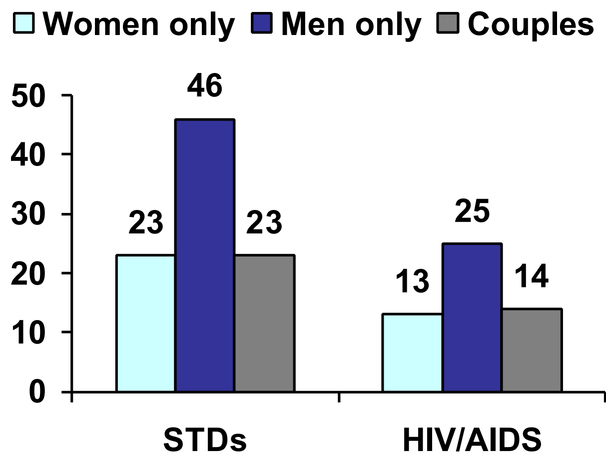

Figure 7. Percent of sessions in which STDs and HIV/AIDS were discussed, by sex of client, according to observation data: Kenya

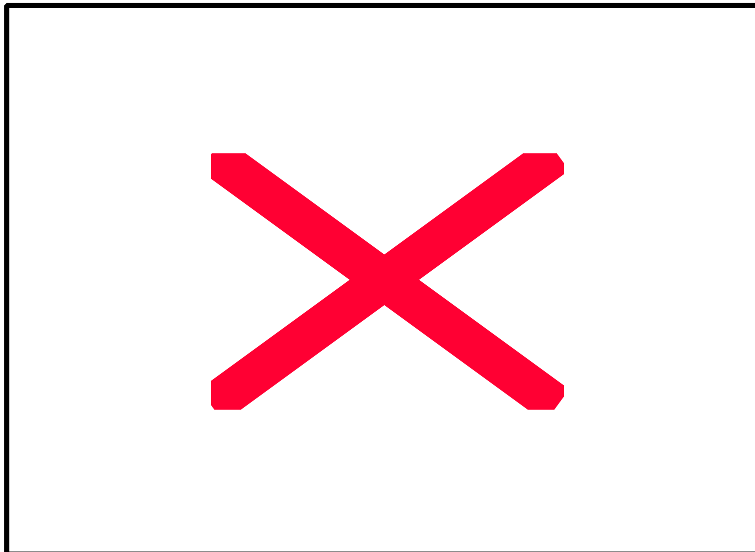

Figure 8. Proportion of active and passive client behavior, transcript analysis: Kenya

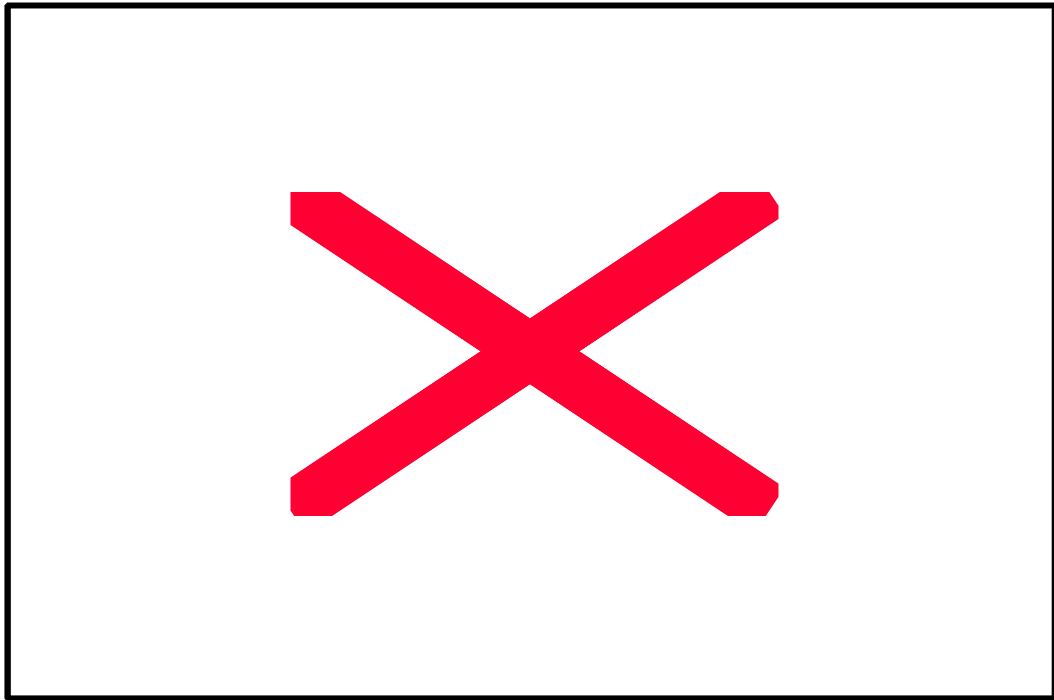

Figure 9: Proportion of client active participation, by type, transcript analysis: Kenya

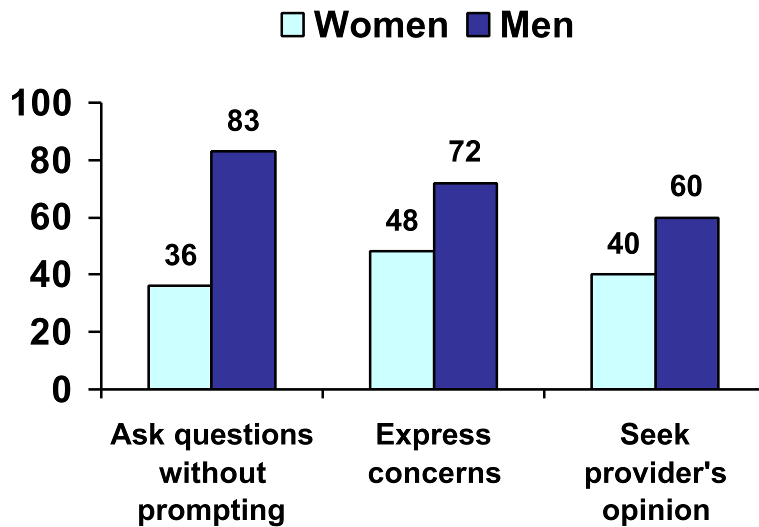

Figure 10. Percent of clients who participated in couple sessions, by sex, observation data: Kenya

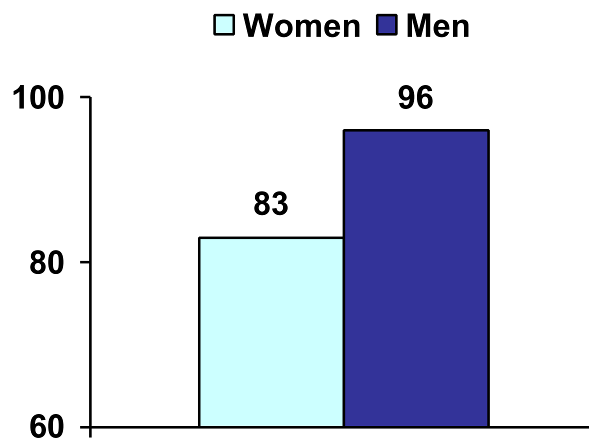

Figure 11. Percent of couple sessions in which clients report provider encouraged them to ask questions, interview data: Kenya

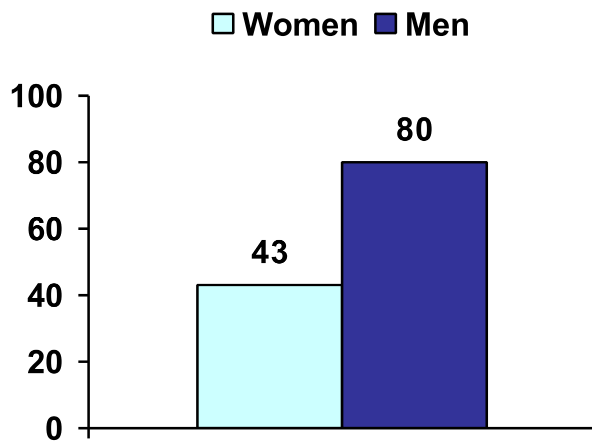

Figure 12. Percent of clients who want to participate more in couple sessions, interview data: Kenya

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2.2.2 Communicating with men to promote family planning: lessons learned and suggestions for programming

Ms Manisha Mehta

Abstract

EngenderHealth has been working on involving men in reproductive health, including family planning, since 1994. The organization's Men as Partners (MAP) programme has four goals: improving men's awareness and support of their partners' reproductive health choices, increasing men's awareness and responsibility for disease protection; increasing men's use of contraceptive methods that require their participation and cooperation; and improving men's access to comprehensive reproductive health services. To achieve these objectives, EngenderHealth has worked at multiple levels: internationally, nationally, institutionally, at the community level, and with individuals. EngenderHealth's MAP work to date has highlighted several key issues that need to be taken into consideration for future programming in men's reproductive health. One of the key lessons learned is that in order for programmes working with men to be successful, they must incorporate a gender perspective. Additionally, service delivery programmes that seek to involve men need to provide training to service providers to increase their comfort and competency in working with men. Other programming lessons learned include the fact that men are concerned about and interested in reproductive health; men need to be reached through special communication and marketing strategies; involving men does not have to be a costly effort, and men's needs have to be addressed holistically. Leadership needs to be supported at all levels for working with men in order for programmes to be successful. Finally, programmes with men need to address difficult or troubling issues, such as domestic violence or female genital mutilation.

INTRODUCTION

During the past several years, especially since the 1994 International Conference on Population and Development (ICPD), there has been increased attention around the world on constructive male involvement in reproductive health. Reproductive health practitioners have recognized that the failure to target men in programmes has weakened the impact of reproductive health programmes since men can significantly influence their partners' reproductive health decision-making and use of health resources (Mbizvo & Bassett, 1996). Moreover, studies have shown that men who are educated about reproductive health issues are more likely to support their partners in contraceptive use, use contraception themselves, and demonstrate greater responsibility for their children (Grady et al., 1996). Most importantly, women express great interest in wanting their partners to be involved in joint reproductive health decision-making. For example, a study in Ecuador surprisingly showed that 89% of women wanted their partner to accompany them on their next family planning visit and 94% would have liked their partner to be present during their family planning session (Roy & de Vargas Pinto, 1999).

Although 1994 was a watershed year for male involvement, EngenderHealth had already been working with male clients for 50 years on the issue of vasectomy, and the Cairo mandate provided an important framework for considering men's constructive involvement in

reproductive health from a more holistic perspective. With this framework in mind, EngenderHealth initiated a formal Men As Partners (MAP) programme in 1996 in response to client, provider, and institutional requests, which became even more frequent and urgent with the onset of the AIDS epidemic.

Programme Goals

EngenderHealth's MAP programme has four primary goals: to improve men's awareness and support of their partners' reproductive health choices; to increase men's awareness and responsibility for disease protection; to increase men's use of contraceptive methods that require their cooperation and participation; and to improve men's access to comprehensive reproductive health services. EngenderHealth's MAP programme is unique in that it focuses on involving men not only to improve the health of women, but also to meet men's own reproductive health needs.

Programme Activities

To attain the MAP team's goals, the team has undertaken activities at multiple levels. At the macro level, activities have been geared to reaching providers and policymakers from many countries; at the micro level, activities have focused on individual countries, communities, and clients.

Macro-level activities
EngenderHealth's MAP programme has implemented several different macro-level activities, such as interregional workshops, global research, and the creation of tools for use around the world in low-resource settings.

A. Interregional Workshops
In 1997 and 1998, EngenderHealth convened two workshops for participants from around the world to discuss research and service delivery issues related to men's roles as partners in reproductive health. The first meeting in Mombasa brought together approximately 150 participants from more than a dozen primarily African and Asian countries to share their experiences, knowledge, and concerns on fostering men's involvement in reproductive health care. Together, these teams developed and presented plans that would create programmes for men in their countries and would integrate these programmes into existing reproductive health systems.

The second workshop, which was held in Oaxaca, was cosponsored by IPPF-WHR. This workshop was attended by over 100 Spanish and Portuguese-speaking policymakers, donors, researchers, public and private sector providers, and media representatives to discuss gender equity and men's involvement in sexual and reproductive health. Since Latin America is very advanced in the level of discourse on gender equity and male involvement, the Oaxaca workshop sought to capitalize on all the work that was already under way in the region.

B. Global Research
In preparation for both the workshops, EngenderHealth examined successful approaches of involving men constructively in reproductive health and gender equity. To this end, for the Mombasa workshop, the MAP team conducted a series of four case studies of organizations—each from a different continent—that could offer insights into creative service delivery designs for men and their partners. In advance of the Oaxaca symposium, EngenderHealth and IPPF-WHR studied five programmes in Latin America that have established effective

outreach, communications, or service delivery systems to reach men and their partners on gender and reproductive health issues.

C. Creation of Tools
Until now, reproductive health has often been synonymous with women's health, and clinical training for reproductive health has often been through the speciality of OB/GYN with no comparable comprehensive clinical training to address men's reproductive health needs.

To address this gap, EngenderHealth convened a two-day meeting in New York in 1997 with diverse professionals who have a wide variety of experience in providing health and social services to men to develop a model for men's reproductive health services.

Although the model was drafted in the USA, it was reviewed by experts in each region of the world and adapted accordingly, and based on their suggestions, EngenderHealth created a men's reproductive health curriculum to train service providers working with men. The curriculum consists of three sections: the first section focuses on helping sites and providers address attitudinal and organizational issues that may affect the delivery of men's reproductive health services and provides basic information on male reproductive health for all staff that interact with male clients; the second focuses on equipping providers to better communicate and counsel men and their partners on reproductive health issues; and the third focuses on training providers on the diagnosis, treatment, and management of diseases and disorders of the male reproductive system.

The first part of the curriculum has been field tested in several countries. Based on the results of the field tests, it has been revised and is currently undergoing a second round of implementation. The second and third parts of the curriculum will be completed this year. Initial results demonstrate that sites where the training has been conducted have made impressive changes to make their services more male-friendly. In Nepal, for example, providers have implemented a client-to-client peer education programme with 20 vasectomy clients and renovated and expanded a male counselling room. In the Philippines, action plan activities developed at the two sites included special male clinic hours on Saturday, development of Information, Education and Communication (IEC) materials, and community education with factory and agricultural workers.

Micro-level activities
In addition to the more "macro-level" work that has framed the Men as Partners initiative, EngenderHealth has also been working at the country and community level. This work has been shaped by the needs of the countries and our collaborating in-country institutions. The following country-level activities highlight the diversity of MAP work that has been conducted at the country and community levels.

<u>A. South Africa</u>
In South Africa, research conducted by the Planned Parenthood Association of South Africa (PPASA), the Reproductive Health Research Unit and EngenderHealth on men's knowledge, attitudes, and practices with respect to sexual and reproductive health indicated that, in the South African context, working with men on issues of gender equity and violence would be key to helping them become supportive partners. PPASA and EngenderHealth, therefore, created a curriculum for PPASA's health educators to help them conduct workshops and form outreach programmes for men. PPASA is now using this curriculum in seven (of the nine) provinces in South Africa. The health educators receive an intensive ten-day training on gender awareness, male reproductive health issues, facilitation skills, and strategies to reach different ages of men in a variety of situations. With these skills and strategies, the educators are able to mobilize men's groups in various community settings to provide information and

hold discussions on gender and reproductive health issues that affect both men and women, and in which men play a key role.

To date, MAP workshops have been held in prisons, schools, community centres, churches, and workplace settings. They reach many different populations of men including traditional leaders, military personnel, boys entering circumcision schools, and members of youth clubs. Recently, PPASA has started to focus its work with groups of men at increased risk for HIV infection. Since the programme was initiated, PPASA has integrated aspects of working with men as partners in reproductive health into their other ongoing work, and has trained staff from other organizations that work with men. Through this integrated approach, it is estimated that tens of thousands of South African men have been reached with the MAP methodology, in a holistic way that helps men to understand the link between gender inequities, violence, and sexual and reproductive health.

A qualitative evaluation carried out with past participants of the programme by an independent evaluation firm in South Africa indicated that their level of awareness with respect to reproductive health issues has significantly increased and is higher than a control group of men with similar profiles. The evaluation also demonstrated that as one of the very few programmes aimed specifically at men in South Africa, the MAP programme has provided important access for men to reproductive health information and services. Most importantly, however, PPASA's MAP programme has succeeded in getting men to rethink their attitudes towards relationships and partners.

B. Pakistan

In 1997, EngenderHealth embarked upon an innovative male involvement project in the Punjab Province of Pakistan, which included the implementation of a diverse but interrelated set of strategies in the areas of research, advocacy, training, social mobilization, community education, and service delivery. The achievements of the programme have been impressive, given the challenges of promoting gender equity in a country where this has traditionally not been the norm. The MAP project has garnered support for male involvement within Pakistan, created various resources that local agencies and institutions can use, identified successful male involvement strategies that can be replicated throughout the country, and, most importantly, demonstrated that when well-planned efforts are made to provide male reproductive health services, men will actively participate in such activities, thereby improving the health of both men and women.

The greatest contribution of the MAP project in Pakistan has been the establishment of evidence-based best practices for providing reproductive health services to men. In 1999, EngenderHealth entered a partnership with several service delivery sites to create demonstration sites for men's services. EngenderHealth worked closely with these sites to orient them to male reproductive health issues, develop strategies to promote services and educate men, train providers on clinical male reproductive health services, develop IEC materials for male clients, and monitor and evaluate each site's progress. Each site developed its own activities for mobilizing men. Some used religious leaders to pass on messages. Others used advertisements and rickshaws that promoted the services offered at a clinic. Still others provided health education at workplace settings to engage men. These efforts, in conjunction with proper training of clinic staff, had a major impact on the number of men seeking services. For example, the Punjab Population Welfare Department's Reproductive Health centre in Faisalabad increased its case load of vasectomy clients from 365 in 1998 to 689 in 1999, which represents an 89% increase in vasectomy clients after the first year of MAP activities. Faisalabad's prorated NSV caseload for 2001 is 1212 clients, which demonstrates a 232% increase of NSV clients compared to 1998. All of the MAP sites demonstrated extremely high increases in caseload. The sites also successfully introduced

new male reproductive health services, including STI screening, diagnosis and treatment.

C. Turkey

Increasing men's involvement in the reproductive health care system without detracting from services for women requires that institutions develop creative initiatives tailored to the unique circumstances of the individual community and culture.

In Turkey, institutions have tried to do this by making use of existing opportunities within the health care system to provide targeted information, counselling, and services for men. Several institutions have established programmes that use couple counselling or group information for men as a way of increasing couples' access to family planning information and services at the time of abortion. These facilities have provided different types of services: some have focused on couple counselling, others have employed group education for men, and some have provided both family planning counselling and vasectomy services at the time of abortion.

The post-abortion counselling programmes have been successful. At one site, according to client records and reports from clinic staff, the couple counselling service resulted in more effective use of contraception and a reduction in repeat abortions: from 1995–1998, between 98–99% of couples who participated in pre-abortion counselling received a method after abortion and the overall number of abortions declined by almost half.

In another programme in Turkey, service providers initiated a postpartum programme for men in response to research findings that indicated the important role fathers play in decisions and practices affecting maternal and child health during the postpartum period and the fact that women wanted to involve their partners more in family planning and child care.

From client input, this site created a postpartum programme for men, which included group education and information sessions on pregnancy, birth and postpartum health. For men who could not attend the sessions, the site provided print materials and a telephone counselling service. An evaluation of the programme indicated that it has had a positive impact on some postpartum health behaviours, particularly regarding the couple's use of a family planning method postpartum. Participants often described the decision to adopt a contraceptive method postpartum as a "couple decision," and couples in which both partners participated in the programme were found to be more likely to have adopted a modern family planning method by four months postpartum (80%) than those couples where the partner had not (55%).

D. Bolivia

In 1998, EngenderHealth/Bolivia, in coordination with the Centro de Investigación Social, Tecnología Apropiada y Capacitación (CISTAC), a Bolivian NGO, became an active participant and supporter of the Working Group on Masculinities. The Working Group defined and implemented a strategy based on participatory advocacy, which included personal reflection on the meaning of masculinity, gender and equity and the promotion of social change on these topics.

The strategy included several different activities: “discussion sessions” to allow individuals from different sectors to discuss their viewpoints on masculinity, gender and equity; qualitative investigations to contribute to the knowledge base in masculinities and gender to support the development of appropriate interventions for the desired change; implementation of workshops on gender, sexuality, and masculinities as a way to reach organizations and individuals not formally involved in the Working Group; and the distribution of information to the public sector to promote, inform and advocate for the inclusion of masculinities in the public debate through the use of the mass media.

The results of this multi-pronged approach surpassed expectations. Between 1998 and 2000, the Working Group:

- Consisted of 128 individuals, representing 67 governmental, private, or international organizations. Each of these individuals attended at least one discussion session. An average of 27 people participated in each monthly discussion.
- Supported five qualitative investigations on men and sexual and reproductive health.
- Cosponsored 13 workshops on gender, masculinities and reproductive health for the Bolivian military, police, and non-profit organizations.
- Promoted the discussion of men and sexual and reproductive health in the newspaper (113 articles), radio (60 programmes) and television (9 programmes).
- Sponsored six public debates on related themes with more than 300 people participating.
- Supported a policy analysis of Bolivian legislation to identify specific political aspects that support or hinder men's access to health care.

E. United States of America

Established in 1999, the Men's Community Network of New York City (MCN), which is coordinated by EngenderHealth, is comprised of nearly 100 organizations in health, employment, technology, and other sectors.

The goal of the MCN is to improve the health of low-income African American and Latino men by increasing their ability to access accurate health information and resources through the Internet. While New York City is home to many organizations serving low-income and minority populations, navigating among these resources can be a daunting task, particularly for those consumers who do not speak English.

As a coalition, the MCN serves as a pathway for communication and collaboration among service providers, thereby increasing the referral potential for providers and expanding low-income and minority men's access to services. In order to provide this pathway, the MCN created a provider web site, which **provides** Internet space and technological oversight for providers and organizations to design their own web pages and to promote community services, referrals, and information. The MCN has created web pages for all participating organizations, the vast majority of which do not have the resources to create their own sites or home pages.

The MCN is now working to establish a companion site for consumers to match the existing site for providers, since low-income and minority men often lack information about social service and health-related issues and generally have a hard time finding information that meets their needs and the needs of their partners and families. Research has found men would like to receive more information not only on health issues but also on such issues as fatherhood, domestic violence, sexuality, employment, training, and education.

LESSONS LEARNED

Through EngenderHealth's work on MAP and the work documented by other organizations on male involvement, there are several lessons that have been identified, which can be used for future programming. These include:

1. To be successful, programmes working with men need to incorporate a gender perspective

Everywhere that EngenderHealth has worked on this initiative, the importance of attention to gender roles and responsibilities is apparent. Work in reproductive health cannot be separated from this context; the idea of vertical programming for gender or special "men's programmes" no longer makes sense, if it ever did.

Without instituting a gender perspective, projects and programmes not only risk re-enforcing damaging stereotypes or mores, but they also hold back progress that many societies are making towards more equitable relationships between men and women. Moreover, there are critical people in every community who have a stake in the success of these programmes and their ultimate impact on health. As a result, it is *always* worth taking the time to listen to what young people have to say; to talk with traditional providers who may find themselves either at the forefront of health care or marginalized, depending on the "cure" that a client seeks. For example, in many places, older women are important message bearers about health, even if they are not officially recognized in this capacity.

2. Realizing that men are concerned about and interested in RH

Everywhere EngenderHealth has worked, it is clear that men **are** concerned about RH. While conventional wisdom has suggested that this is not the case or that men consider it a women's issue, the organization has not found this to be true in any place where it has worked.

EngenderHealth conducted a six-country vasectomy decision-making study in the US, Rwanda, Sri Lanka, Mexico, Kenya, and Bangladesh and it was surprising to learn the extent to which men actively thought about their partner's health and cited it as a reason for choosing vasectomy.

In Pakistan, some research commissioned with the Population Council found that the surprisingly high rates of the effective use of withdrawal were based, in part, on men's concern for their wife's health.

In Mexico, men who are part of small working groups asked us a number of questions about women's bodies, explaining that they had never had the opportunity to ask these kinds of questions before.

3. The importance of reaching out to men with special communication strategies

As summarized by the UNFPA technical report on male programmes, communicating or marketing programmes for men "must be tailored to male audiences, since men are not a homogenous group and must be differentiated". For many people, especially men and young people, clinics represent a very small part of life. Accordingly, outreach is critical and should target new outlets such as the workplace or places where men tend to congregate. When trying to attract male clients to new or expanded services, male-specific information,

materials, and counselling must be provided. Through EngenderHealth's work, it has learned of, and in many cases tried, creative ways to reach men. Here are several examples:

In Kenya, EngenderHealth worked with a local NGO to run small newspaper advertisements on vasectomy in local papers for several months which included coupons that interested men could clip, fill out, and mail for further information on vasectomy. These advertisements produced over 800 written enquiries within a few weeks.

In Ghana, the National Council on Women and Development has organized several workshops to train police, male leaders, chiefs, and labourers on how to present positive messages about reproductive health to men. Also in Ghana, satisfied vasectomy clients are trained as peer educators and promote joint decision-making on radio stations and through community presentations.

In Mexico, Mexfam's *Gente Joven* or Young People's programme, has had success reaching young men through an innovative peer educational outreach programme targeting peers in schools, streets, the workplace, and other locations where young people congregate. Also in Mexico, *Salud y Genero* (Health and Gender) has found women to be the most important communicators and advocates for men's involvement in the workshops they convene on gender relations, sexuality, and/or male involvement.

4. Service providers need additional training to work with male clients

Since most reproductive health efforts have been focused on female clients, providers need additional training to increase their comfort and competency for working with male clients. In fact, it is providers who have been asking for help, and their requests are getting louder and more frequent as men's and women's interest in men getting services grows. In fact, when EngenderHealth looked for training tools to assist providers who wanted to work with men, little was available. As a result, the organization embarked on a process of creating a men's reproductive health curriculum.

5. There's no magic formula: new service delivery models are essential

Observation and implementation of MAP programmes illustrates that many different models have been used and are needed to reach men. In New York City, for example, the Community Healthcare Network deploys a fully equipped medical mobile van for evening visits to communities throughout the city providing HIV testing, education and counselling; STD diagnosis and treatment; physical exams; immunizations; family planning services; and pregnancy tests. Over half (60%) of the clients attending these vans are men, compared with less than 5% of the clients seen by the van's sister stand-alone clinics.

Another innovative, effective, and convenient way to reach large numbers of men for reproductive health and family planning is through the provision of family planning information and education in the workplace. In Turkey in the early 1990s, EngenderHealth worked with the Turkish State Railway Hospital to find out how educational sessions for male railway workers affected their family planning knowledge, attitudes, and behaviour. Three monthly educational sessions were conducted for 25 men, 68% of whom were not using a family planning method before their last pregnancy. After the training, 91% were using a family planning method.

Other innovative programmes include a programme in Uganda, where men who offer bicycle fares called "boda boda" often wait for business under a tree. This gathering of men has provided a great opportunity for health workers to initiate conversation about RH care.

In Ghana, one EngenderHealth staff member has initiated a call-in "ask the doctor" show. Because men's identities are not revealed, he finds that the questions are often very specific and, at times, more basic than he would expect. Of particular concern to men who call in has been sexual performance and concern about impotence.

6. Men's needs have to be understood holistically

Both the research and our own work have pointed out that men prefer to visit facilities that offer an array of services, including general medical care and treatment for urological problems, sexual dysfunction, STDs and infertility.

EngenderHealth's experiences through our case study research and service delivery bears out the fact that men seek services for reasons other than reproductive health. Thus, many programmes use services men are seeking to get them in the door, and then use that opportunity—or "teachable moment" as Bruce Armstrong of New York City's Young Men's Clinic calls it—to provide information and services on reproductive health.

The Young Men's Clinic first got adolescent males in the door by offering physicals to engage in sports or to obtain working papers—and then used that opportunity to address the broader range of STDs and pregnancy prevention.

In Ghana, medical providers at the EngenderHealth workshop confirmed that the most common reason for men seeking out reproductive health care is to receive treatment for some type of sexual dysfunction including "sexual weakness", impotence, or infertility—a point confirmed by Planned Parenthood Association of Ghana staff. Moreover, recent research in both the US and Ghana found that concern over AIDS has resulted new interest in reproductive health on the part of men.

In all five of EngenderHealth's and IPPF's 1998 Latin America case studies, the organizations involved have recognized that focusing only on family planning, or HIV/ AIDS, or vasectomy is insufficient for the needs of men. Hence, in addition to addressing those reproductive health needs, programmes also include discussions on male-female relationships, sex education for children, fatherhood, men's roles, and the value of work, violence, and alcohol use.

7. Integrate services for men into existing structures or services for greater sustainability

Many programme managers assume that programmes for men require a separate department with its own staff and budget. In the face of budget constraints, however, this is unrealistic. Instead, the key to initiating and sustaining programmes for men is to adapt existing programmes for women to include men, while ensuring that women's needs are still met. Profamilia's experience in Colombia makes this case very strongly.

In 1985, Profamilia opened three clinics for men and subsequently opened five more. At the first three clinics for men—in Colombia's three largest cities, Bogotá, Medellín and Calí—men have either a separate entrance or space that has been adapted for them. In Bogota, men

have their own clinic, and women are welcome there as well. All three of the clinics, until recently, had separate staff and services for men. However, with the advent of national health insurance and the subsequent decline in numbers of clients (as well as the decline in international funding for family planning in Colombia), Profamilia decided that it was financially unsustainable in most locations to provide stand-alone services for men. Staff working with men in all clinic sites in Colombia now generally work with both men and women clients, and the future for Profamilia's services for men lies in bringing men into existing clinic spaces utilizing existing staff who also work with women.

8. Much can be done at no/low cost

As pointed out in the UNFPA technical report, initiating male involvement programmes need not be an expensive proposition. There is much that can be done to make existing services more "male-friendly" with limited capital investment. These include:

- Training health educators in gender sensitivity and messages for men.
- Dispatching trained health educators and outreach workers to workplace sites.
- Rearranging hours of the clinic to accommodate women's and men's needs.
- Reorganizing facilities so that there is private counselling space for men, women, and couples.
- Making the environment of the clinic welcoming for both sexes.
- Training clinicians in male exams.
- Training surgeons (or other providers doing tubal sterilization or other surgical procedures) in vasectomy.
- Encouraging women to come with their partners for counselling and services if they desire.

9. Support leadership at all levels for working with men

Leadership is needed at all levels, from the signing by a country's leader of international agreements such as those reached in Cairo and Beijing, to training a local provider to talk to men about contraception, sexuality, and fatherhood, if a programme reaching out to men is to be successful.

EngenderHealth learned this firsthand when it brought together individuals representing all sectors involved in a given country programme—various ministries, nongovernmental health providers, and the media—at an interregional workshop such as the one held in Mombasa, and realized the impact it had on initiating Men As Partners programmes in those countries.

Since their return home, five of the nine country teams participating in Mombasa convened in-country workshops to begin to implement the programme strategies they developed. The fact that one of the first in-country workshops convened post-Mombasa was in Punjab, Pakistan is due in no small part to the fact that support for this initiative existed at the Divisional and District levels, spearheaded by the Secretary of the Population and Welfare Department in Punjab, and also included writers, educators, members of the print and electronic media, private sector entrepreneurs, and a variety of service providers. It also had the full support of the Director of the Women Division.

Throughout the USA, a recent evaluation of successful public-sector vasectomy programmes found that those programmes that had an entire cadre of staff—from receptionists to counsellors to physicians—who were committed to offering vasectomies, saw their caseload

increase, compared to those sites where staff did not universally welcome the new vasectomy service.

10. Recognize the need to work on difficult or troubling issues

When EngenderHealth originally set out on our Men As Partners initiative, we focused a great deal on reproductive health issues as defined by family planning and STD/HIV transmission. The agency learned, however, that this conceptualization had to be broadened to include a number of other important and difficult issues.

In particular, the development of the men's health curriculum was geared mostly towards health topics, with the plan to include one module on organizational topics, and another on communicating with and counselling men. However, experience of follow-up work in Africa and Asia, coupled with on-going research in Latin America, indicated the need to expand the Organization's work with men to include the issue of domestic violence towards their partners.

11. Recognize the need to continue asking questions

Finally, a review of the lessons gained from research and of the agency's programmatic experience in male involvement programmes shows that a lot of progress has been made in the past several years in terms of improving the agency's knowledge base of what works when programming services and education for men, but there are still some important questions that need to be addressed, including:

Service design: What are we assuming men and women want for men? What do they really want? What is the best service design?

Costs: What is the true financial cost of adding education and services for men, and what is the cost of *not* adding those services?

Communications and marketing: How do we design effective, culturally sensitive and context-specific marketing strategies for men?

Empowerment issues: How do men and women negotiate sexual behaviour? What happens when one partner is dramatically disempowered?

Masculinity: How are social constructs of identity created? How do men internalize notions of what it means to be a man? How does this impact women and men?

Sexuality: What are men's attitudes and practices with regard to sexuality?

CONCLUSION

Since the mid-1990s, significant progress has been made towards male involvement within the reproductive health community. Unfortunately, however, in many places, male involvement continues to be seen as a programme and not a paradigm. In order to make a sustained difference in the reproductive lives of both men and women, it is critical that men's

involvement be seen as a framework that can be applied to all areas of reproductive health, including safe motherhood, post-abortion care, cervical cancer prevention, adolescent health, and gender-based violence.

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2.3 Programming for men in promoting safe motherhood

2.3.1 Involving men in safe motherhood: the issues

Dr A.B. Ntabona

INTRODUCTION

Safe Motherhood refers to a set of interventions and services the effectiveness of which is well documented and which are required at household, community and health sector levels in order to "*enable every pregnant woman to go safely through pregnancy and childbirth and provide couples with the best chance of having healthy infants"*. Thanks to intensified efforts on the part of the international community, access to these interventions and services is being elevated to the level of a human rights issue, in particular rights relating to life, liberty and the security of the person; rights relating to the foundation of families and of family life; rights relating to health care and the benefits of scientific progress, including health information and education; and rights relating to equality and non-discrimination.

Ten action messages were developed at the Safe Motherhood Technical Consultation held in Colombo, Sri Lanka, in October 1997, which clearly indicate the way forward in this field during the current decade in relation to changing the political environment around women's health end empowerment, and in relation to the design and implementation of programmes.

Most WHO Regions and Member States have built on the above guiding principles to develop regional and country reproductive health strategies which focus on accelerated reduction of maternal mortality and severe morbidity related to pregnancy and childbirth as a top priority component of reproductive health programmes. Male involvement and participation in the implementation of these strategies is also underscored, given the role of men as leaders and decision-makers at household, community and policy levels. However, it is widely recognized that men are often marginalized by maternal health services and are provided with limited access to basic information and knowledge to help them make informed choices and decisions in order to protect and promote their own health as well as that of their families.

The presentation that follows highlights some issues that are commonly raised by men in the communities regarding the new move to enhance their participation. It is intended to stimulate the discussion on how men's perspectives can be factored into the design of social mobilization strategies for ensuring safe motherhood.

Men as gatekeepers

Improving maternal health: men have a unique role to play. Too often in the past, men were presented as an obstacle and not as part of the solution. The majority of interventions and services to promote sexual and reproductive health, including care during pregnancy and childbirth, have been exclusively focused on women. Yet, men and women living in the same society are influenced by the same beliefs about the roles and responsibilities that are appropriate for each gender. Men are not the only ones to blame for the slow changes in gender-based imbalances. In societies where maternal mortality and severe morbidity are high, men and women face similar challenges related to the social, cultural and political complexities underlying these events, including the pressure for high fertility and lack of

safety measures when obstetric complications arise. Therefore, it should be assumed that, for all the steps leading to maternal survival as defined in the *Mother-Baby Package*, there is always a man standing by the side of every woman knocking at the "gate" before, during and after each pregnancy (Video *Opening the gate to life*) (WHO, 1995).

Significant power differentials within the men's group. At the household and family levels, the men's group is comprised of women's husbands/partners, fathers, brothers, in-laws, and other male relatives. They do not have the same power in influencing the male's behaviour in enhancing mutual supportive relationships within couples. Community-based initiatives need to take this differentiation into account in addressing the issue of male participation in safe motherhood interventions. For example, husbands/partners should not only be approached through public information and education campaigns, but should also have more private interaction with health care providers. There may also be need for closed sessions among male elders (fathers, in-laws) and community leaders when deliberating on customary issues that impinge on pregnancy and childbirth process, e.g. why delaying the age of marriage and first birth is important, the consequences of selected traditional practices. Other able-bodied males, e.g. the brothers and other male relatives who are usually called upon to speed up emergency referrals, may require more practical information on how to deal with danger signs during pregnancy and childbirth. Clearly, lumping everybody under the concept of men's group in a community could result in overlooking the positive effects of this differentiation on the pregnancy outcome and survival of women in that community.

The death of mothers is a devastating event for the health of the bereaved husbands, too. We need to remind ourselves of this within the context of the World Health Day 2001 theme which drew our attention to mental health. The adverse effects of maternal deaths on the survival and well-being of newborns, young children and daughters left behind is well documented. In our effort to elicit men's contribution to reducing maternal mortality, we need to do the same investigation regarding bereaved husbands: do they always cope with the break-up of the household after the death of their wives? Are they able to prevent this break-up from happening? Thus far, DALY (Disability-Adjusted Life Year) and other related disease-burden measurements and verbal autopsies of maternal deaths have not looked at the changes in the physical and mental health status of men who have lost their spouses due to pregnancy-related causes. Men would be interested in knowing that by ensuring safer outcome of pregnancy for their wife/partners, they are actually investing in one of the most effective ways of preventing their own premature death as well.

Meeting the increased expectations

Pregnancy and childbirth are traditionally seen as the domain of women. For the majority of men, even the most educated ones, these events are "shrouded in mystery". Hence their fear of losing face when they are asked to participate in solving problems which suddenly emerge in this area. This fear results in wide-ranging reactions which can grouped into four main categories:

"We are already involved": Although this statement may seem too naïve, it is often stated in good faith. This "minimalist support" attitude should be examined in the light of the limited information that men have about the variety of pregnant women's needs and their lack of clarity about their roles and responsibilities in meeting these needs. Evidently, the degree of involvement will also vary according to the social and cultural context. In the Gambia, for example, men reported that it is their duty to cover the financial cost of antenatal care for each of their multiple wives, but the reasons for completing the recommended four antenatal care visits are not yet obvious to them.

"Many factors come into play which are beyond our control": Although safe motherhood interventions are reportedly cost-effective, public investments in this area have always been lagging. Consequently, whatever the good will on the part of men, their participation in tackling safe motherhood issues is constrained by externalities, such as widespread poverty, multiplicity of physical barriers to access to maternity care, inadequate health infrastructure, low morale of personnel. Too often the community-based mechanisms to which they contribute in the form of risk-sharing fund loans (mutuelles) do fall short in overcoming these macro-level constraints.

"We need to be educated about the new responsibilities": male involvement in safe motherhood is still a new topic compared to other areas of sexual and reproductive health, such as family planning, prevention and management of STIs, including HIV, and prevention and management of sexual and gender-based violence. This may explain why the health care providers themselves also admit feeling uncomfortable in engaging men in the pregnancy and childbirth process. For example, companionship during labour (presence of a female relative or husband) is being introduced in some facilities as a very effective intervention for improving delivery outcomes, including a reduced need for caesarean section. It is reportedly an overwhelmingly positive experience for the husband as well. However, there are not yet clear-cut guidelines on how far the partner/husband's participation can go. Some pioneers of these interventions find it extremely daring to let the husband actively participate in the third stage of labour or to allow him to take pictures of the actual birth event. The adverse effects on the sexual life of the couple of what they saw is sometimes unpredictable. Not to mention the lack of adequate preparation of the health care providers in the event that the husbands start panicking, or perhaps faint, when a serious and life-threatening complication arises.

"We need more time for the change": Since the issue of male involvement in sexual and reproductive health, including safe motherhood, is built on gender-based roles within the entire society, some aspects could achieve dramatic changes within one generation, whereas others might remain wishful thinking for a long time or be naturally impossible to accomplish (e.g. men taking turns to get pregnant so that they know from experience what it entails). As a first step, there is need to develop ways and means to implement the ICPD+5 recommendation which urges Governments and their partners to "support public health education to create awareness of the risks of pregnancy, labour and delivery and to increase the understanding of the respective roles and responsibilities of family members, including men, as well as of civil society and Governments, in promoting and protecting maternal health" (United Nations, 1999). Also, programmes engaging youth in discussions on sexuality, reproductive health and fatherhood should use this opportunity to also cover issues related to mutually supportive male-female relationships during pregnancy and childbirth in addition to those related to male participation in caring for children.

CONCLUSION

Male involvement in sexual and reproductive health has become a topical issue since the concept of reproductive health and rights was adopted at the ICPD in 1994. While the implications of this initiative are deeply rooted in the way each society defines gender roles and responsibilities, progress in the involvement of men in safe motherhood specifically, i.e. in matters directly related to ensuring well-being and survival of mothers during pregnancy and childbirth, might take more time. According to the majority of men in most societies, this area is traditionally seen as the domain of women and still shrouded in mystery. Given that the aim is to promote mutually supportive male-female relationships during this critical period

of women's life, this subject could be internalized more rapidly through relevant educational opportunities offered to young people.

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2.3.2 Male involvement in a reproductive health programme: where we stand today. A critical review of the initiatives taken in India

Dr M.E. Khan, Dr J.W. Townsend and Dr U. Rob

INTRODUCTION

Since ICPD Cairo (1994), male involvement in reproductive health has become a fashionable topic and is mentioned in most forums addressing the issues of reproductive health, gender equity and empowerment of women. Very little however, is known about how to enhance male involvement. Given the patriarchal social structure of South Asian countries, bringing about changes which strive to enhance male involvement and the gender equity this implies, is not easy. Against this backdrop, it is interesting to take a look at how the Ministry of Health and Family Planning, Government of India (MOH&FP), which is committed to implementing ICPD Programme of Action, is addressing these issues. What efforts have been made either by government or by NGOs to involve men in reproductive health and safe motherhood and what results have been achieved? Are innovative and replicable model(s) to enhance male involvement available?

DATA AND METHODOLOGY

To answer these questions in the present paper, three sets of data have been used. These include:

- review of various policy documents;
- in-depth interviews of 32 national, state and district-level programme managers;
- review of 11 NGO projects having a male involvement component.

In the present study, male involvement was defined as participation of men in activities which help and facilitate:

- access to information about the sexual and reproductive health of men and women;
- the prevention of unwanted consequences of sexual activities - unwanted pregnancy and transmission of STI/HIV to self and partners;
- treatment of the unwanted consequences for self and partners and
- the ensuring of safe motherhood.

FINDINGS

Content analysis of policy documents:

All relevant documents of MOH&FP produced since 1992 including policy statements, programme objectives and Approach Papers of the Planning Commission were reviewed to identify the Government's commitment to male involvement in reproductive health programmes. Table 1 summaries the findings of this review.

Table 1: Content analysis of various programme documents from the point of view of male involvement

Name of document	Year	Content with respect to male involvement
Action Plan for Revamping the Family Welfare Programme	1992	A 12-point strategy for revamping the family welfare programme. No mention of gender disparity or male involvement.
Draft National Population Policy	1994	A significant departure from demographic goal-oriented population policy. Suggests holistic approach to the family welfare programme. Issues related to the elimination of gender inequality are raised prominently in many places. Need for male involvement is discussed in a gender framework. Indicates limitations of top–down target approach and justification of its withdrawal and replacement by a needs-based approach.
Manual of Target Free Approach in Family Welfare Programme Manual of Community Need Assessment Approach	1996 1998	Neither gender issues nor male involvement find any reference. Some of the forms designed for monitoring purposes, collected data by sex.
Reproductive and Child Health Programme (RCH)—Schemes for Implementation	1997	Outlines philosophy of RCH, stresses urgency of making the programme needs-based, client-oriented and demand-driven. Quality of services, follow-up of the acceptors and client satisfaction are considered important pillars of the programme. Provision of Mother & Child Health (MCH), Reproductive Tract Infection (RTI)/Sexually Transmitted Disease (STD) and family planning services is conceived of as a package of services which cannot be separated. Interestingly, however, no allowance is made for gender issues or male involvement. Need for interpersonal communication in providing district level information to women is emphasized. Among the list of interventions, a line item includes "IEC activities and counselling on health, sexuality and gender."
Reproductive and Child Health Programme—Progress Report up to 31 March 1998	1998	Gives progress report of RCH programme. No reference to gender or male involvement.
Population, Family Welfare and Health: Chapter in Approach Paper to 9th Five-Year Plan 1997–2002	1998	Only a two-line reference is made, stating, "promoting male participation in the planned parenthood movement and increasing level of acceptance of vasectomy" (p.85).
Survey Instruments for RCH Baseline Survey	1998	No questions on husband-wife communication, gender issues or women's autonomy in decisions about reproductive goals. In household schedule, a set of 13 questions to a male member of the household (not necessarily the husband) on STD and AIDS awareness and the disease.
National Population Policy	2000	Under the section "Un-served Population Group" in a paragraph on "Increased participation of men in planned parenthood" the role of men in family formation is recognized. Need for promoting non-scalpel vasectomy and focusing family planning educational campaigns on men is emphasized.

As the table shows, while the policy documents place major emphasis on making safe motherhood services needs-based, client-oriented and demand-driven and improving quality of services, only the 9th Five-Year Plan mentioned—in two lines—the need for addressing gender disparities and male involvement. The Population Policy which was recently approved also briefly discusses this issue.

In the absence of a clear policy directive and a monitoring system with built-in indicators to measure achievements of the programme in enhancing male involvement in reproductive health programmes, it is difficult to understand how the Family Welfare Programme could address this issue, which is not only new for programme personnel, but also difficult to implement.

Observations from programme managers' in-depth interview

In-depth interviews with programme managers at different levels clearly illustrate this dilemma. The top programme managers, both at the state and central levels, have good comprehension of the issues involved. They appreciate and agree that male participation in the provision of reproductive health services is critical for the success of the RCH programme, but they are not sure how to do that. Lack of innovative and replicable models was mentioned several times during the interviews. Other important hurdles which they see are the lack of intersectoral coordination and the need for broad-based social change addressing issues related to gender equity. As one senior official put it:

"To achieve what you are asking (enhancing male involvement), action has to be taken at two levels—service delivery and society at large. Unless both are addressed and required changes are made, we may not succeed to the desired level. However, given the limited resources and time to achieve some positive results, at present we can concentrate mainly on delivery systems. We are trying to reintroduce vasectomy in the programme and enhance access to condom through various channels."

On the same question a top bureaucrat from the State Government said:

"Change of mind set has to be done at all levels including politicians and ministers. Most of these politicians represent mentality and ideology of the rural community to whom we are trying to change (sic)*. Because of this I am seriously handicapped in introducing family life education at school and college levels. My minister fears that introducing such course amount to 'spoiling young students and encouraging them to indulge in pre-marital sex.'*

What NGOs are doing

A search of the literature indicates that at least 11 NGOs have experimented with one or the other intervention to involve men in safe motherhood and reproductive health. The NGOs covered here include Family Planning Association of India (FPAI), Social Education for Women's Awareness (SEWA), Child in Need Institute (CINI), Deepak Foundation, Vellore MC, the Community Aid and Sponsorship Programme Plan (CASP), Adithi, Centre for Health Education, Training and Nutritional Awareness (CHETNA), Talking About Reproductive and Sexual Health Issues (TARSHI) and Family Welfare and Education Services (FWES). The review shows that all these projects were initially planned for addressing only women's reproductive needs. Male involvement was an afterthought. In

some cases, a male component was included in the project on the demand of women themselves who felt that unless their husbands and other male members are also educated about reproductive health issues and involved in services provision, they could not get the greatest benefit from these programmes. This led to the addition of a male component to the programme.

The interventions to involve men which were tried out varied in nature, depending on the thrust of the NGO's reproductive health projects. It included the addition of male workers, using male peer educators, contacting husbands of pregnant women, contact with newly married couples, educational camps, question boxes in schools and male clubs.

The populations covered ranged from 100,00 to 600,000 persons. However, in the majority of cases the population covered was of around 100,000 persons.

As most of the NGO's projects were planned as service delivery projects, the interventions were rarely properly designed, implemented or evaluated. As a result, assessing the precise impact of the interventions is difficult. However, they certainly provide indications as to which interventions are more promising than others. Interventions or programmes which appeared more promising in changing attitudes as well as behaviour include:

- making use of male health workers as well as women health workers;
- younger male providers are more effective and better change agents;
- using peer group educators;
- contact with newly married couples;
- contact with husbands of pregnant women.

Interventions which appeared to be helpful in dissemination of knowledge include: a hotline, community involvement through meetings, camps, question boxes in schools and special educational camps or exhibits for men.

Interventions that are either not effective or achieve unclear results include: clubs (men's club, adolescents' club), male-only clinics and condom vending machines.

In the absence of a well-designed study, the conclusion arrived at above could be questioned, but at least these NGOs' initiatives give some useful leads as to where to begin. It is suggested that some of the more promising interventions should be properly designed, implemented and evaluated before planning up-scaling.

CONCLUSION

The study thus reveals that a serious effort to involve men in reproductive health has yet to be made in India. While the NGOs have taken some initiative and could provide some leads as to possible interventions, ultimately it is focused policy and programmes on the part of government which will make a difference. At present, the Government has not crystallised any definitive policy or programme which could help in the involvement of men.

In South Asian countries, where men are equally subject to strong social constructs which discourage them from straying from socially ascribed 'gender roles', involving them in safe motherhood or promoting gender equality demands intersectoral coordination between various ministries such as Education, Women and Child Welfare, Health and Family

Planning. In the absence of a collective initiative of this kind, efforts for male involvement within the Ministry of Health and Family Planning are reduced to a few initiatives to promote vasectomy and the condom—male involvement in reproductive health remains a remote goal.

2.3.3 Field experiences in involving men in safe motherhood

Dr Imtiaz T. Kamal

Abstract

The alarmingly high maternal mortality ratio in Pakistan is influenced by multiple factors, including women's extremely limited freedom of action. The National Committee for Maternal Health (NCMH) is developing a network of organizations interested in women's health in general, and safe motherhood in particular.

Until recently most information, education and communication (IEC) activities aimed at educating women about conditions during the maternity cycle for which they should seek medical help. A suggestion came from the women that similar programmes should also be held for men because, if men are made aware of women's needs for medical attention, hopefully, they will react positively.

Precedents and some documentation existed for male involvement in promoting and/or supporting contraceptive practices in Pakistan, but no example was available of any efforts to elicit supportive behaviour on the part of men during pregnancy and childbirth.

With the financial assistance of the Canadian International Development Agency (CIDA) and using the platform of various NGOs, NCMH, despite some apprehension, launched an experimental province-wide project in Sindh entitled "Male Involvement to Promote Safe Motherhood." Seminars costing between US$40 and $50 per seminar are being held for groups of 50 to 60 men in hard-to-reach areas. A video film on two of the killers i.e. haemorrhage and eclampsia is shown, followed by open discussion on other killers, preventable maternal deaths, STIs, HIV/AIDS and fertility regulation. Inexpensive handouts in the national language are distributed. After getting feedback from communities, the original teams of male facilitators were modified to include female health professionals.

Many myths were exploded within the first two months. It was proved that: contrary to common belief the average male is interested in learning about pregnancy and childbirth; not only the illiterate or the rural male, but also the urban, supposedly educated male needs information about reproductive health; men are not shy about seeking information from a female health care provider about pregnancy and childbirth related topics; men want to discuss sexuality related issues but with a male health professional; there is no opposition of any kind from religious leaders when motherhood is the theme of a community activity and/or of an open discussion.

The project was only for one year and is coming to an end. So far 15 organizations have participated, including the Pakistani Navy. The initial follow-up in two communities indicates a slight rise in the number of women attending antenatal clinics. It is too soon to talk about the impact of male participation on maternal mortality rates (MMR), but the hypothesis is that it will have a positive effect by reducing the first two of the three delays. From the reaction of men in these seminars however, it seems that women might get better support than before when they need it, provided more men can be reached and sensitized. NCMH plans to identify resources to make it a nationwide IEC programme and evaluate the outcome through maternal death audits.

Key words: maternal mortality, male involvement, myths, safe motherhood, support.

BACKGROUND

Note: it is important to appreciate the environment in which the average Pakistani woman spends her life. Only then can the need for special strategies to elicit male support for making motherhood safe be understood. Those readers who are familiar with cultures where women have little control over their own lives can skip part one of this paper if they wish.

The Country

Pakistan, the world's 7th most populous country, came into being in 1947 when India got its independence from the British and at the same time, was divided into two countries, i.e. Pakistan and Bharat (commonly known as India). The areas with a Muslim majority became Pakistan, but in two parts, East and West Pakistan, separated by a thousand miles of Indian territory. This not being a very realistic situation, East Pakistan separated in 1971 and became Bangladesh. Hence, the present Pakistan is what was originally West Pakistan.

One of the developing countries, Pakistan is not independent of external financial assistance in various forms and shapes. The gap between rich and poor is wide. It is a land with a rich historical and cultural heritage, but it is facing many problems including political turmoil and a rapidly growing population, which doubles every 20 years. The health of the masses is one of the major concerns of the government. (See Annex 1 for country profile.)

Health Care Delivery System

With per capita expenditure of US$ 11.00, Pakistan’s investment in health is the lowest in Asia and one of the lowest in the world. An impressive health care delivery system infrastructure was designed to reach the remotest areas. Though structurally strong and accessible to the rural population within 5 km, the system is weak functionally, hence poorly utilized (Federal Bureau of Statistics, 1992).

Health indicators reflect the economic status of the masses and of the limited availability of public sector health care facilities (Pakistan Medical Research Council, 1998). Eighty per cent of health care is provided by the profit-oriented private sector and by NGOs. The quality of care ranges from excellent and to very poor. State of the art medical care is available in large cities, but only to those who can afford it. The average Pakistani depends on household remedies, easily available over-the-counter self-prescription drugs, traditional health care providers and spiritual healers. As a last resort or if available and affordable, services are sought from the self-employed “doctor”, who could be a medical graduate or an unqualified medical practitioner/quack. It is not uncommon for the trusting public to be subjected by both categories to the irrational use of drugs, including antibiotics and steroids.

Access to health care from the cradle to the grave is more limited for the female than for the male, because of the value attached to sons. Gender differentials in mortality figures explain why the male–female ratio is 108:100. This in itself is indicative of the low status of women in Pakistan (Jafarey, Rizvi & Kamal, 2000).

Status of the Pakistani female

The Pakistani woman represents the two extremes of high status and low status. On the one hand, there are examples of her political empowerment, achieved through various possible strategies, as in the case of the election of a woman in open elections to two terms of office as the first Muslim female Prime Minister. Some women have been privileged and educated enough to be appointed ambassadors to foreign lands and to represent Pakistan in the United Nations etc. Professionally, women can be pilots and fly aeroplanes, perform the most intricate surgery, defend women's rights in courts of law and in other public forums, head NGOs, run successful businesses, compete for international jobs at the regional and global levels, become regional advisors in UN agencies, head one of the largest UN organizations, win international awards and so on. But these examples are too few to be of real significance—the proportion of women in top managerial positions is 3% and in the national parliament only 1.6% (Jafarey, Rizvi & Kamal, 2000).

On the other hand, the majority of her lot are illiterate, undernourished, overworked and victims of various kinds of violence including forced marriage, sexual abuse and honour killing. Although the Constitution guarantees her equal rights and the promise of equal opportunity, throughout her life, the Pakistani woman remains by and large a second class citizen under the male dominance of her father, her brother or her husband and, later on, even her son.

The premium on her virginity, chastity and celibacy if single or widowed is very high. For this reason she is housebound by selected sanctioning of her mobility. While she is allowed to go to fetch water and firewood, pick cotton and work in the fields, she cannot, without permission and or a chaperon, go on her own to see a doctor or visit a health facility.

Marriage is almost universal. The age of marriage is rising (Pakistan Medical Research Council, 1998) but the marriage of teenage girls is still very common. To produce children, particularly sons, is an expected function of a female.

Health of the Pakistani woman

In the last 50 years there has been some improvement in the health status of women, but progress remains to be made. Her life expectancy has increased (Federal Bureau of Statistics, 1998) but the quality of life has not improved much. Lack of an identity, overwork, high fertility, poor nutrition (National Institute of Health Report, 1998) and low quality and/or non-availability of health services render her vulnerable to physical ill-health and death. Based on the scant information available on the mental health of women, depression is quite common among the adult female population (Unaiza, 2001).

The health indicators of the average Pakistani woman are worse than in many other countries which are at the same or even lower economic level (Jafarey, Rizvi & Kamal, 2000). The married fertile woman is at much greater risk of morbidity and mortality.

Maternal Health, Morbidity and Mortality in Pakistan

Maternal Mortality Ratio (MMR) of Pakistan is alarmingly high. Every 20 minutes a maternal death takes place. The estimated MMR is 340/100,000 live births (WHO and UNICEF, 1996).

For every woman who dies, 27 are left with morbidities. Vesicovaginal fistulae are the worst of these. Some women are in such a state that they wish they had not survived.

The multiplicity of factors influencing maternal health and maternal mortality are so intertwined that it is humanly impossible for one programme or individual institutions to address all of them. Some of the specific factors/indicators influencing maternal mortality and morbidity are given below. If these are added to the poor general health and low status of women, it becomes obvious that the estimated MMR (20) does not present a true picture:

- The fertility rate, which has declined from 6.2 in 1987 to 5.2 in 1998, is still 65% higher than the average of countries with low-income economies (National Institute of Population Studies and London School of Hygiene and Tropical Medicine, 1998).

- The current contraceptive prevalence rate (CPR) is quoted at 28% for modern methods and 32% for all methods. CPR has had its ups and downs in the last 30 years, depending on the attitude of the national leadership which influences population policies and the availability of family planning information and services (Government of Pakistan, 1984–1985; Federal Bureau of Statistics, 1992 and 1998; National Institute of Population Studies, 1992; National Institute of Population Studies and London School of Hygiene and Tropical Medicine, 1998). Family planning services are officially available to married women only through the public and the private sector service outlets. Contraceptives are, however, available from pharmacies without prescription. But culturally, a woman is not generally in a position to go to a pharmacy and buy a contraceptive. She can send a child to get a packet of oral contraceptives with or without the husband's knowledge.

- Approximately 5,000,000 births take place every year (9 babies are born every minute). Forty per cent of the births are less than two years apart (Jafarey, Rizvi & Kamal, 2000). The population doubles every 20 years.

- Eighty-three per cent of rural and 60% of the urban women receive no antenatal care (Jafarey, Rizvi & Kamal, 2000).

- Eighty per cent of the births take place at home. Only five per cent of these are assisted by a skilled birth attendant. All the others are handled by the traditional birth attendants (TBAs), family birth attendants or the woman herself. Some of the TBAs have received some theoretical training, but they are neither supervised nor supported.

- Two of the three delays are a common occurrence at the community level (Jafarey & Korejo, 1995), i.e. delay in recognizing the danger signs throughout the maternity cycle, particularly during the intranatal period, and deciding that medical intervention is required; delay, due to many reasons, in getting to the source of medical help, e.g. non-availability of transport in an emergency or financial constraints or the absence of the male head of the household to give permission.

- The third delay is not uncommon. Emergency Obstetrical Care (EmOC) services are either not accessible or not affordable or not functioning properly.

- Nutrition of the pregnant woman is poor (indicated by 25% low birth weight neonates).

- Unplanned and unwanted pregnancies are the rule rather than the exception. Preventing a pregnancy is considered the woman's responsibility.

- Unsafe abortion as a sequel of unplanned pregnancy is one of the five killers of women (Fikree, Rizvi & Hussain, 1996).

- Theoretically women have equal access to whatever health facilities are available. In reality they do not have the freedom of movement and or financial capacity to utilize the health services, even when these are accessible/available.

- Almost all of the above are issues related to women. Logically, women should be able to deal with matters related to their own fertility and health but in reality they cannot take a decision and or act on a decision. Much stronger factors than logic, however, are influencing women's lives, not only in Pakistan, but in all the developing countries.

Strategies to address some of the maternal health/death issues

In the last five decades there have been many plans and strategies designed to address the issue of high maternal mortality (Tinker et al., 1994). Mother and child health is dealt with in every National Health Plan and Health Policy, but the implementation of these plans is generally somewhat deficient. On paper:

- The number of public health facilities has risen from 6,017 in 1981 to 10,924 in 1991, and to 12,000 in 1997 including 800 Mother and Child Health Centres.

- Most of these are either non-functional or work only a few hours in the morning. The situation has improved a little in certain areas because of the training and utilization of a cadre of female community health workers in the public sector. They are called, "Lady Health Workers (LHW)". They are trained to provide some basic antenatal care and make referrals to the first level health care facility for routine care and for complications of pregnancy and the puerperium, but are not of much assistance during labour and delivery. TBA handles that crucial stage of the maternity cycle in homes, both urban (60 to 70%) and rural (90 to 95%).

- Some NGOs have directed their efforts towards improving the health of mothers and children. The Maternity and Child Welfare Association of Pakistan (MCWAP) an affiliate of the International Association of Maternal and Neonatal Health, (IAMANEH), was the first NGO to focus on maternal health. Others followed. The most active and successful one was the Mother and Child Welfare Association in Faisalabad. These efforts are a drop in an ocean of need.

- The National Committee on Maternal Health (NCMH) has been functioning as the extended arm of the government for the last seven years.

- Thousands of private practitioners and maternity homes and hospitals have opened in all parts of the country, but mostly in urban and peri-urban areas (Unaiza, 2001).

WHAT HAS NOT RECEIVED DUE ATTENTION SO FAR:

- Plans to replace TBAs with skilled birth attendants, particularly with qualified midwives.
- Strengthening of secondary and even tertiary level facilities to deal with obstetrical emergencies.
- Provision of ambulances to the Basic Health Units and Rural Health Centres.
- Accountability of the health care providers regarding their presence on duty and their performance (Jafarey, Rizvi & Kamal, 2000).
- Educating and sensitizing men with regard to pregnancy and childbirth to elicit their support in more ways than one.
- Educating youth about responsible sex lives, including marriage and parenthood.

Strategies for male involvement in reproductive health

The precedents of male involvement in reproductive health in Pakistan
In Pakistan, male involvement in reproductive health started long before the concept of a holistic approach emerged from ICPD in 1994. Reproductive health has been synonymous with family planning since the days when surgical contraceptive centres opened in the public sector and were also promoted through NGOs in the private sector. The sign boards outside these centres read (and still do) "Reproductive Health Centre."

The period was the mid-eighties. The contraceptive prevalence rate of Pakistan was 7.6% for modern methods and 9.1 for all methods. Almost all family planning services catered to females (Government of Pakistan 1984-1985).

In 1985, Pathfinder International, a USA-based NGO, established its office in Karachi Pakistan and started identifying virgin territories in which to provide family planning information and services. Educating and involving men in promoting positive contraceptive behaviour was identified as one of the untried approaches. The apprehension level of the planners was high. They were afraid of the INVISIBLE PHANTOM of opposition from the men and particularly the Muslim clergy.

After almost a year of detailed groundwork, it was realized that community leaders and religious leaders needed to be involved in Information, Education and Communication (IEC) activities, as well as to function as role models. It also became apparent that selected men needed to be trained for community-based distribution of contraceptives and that both male and female doctors needed to be trained in family planning to provide correct family planning information and services to the public and back-up support to the field workers.

Gradually, over a span of one year, four projects started in the northern and the central part of the country. Two of these were to involve men in reproductive health and two were to train private practitioners, both male and female, in providing a full range of nonsurgical family planning services (Family Planning Association of Pakistan, 1993; Federal Bureau of Statistics, 1998). After the success of the first two projects involving men, a third project was started in the south.

The GILGIT project (1987-1993)

The northern areas which border China are known as the "Roof of the World", because of the very high mountains, one of these being the second highest in the world. Gilgit valley is a hard-to-reach area. When the project started in 1987, the CPR in the valley was almost zero. The Family Planning Association of Pakistan (FPAP) was the grantee for this project.

A group of men called Health Guards had been trained to function as primary health care workers, but were not being employed as such. One hundred and thirty of these were recruited and given extensive training as motivators, counsellors, providers of certain temporary methods of contraception at the doorstep and as referral agents. In addition to contraceptives, they were given certain medicines for treating minor ailments. They worked through men, but served both men and women.

For community mobilization, a public health awareness festival was held with the help of various pharmaceutical firms. Even though it was the first project of its kind, it did not take much time to take off because the need already existed.

An existing Maternal and Child Health (MCH) centre run by FPAP in the town of Gilgit was strengthened through training of the doctor and the Lady Health Visitor in family planning and material resources were provided for its additional role as a family planning Centre. This provided back-up support to the Health Guards. The Centre provided health services for women and children, as well as full range of nonsurgical contraceptive services for women.

The health guards provided whatever health and family planning services they were authorized to provide and made referrals to the Gilgit clinic. They also were successful in helping men decide to limit their family size. Mobile surgical teams were brought from a 1,000 miles away and camps were held in the community for tubal ligation. Vasectomies could not be popularized.

Within a year the MCH centre began to become overcrowded and discussions started to identify resources for bigger premises.

Apart from the female physician in the FP clinic, there was no woman doctor in the area. There were very few male physicians. They were given training in IEC, temporary methods of family planning and making referrals to the MCH Centre. This proved useful because men started using male physicians for advice. Doctors enjoy a certain level of prestige, which obviously the health guards did not.

A few TBAs also expressed the desire to take training in family planning. They complemented the work of the male guards, particularly when some of the husbands wanted their wives counselled.

A population of 150,000 scattered in 17 villages was covered by this project. The villages were situated on very difficult terrain with foot paths and only one major mettled road, which

goes to China and is known as the Silk Route. Therefore, mobile services had to be added to ensure continuity of use and management of side effects.

The medical kits were not a success, because the Health Guards were to charge for the medicines and replenish the kits. Culturally, it was not appropriate to ask for five cents for a tablet of aspirin. When the first supply finished, the kits remained empty, as replenishing meant money out of the health guards' own pockets.

The project achieved very good results:

Methods	No. of Acceptors	No. Shifted to Permanent method	% Shifted
Pills	18368	134	0.73
Condom	6841	--	--
Injection	5825	579	9.94
IUD	1210	42	3.5
Total	32244	755	14.17

Figures are up to mid-1993. Performance went down in 1992 because of communal riots in the project area.

The project lasted for almost six years. At the close of the project in 1993, CPR had gone up to 17.5%. Since then FPAP has changed the design. There are no health guards employed for Community Based Distributor (CBD) services, but mobile FP services and tubal ligation camps have continued. Male volunteers, however, are involved in various health-related activities. FPAP now approach the FP issue as a family health issue. In the meantime, the Aga Khan Health Foundation has given advanced training to some of the Lady Health Visitors who are also providing family planning services in addition to maternity services in that area.

Although the impact of male support for the women with regard to contraception has not been formally documented, a palpable change has taken place. According to a recent telephone conversation with the ex-project director and a meeting with a health visitor working in the area, most pregnant women are attending antenatal clinics and seeking help for minor and major complications. These two contacts could not provide the exact figure for CPR, but, according to them, it seems to be going up slowly.

The MARDAN project (1988–1993)

The second project was implemented in Mardan and its surrounding villages a few months after the Gilgit project. Mardan is the second largest town of the Northwest Frontier Province bordering Afghanistan. Ethnically Pathaan, the population is organized into various tribes. Known as warriors and fierce protectors of "honour" the Pathaans have not yet granted much freedom of choice to their women. The best way, or perhaps even the only way to reach Pathaan women was through their men. The big question was, HOW to communicate to men that both male and female partners have to participate in keeping the family size at a desired level? After a lot of groundwork, an NGO called the Urban Community Development Council (UCDC) with all-male membership was identified. The project "Family Planning Through Male Involvement" was launched. It focused on training men to become the agents of change to influence the existing concepts, taboos and attitudes surrounding contraception

and to promote positive
contraceptive behaviour. From the very start, this project began exploding certain myths surrounding the Pathaan male.

The Community Educators

Men volunteered to be trained as family planning workers called Community Educators (CEs), in their spare time. Gradually, 300 men were trained to work in teams of five, with one man acting as the team leader. The men were from all walks of life including teachers, businessmen, and farmers, as well as a few religious leaders. They worked as educators, motivators, suppliers of condoms and referral agents. They were paid a very nominal honorarium. They were supervised and guided. After the first six months, the CEs requested that female workers be included in some of the teams, because men wanted their wives to be counselled. Eventually 40 of the 60 teams had TBAs.

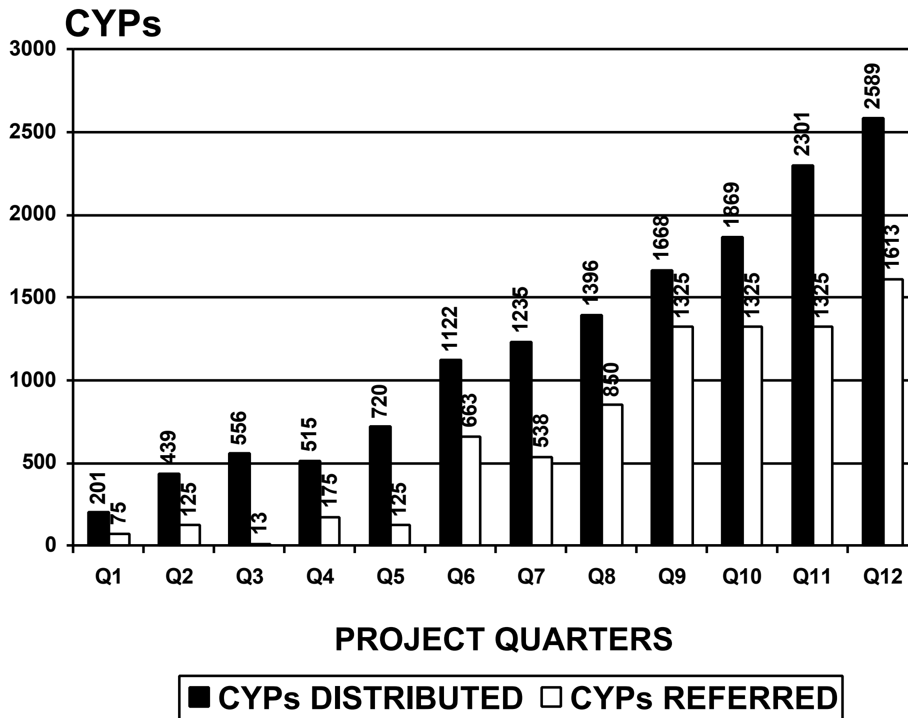
A support structure was developed by coordinating with other NGOs and by training the practising family physicians, both male and female, to provide IEC and full range of nonsurgical contraception.

Surgical contraception was provided by Engender Health (then called AVSC), in Peshawar about 60 km away. Once or twice a week, women were transported to Peshawar for tubal ligation. In spite of all the efforts, vasectomy could not be popularized. The planners felt that as long as unwanted pregnancies were averted, it was not of great importance whether the men used a contraceptive themselves or supported contraceptive use by women. The Pathaan men surprised everybody. The use of condoms went up rapidly within the first six months. The project document had to be revised and outputs increased because of overshooting of all the targets and demands from neighbouring communities for similar activities.

Initial Outputs

Objectives (Q1-Q4)	Results (Q1-Q2)
1. To establish contact with, and provide family planning information to at least five thousand men in the project area.	• 7,000 contacts (Q1 only)
2. To distribute ten thousand condoms through males CEs (100 "couple years of protection" or CYPs).	• 78,367 condoms distributed
3. To refer five hundred women to clinic based family planning services.	• 611 women referred to clinics for family planning services In the Clinics: 74 IUDs inserted, 804 pill cycles distributed, 783 injectable doses utilized, 124 foam cans given and 29 effective referrals made for tubal ligation.

Outputs of first 3 years



With its 300 CEs, this project was able to cover the entire town of Mardan and its surrounding villages. Most city dwellers in northern areas have their roots in the villages.

The CEs took the message to the rural areas. It is estimated that a population of almost half a million was covered by the project's activities in the five-years of the project's existence.

The results were phenomenal. The success story made the international press. UNFPA cited it in one of its reports as a successful venture. A paper was presented in the American Public Health Association (APHA) Conference in Atlanta, Georgia in November 1991. This project became a prize exhibit for all concerned. Men of Mardan were certainly mobilized as a result of this project.

It leaves one wondering whether the results would have been similar if the project had been for women only and managed by women.

In an informal visit to the UCDC in October 1998, the writer found that the activities have continued, but on a smaller scale. Some of the CEs continue working as volunteers. The Asia Foundation was funding two full-time male motivators. Some financial assistance was coming in from the Trust for Voluntary Organizations. There are now two back-up support clinics. Some of the NGOs have handed over the management of their family planning activities to the Council.

In addition, the Council has started a self-financing career development centre to teach typing and word processing skills to young boys and girls to enable them to get jobs. Only a decade and a half-ago, young Pathaan girls would not have been able to come out of their homes to get training with the objective of finding a job.

The Karachi project

In 1990 the Mardan model was replicated in the suburbs of Karachi, the largest city of Pakistan. Unfortunately it was not as successful as the other two projects. Certain undesirable elements of a large metropolis influenced the project. After one year of funding, the project had to be closed down.

The Gilgit and the Mardan projects had to be terminated in1993 because of the withdrawal of USAID's financial assistance to Pakistan. (Eighty per cent of Pathfinder's funds came from that source). Both NGOs are continuing the activities.

A third precedent

In the period 1998–1999, the Asia Foundation implemented an experimental project using the TIPS approach. They found that when men were involved in giving diet supplements to pregnant and lactating women, the compliance rate was much higher than when only women were given the tablets and instructions for use.

Identification of the need for male involvement to promote safe motherhood

The existing literature and precedents are all about men's involvement in family planning (Kamal & Christina, 1991; Family Planning Association of Pakistan, 1993; Aqil, 1997; Douthwaite, 1997; Federal Bureau of Statistics 1998; Kamal, 1999). Nothing has been documented with regard to male involvement in providing support to woman during the maternity cycle, particularly during the intranatal period.

National Committee for Maternal Health (NCMH), which was established by Benazir Bhutto when she was the Prime Minister, functions as a technical advisory body. Its main mandate is to lower MMR in Pakistan.

One of the strategies selected by the Committee was to educate women about the possible risks of pregnancy and danger signs during the entire maternity cycle which require immediate medical intervention.

A video film "Maamta ki Hifaazat" (protecting motherhood) was produced. It was based on two actual case studies of two of the leading killers of mothers i.e. haemorrhage and eclampsia. Some very inexpensive IEC material was developed in the national language for free distribution.

Using the platforms of various NGOs, NCMH assisted the Maternity and Child Welfare Association of Sindh in starting a series of very low cost seminars with CIDA's financial assistance. The theme was, "Healthy Women: Learning to Stay Healthy". The seminars were very informal and given for groups of 30 to 50 women. Young girls were encouraged to attend if the mothers permitted. After a brief introduction, the video film was shown, followed by open discussion on any aspect of pregnancy, childbirth, sexually transmitted diseases and menopause etc. The feedback was always very positive.

More than once, the participants expressed their inability to follow the advice given in the film and by the facilitators. There were many reasons, but the two major constraints which

emerged were the need for male/family approval and the lack of available cash. When the problem was discussed in more than one seminar, the women suggested that similar meetings also be held with groups of men. **The need was identified by the women themselves.**

The Maternity and Child Welfare Association of Sindh (MCWAS) tested an approach to mobilizing the community for Safe Motherhood with very good response from men in a desert area. MCWAS made use of its past experience and held a seminar for men in one of the not-as- developed areas of Karachi. The seminar was well accepted. From the opinions taken from the men, it also emerged that men did not mind discussing women's health problems with female health care providers. MCWA requested NCMH funding for male seminars and offered its assistance in planning and implementing the project. They also suggested coordinating, whenever possible, the scheduling of seminars for women so that they coincide with those for men to increase the impact and to ensure that all participants received the same message. It would also increase the cost-effectiveness, as one team of facilitators could take care of both.

Seminars for Men to Promote Safe motherhood

CIDA was approached by the National Committee for Maternal Health. The idea seemed attractive to them and they agreed to fund the project.

Difficulties in planning:

Apart from the several examples cited above, there was no real precedent for such seminars—whatever was done was experimental.

The following questions needed to be answered before the seminars could be started:

- Will the women facilitators actually be acceptable to men?
- Where to find male doctors and social scientists experienced enough in addressing men on topics related to the maternity cycle? Male obstetricians are scarce in Pakistan, but even if available, for them to come down to the level of laymen was almost impossible.
- Where and how to collect groups of men to talk to?
- What social stratum of male should be targeted?
- Literacy rates being low even for men, what approaches for communicating the messages, what kind of audio visual aids and what sort of IEC materials should be used?
- How will the effectiveness of the efforts be evaluated?

After about three months of planning and efforts to deal with the above questions, the seminars started. Many changes had to be made as the work progressed. Everyone was new to the experience. (See Annex 2 for details of planning and implementation of the seminars.)

Seminar Cost

It was decided to keep the cost of each seminar between US$40 and $50. This was to cover the rental of the VCR, public address system, and chairs or mats, and light refreshments.

Summary of Seminars (for details, see Annex 3)

Between May and August 2001:

Eleven seminars were given for men, four of which coincided with women's seminars. The number of participants ranged from 35 to 100 in each seminar. Venues included open space, basic health units, an MCH centre, schools, NGO premises, a training institute (Navy), a young labour organization office and a Hindu Temple. Collaborating partners included various NGOs, Community Based Organizations (CBOs), the Rotary club and the Pakistani Navy. No seminar cost more than US$ 50.

THE HIDDEN AGENDA OF MALE INVOLVEMENT

These seminars had two unwritten objectives:

1. Gradually men will be made aware of women's rights as human beings. If they get sensitized to that at least, other rights might follow.

   To achieve this, the discussions focused on the need for equal access by daughters to education and to hospitals when they are sick.

   Some posters were put on the walls, where possible, depicting equity for women. The facilitators are cautioned to deal with the subject of equal rights in a tactful manner.

2. If men begin to recognize the signs and symptoms during the maternity cycle that mean the mother or baby's life is in danger and that the woman must get to the health centre, they may let her go on her own if there is no one available to accompany her. This might be the beginning of somewhat less male control over the freedom of movement of women. Peaceful, rather than militant change might be initiated.

3. If men start participating in women's health, they are bound to become aware of the poor state of health services. In rural areas, they may start some action through the health committees to improve the situation, particularly with regard to the absenteeism of health staff and the shortage of essential drugs.

   This is perhaps wishful thinking, but history bears witness to the fact that change comes from within the communities.

4. Sensitizing men to the possibilities of risks and dangers in pregnancy might have some effect on their emotions and minimize their tendency for violence.

MYTHS EXPLODED AND LESSONS LEARNED

1. There is no spectre of opposition from the religious leaders. Much of the apprehension on the part of planners and/or implementers is unfounded

2. Men, by and large, are not as uncaring about the health of their wives as they are reputed to be. They are genuinely interested in reproductive health. They leave decisions at the time of childbirth to the women who are with the woman in labour because they think the women know what to do.

3. Men want to make use of the existing public sector health care facilities, but the way these facilities function is not very conducive to their utilization. This includes time to schedule their visits, the attitude of the health care providers, and the expense involved.

4. Men do not mind discussing reproduction, pregnancy and childbirth with female health care providers.

5. Men seek information on sexuality and sexually transmitted diseases, but want to discuss these with a male health care provider.

6. The religious leaders are just like other men as far as information about women's health needs is concerned, i.e. they know very little, but they want to learn. They can be mobilized for talking to husbands about their responsibilities in providing support to their wives in general, and during the maternity cycle and menopause in particular.

7. It is not an either-or question: both men and women need to be educated about safe motherhood.

Ripples created by the project

1. One NGO which is working with a large number of communities has requested that their own workers be trained so that they can conduct these seminars on their own.

2. The topic of male involvement in safe motherhood has been added to the curriculum of a series of workshops on Reproductive Health being conducted by the Maternity and Child Welfare Association of Sindh. These workshops are for teachers and teachers-to-be of schools of nursing, midwifery and public health.

3. NCMH is propagating to all its partners and collaborating NGOs to advocate male involvement in reproductive health in general and in safe motherhood in particular.

4. Requests are coming in from far and wide for male seminars.

Impact of male seminars to promote safe motherhood

The efforts to involve men directly in order to elicit supportive behaviour for women during the entire maternity cycle is something very new and very recent. It was an experimental project. There is ample proof that the seminars are accepted by men. They attend when invited. They promise to talk to their friends and spread the word through the leaflets. They

request that the women be made aware of risks and danger signs during pregnancy. There have been requests for more seminars from the collaborating NGOs. All these may be pats on NCMH's back, but this is no cause for self-glorification because there is no solid proof yet that these seminars will have the desired effect. The reason for this is that so far, no tools for evaluation have been developed. Only a couple of indicators have been used.

These are:

- Are the NGOs experiencing any change in the attendance by pregnant women at antenatal clinics?
- Are the nearby hospitals experiencing more timely referrals than before regarding complicated labour and delivery?

From two situations, according to verbal information, there is slight increase in the attendance in their antenatal clinic. It needs to be verified whether this is due to the seminars.

RECOMMENDATIONS

National Committee for Maternal Health:

1. Develop two more video films on the remaining three killers of mothers i.e. obstructed labour, sepsis and abortion. Also, make one more video film on the positive effects of male support during obstetrical emergencies, of timely referrals and of minimizing the three delays.

2. Document the experience with male involvement in promoting safe motherhood. Present it to the donors and secure funding for at least three years for a countrywide project.

3. Solicit the support of its provincial chapters to start collecting information about the NGOs which are willing to collaborate in this activity and prepare a plan of action for implementation as soon as the funding becomes available.

4. After testing various approaches, guide the provincial chapters in developing the capacity of local NGOs to carry out the seminars on their own, not necessarily in large groups but for whatever number is available and willing to attend.

5. Develop a mechanism for evaluating the long-term impact of male involvement in not only safe motherhood but on other aspects of women's lives as well.

CONCLUSION

There are strong indications that involving men to promote safe motherhood is a worthwhile approach and promises positive results which can contribute towards improving the status of women in Pakistan. There is a definite need to extend and expand this activity throughout the country. Involving men to promote safe motherhood is a very new concept. It has been put to the test in the second most populous province in Pakistan. There is ample proof that men want information. Will knowledge bring about positive change in their behaviour? It is too early to start answering that question.

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Annex 1: Statistics of Pakistan
(National Institute of Population Studies, 1999)

Health and Demographic Indicators:

Total World Population		6 billion
Total Pakistan Population		135.6 million
Urban		33%
Rural		67%
Population Growth Rate		2.3%
Doubling time		30 years
Pakistan ranks (most populous country)		7th
Population Distribution by age		
< 15 years		43.2%
15 – 64 years		53.4%
65 + years		3.4 %
Sex Ratio	Male	52% (108)
Female		48% (100)
Life expectancy	Male	62.10 years
Female		62.90 years
Literacy Total		45%
	Male	56.5%
	Female	32.7%

Per capita income $400/annum (below $390 is considered below poverty line)

Contraception

% Knowing method	97%
Contraceptive Prevalence Rate	**30%**
Total Fertility Rate	**5.0%**

Health Facilities/Personnel:

Health outlets	12,000
Doctors	83,000
Nurses	33,000
Hospital beds	91,000
Population per doctor	1,640
Population per nurse	4,117
Population per hospital bed	1,496
Deliveries at home	83%
Births with skilled attendants	18%

Births and Deaths:

Crude Birth Rate		39/1000
Crude Death Rate		11/1000
Low birth weight babies		25%
Number of births per minute		8
Number of deaths per minute		2
Infant mortality rate		90/1000 live births
Under 5 years mortality		13%
	Male	108
	Female	104

Maternal Mortality Rate **340/100,000 live births (WHO and UNICEF)**

Annex 2: Male involvement to promote safe motherhood

SEMINARS FOR MEN

Planning	Implementation
Initially, only male facilitators should be called upon. Get the opinion of two male groups and if they agree, then add female facilitators to the team	**Surprisingly there was no objection from the participants. After the first couple of seminars, an ob/gyn specialist or an experienced female physician and/or a public health scientist (nurse midwife) was included in the team of facilitators for every seminar. After the maternity cycle was covered, the men wanted the male doctor for discussion on "men's topics.'** These were basically related to sexuality and STIs.
Recruit one or two male doctors and give them training by admitting them to the female seminars with the permission of the women attending the seminar.	One doctor was trained on a one-to-one basis first. He attended women's seminars if the group of women did not object to having a male doctor. There were no real objections, except in one group where the women wanted the male doctor to come in after they had presented their questions to the female facilitators
Develop a network of organizations that are working in certain communities and have already established their credibility. Let them give the briefing to the groups of men and then NCMH team give the seminars	Questionnaires were sent to about 50 active NGOs and CBOs asking them if they would be willing to give seminars to the men in the communities served by them and let the NCMH use their platform. Response was not as encouraging as was hoped for: 15 NGOs/CBOs expressed their interest.
Use various venues for the seminars. These should be places of importance for the community.	This proved to be a brilliant idea. Schools, Health Centres, premises of the NGOs, available open spaces and women's training centres for income generation are being utilized. One CBO used a Hindu temple.
As far as possible give one seminar for women and one for men in the same area and on the same day.	Giving two separate seminars on the same day is not always possible. Effort is made to have them not too many days apart. In remote areas, they are either on the same day or within 24 hours of each other.
Target illiterate and semi literate groups of men, particularly in rural areas	This was implemented. The assumption that only the illiterate or the semi-literate needed to be educated proved wrong. Educated men needed the information about safe motherhood just as much as uneducated men. Request was received and honoured from one of the naval establishments for two seminars first and then another later.
Involve religious leaders as facilitators	Religious leaders have participated in a couple of seminars but their utilization as facilitators is still not finalized. This might prove more effort intensive

	than conceptualized.
Experiment with having seminars with men and women together.	This was tried twice but the atmosphere was too constrained. Neither the men nor the women seemed to feel comfortable. There was hardly any discussion.
Involve the local health care providers from the government and NGO health services outlets. Aim at training them as local resource so that the activity can become self-perpetuating.	This is being implemented. A group of community workers was given a briefing (Hala), 2 doctors were trained and subsequently used in two seminars (Kunri and Larkana).
Use simple, inexpensive leaflets for free distribution.	Leaflets were designed, pre-tested and printed on very inexpensive paper. These are being distributed freely.
Use effective approaches to get the messages across	Approaches being used are, the video film "Maamta Ki Hifaazat" Street theatre Leaflets which are given to mothers are also given to men. Leaflets for men, which include sexually, transmitted infections. Open group and one-to-one discussion
Develop mechanisms to evaluate the impact of the male seminars.	Indicators are being developed. One is being used i.e. pre- and post-seminar attendance in the antenatal clinics of the NGOs collaborating with the Male Involvement project.
Look for resources to extend and expand the activity.	Search continues
Document results and lessons learned	Being done.

Annex 3: The seminars

The following seminars have been given since August 1999. The first two were experiments to test the approaches:

Month and year	Geographical Location and Venue	Partner NGO/ Institution	# and sex of Participants	Distance from NCMH office
August 1999 (Pre-test for community Mobilization	Chachro Desert (Rural) Open Space	Thar Sath	300 males +females	500 km
September 2000 (Pre test)	Lyari (Urban) Community Center	Lyari Development Association	60 males	15 km
May 2001	Karachi (urban) Officers Training Institute PNS Bahadur	Pakistani Navy	35 naval officers. male	25 km
June 2001	Hazara City Squatters colony. Womens' Sewing Center	All Pakistan Women's Association	28 males	5 km
July 2001	Orangi (Peri-urban). FPAP field office.	Family Planning Association of Pakistan (FPAP)	40 males	30 km
July2001	Kehr village (Rural) Basic Health Unit (government)	Health and Nutrition Development Society (HANDS)	50 males 35 females (2 separate seminars. Same day)	270 km
July2001	Naval establishment SRE "Majeed" Karachi (Urban)	Pakistani Navy	100 seamen	25 km
July 2001	Abidabad, Orangi Town, Karachi	(FPAP)	40 males	30 km
July 2001	Naval Establishment 'PNS Bahadur"	Pakistani Navy	45 naval officers	25 km
August 2001	Ghaggar Phatak (rural) MCH Center	HOPE	29 males	45 km
August 2001	Chachro Desert(Rural) Hindu Temple(F) MCH Center(M)	Thar Sath	35 males 45 females (2 separate seminars on same day)	500 km
August 2001	Kunri (small town) High school for both seminars.	Rotary Club Maternity & Child Welfare Association(MCWA) Inner Wheel Club	48 male 40 female (2 seminars same day same place)	425 km
August 2001	Hyderabad (Peri-urban) Young Labourers' Literacy Center	FPAP and Pak Social Welfare Association	45 males (including press, Nazim and elected counsellor	220 km
August 2001	Larkana (rural) open space	(support staff of Medical college teaching hospital)	50 female 50 male 2 seminars, same day same place	450 km

2.4 Targeting men for improving the reproductive health of both partners

2.4.1 Opportunities and challenges for men's involvement: the regional reproductive health strategy

Dr Andrew Kosia

INTRODUCTION

The World Health Organization, Regional Office for Africa has identified reproductive health as a priority area in the delivery of health care services in the African region. This is in response to the persistently high levels of maternal and neonatal morbidity and mortality and infection with the Human Immunodeficiency Virus (HIV). The long-term vision of the Organization in the region on reproductive health is to ensure that every woman goes safely through pregnancy and childbirth and infants are born alive and healthy.

In pursuance of this vision, the reproductive health strategy for the African region was developed in 1998. The strategy is aimed at assisting member states and partners to identify priorities and plan their programmes and interventions at various levels, particularly at the district level. Male involvement and participation is one of the strategic directions of the reproductive health strategy for the African region.

The opportunities and challenges for the involvement of men in reproductive health programmes in the African region are described and the future perspectives highlighted.

Objectives

- To outline the approaches used by member states to involve males in reproductive health programmes;
- To describe the initial impact of male involvement in reproductive health programmes in the region.
- To identify gaps for male involvement.
- To define future perspectives for the region.

METHODOLOGY

The Division of Reproductive Health, Regional Office for Africa developed a regional strategy for Africa in 1998. Male involvement is one of the strategic directions in the document. In order to assess the implementation of male involvement in reproductive health in the region, member states were contacted through the World Health Organization Representatives to forward their contributions to the Regional Office. Responses received from countries were analysed and the findings form the basis of this presentation.

FINDINGS

The approaches used for male involvement by countries

- Formation of men's clubs.
- Running of the male clinic.
- Public sensitization through sports and printed (couple-friendly antenatal care handbook) and electronic media.
- Holding of seminars, workshops targeting opinion leaders (men).
- Group counselling sessions for men with their pregnant partners.
- Development of policy guidelines.

Opportunities

- Men have an important role in the promotion of their own reproductive health as well as that of women and young people.
- The countries acknowledged that men, if properly sensitized, could serve as agents to bring more women to accept and practise family planning.
- Sexually transmitted infection (STI) services, including on-site syphilis testing and management, had greatly improved as a result of male involvement.
- Appropriate information, education and communication (IEC) materials targeting men have been developed and this has resulted in an increased number of men accompanying their partners to antenatal and postnatal clinics.
- Countries are now designing maternity wards with special space for partners during labour and delivery.
- Partner notification for STI management has improved.
- The positive impact of peer pressure for men to convince their male peers against violence is now widely practised.
- Willingness of men to discuss their past acts of violence in group settings run by nongovernmental organizations is common in many countries.

Challenges

- Men are at risk of reproductive health problems linked to puberty, substance abuse, sexual and domestic violence and of infection with HIV and STI.
- Men do not possess sufficient information and knowledge with regard to sexual and reproductive health.
- There is a general lack of interest on the part of men in the region in their partners' reproductive health.
- Men are maginalized by the sexual and reproductive health services.
- Most men do not actually accompany their partners to family planning or antenatal care consultations and during labour or delivery.
- Partner notification and treatment of STIs are difficult due to poor inter-partner communication and unequal balance of power relationships between men and women.

Future perspectives

- Involvement of policy-makers, religious and community leaders, most of whom are men in the region.
- Formulation of national policies on male involvement in reproductive health.
- Strengthening of male participation and full involvement in reproductive health by ensuring their rights to participate equally, actively, directly and supportively as women in reproductive health.

Finally, empowerment through the provision of information and services targeting men within the home, communities and place of work is crucial.

2.4.2 The sexual health of men in India and Bangladesh: what are men's concerns?

Dr Sarah Hawkes and Dr Martine Collumbien

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Abstract

Health sector priorities are ideally set according to a number of variables, including: burden of disease; whether effective and proven 'solutions' are available; and the calculated cost-effectiveness of those solutions.[1] In the case of sexual health services, we argue in this paper that this conceptual framework is useful for programme planning, but needs to take into account one important additional element: the client's perspective. We further argue that the sexual health of men in south Asia can not be adequately addressed unless men's beliefs about their bodies, men's health priorities, and men's sexual health concerns are evaluated, interpreted and acted upon. Services which do not correspond to men's own perceived sexual health needs are unlikely to attract men as clients, and thus remove many of the opportunities for male involvement in other aspects of reproductive and sexual health prevention and care. Men's own sexual health priorities may not correspond exactly with the priorities of public health programmes; we therefore discuss how the two sets of concerns may be reconciled and men brought more equitably into programmes. Finally, we outline areas which may be of particular concern to programme managers if this approach is adopted.

INTRODUCTION

Historically the sexual health of men in low-income countries has received very little attention, either from the research community or from public sector health care planners and providers.[2] This situation is predicated on the fact that women bear a greater burden of reproductive mortality and morbidity as they shoulder the physical, and most of the social, responsibility for childbearing and childcare. Thus, the focus of most programmes and service provision in this field has until recently been on family planning and safe motherhood services.

Similarly, research in the arena of reproductive and sexual health in resource-poor settings has concentrated on understanding the perspectives and needs of women—as users of contraceptives, as pregnant women, as women in labour, and as mothers. As a result of this focus, for example, research into new contraceptive technologies has concentrated on finding

effective female methods of fertility control. The IUD, hormonal pills and injectables, hormonal implants and tubal ligation do not interfere with the sexual act and thus do not require direct male involvement. These methods provided women with the means to control their own body and fertility.

This predominantly female focus is, however, changing as the result of a number of interwoven influences on health priorities and health policies. Following the International Conference on Population and Development (ICPD) in 1994, there has been a great deal of commitment to move away from demographic targets towards a broader focus on human welfare, individual choice and the goals of gender equality. As a result, there has been a programme-level shift away from vertical family planning services and towards the provision of comprehensive integrated reproductive health (RH) care at all levels of health sectors.[3] The Government of India, for example, has stated that the principles guiding reproductive health service delivery are that they should be 'Client-centred, demand-driven, high quality, integrated services'.[4]

Such integrated services are now being defined to include "…treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions".[5] The increased salience of the sexually transmitted infections (STIs) on health policy agendas has arisen partly as a result of the growing human immunodeficiency virus (HIV) pandemic and the finding that control of STIs could be a key component to reducing HIV transmission in some areas.[6,7] In addition, the 1993 World Development Report detailed the burden of ill-health caused by sexually transmitted infections and raised the profile of the importance of these infections.[8]

The introduction of STIs, including HIV, into the framework of reproductive health care provision has necessitated the incorporation of men, usually as 'responsible partners', in service delivery and interventions. Policy makers, programme planners, researchers and health advocates alike have recognized[9] that men's reproductive health and their sexual behaviour have direct effects on women's health as well as on their own health needs.

The 1994 ICPD highlighted the need to develop more programmes that reach men with reproductive health information and services, with the promotion of greater gender equality as the main goal. The key ways proposed to involve men directly in women's reproductive health are: use of male methods of contraception; supporting the partner's use of contraception through joint decision-making; and preventing the spread of STIs through more responsible sexual behaviour. However, the ICPD document pays relatively little attention to men's own reproductive and sexual health concerns.

The rising concern and need for STI/reproductive tract infection (RTI) control programmes now provides a biomedical rationale to target men, in addition to social and cultural reasons. In south Asian societies, as in many others, it is reasonable to assume that men are the ones who are more likely to initially contract STIs and transmit them to their wives.[10,11] In societies where sanctions against non-marital sex are less harsh for men than for women, men are more likely to have sex before marriage, and more likely to be the clients of sex workers. In India, for example, studies using the 'general population' as the survey group, in both rural and urban areas, have reported premarital sexual activity among 7-48% of male respondents compared to 3-10% of female respondents.[12,13,14,15,16,17,18] Furthermore, labour migration and the male demographic shift to
urbanization may increase both the opportunity and the need for men to engage in commercial sexual relations.

The "good news" is that, although men are more likely to be at greater risk of transmitting STIs (through their patterns of sexual behaviour), the diagnosis and management of the sexually transmitted infections is relatively easier in men compared to women, as the symptoms and signs are more specific and less likely to lead to over-diagnosis.[19,20] In addition, policies to provide clinical services for men may as a consequence reach asymptomatic but infected women through partner notification strategies.

While there are clear public health reasons for targeting men in STI/HIV-control strategies and programmes, we examine the situation of men in South Asia in order to understand whether these interventions are necessarily a priority for men themselves.

The burden of biomedical disease - STIs in men in Bangladesh and India

A recent comprehensive review of the published epidemiology of STIs in India found that data on STI prevalence in men are lacking, especially men in the 'general population'.[21] The majority of facility-based and community-based studies have focused on examining STI rates in women. The recent review located only three surveys of STIs which were undertaken in men in 'general' communities in India: a population-based survey of STI prevalence in Tamil Nadu;[22] a sexual health survey among men in a Delhi slum;[23] and a survey of men participating in a rural education project in Maharashtra.[24] This type of data imbalance has the potential to lead to unbalanced programme responses and interventions. Nonetheless, although there is more information available on the epidemiology of selected STIs (and other reproductive tract infections) among women in India than among men, the data for women are still relatively patchy and certainly incomplete, given the size of the population.

The results of studies of STIs undertaken among men in India are presented in Table 1.

Table 1: Published STI prevalence in men in India

Study population	Prevalence ranges (%)								
	GC	CT	Syphilis	Chancroid (clinical diagnosis)	TV	HSV (clinical diagnosis)	HPV (clinical diagnosis)	HbsAg	HIV
Community-based or convenience samples									
Males aged 15–45 years [22]	3.4	2.0	0.3	---	---	---	---	6.0	1.4
Male participants of a community education program [24]	1.7	15	---	---	5.6	---	---	---	0.4
Transport & industrial workers [25,26]	2.1	---	0.8 – 4.4	---	---	---	---	---	---
Facility-based									
STD clinic Patients [27,28,29,30,31,32,33,34]	8.5 – 25	20.0 – 30.0	12.6 – 57.0	16.1 – 34.7	---	3.0 – 14.9	4.9 – 14.3	---	2.0 – 7.4
STD clinic patients with genital ulcers [35]	---	---	---	33.0	---	---	---	---	---
Patients attending primary health care [36]	---	---	3.6	---	---	---	---	---	---
Specific groups									
Spouses of females with candida & trichomonas [37]	---	---	---	---	60.6	---	---	---	---

Notes on Tables: GC = gonorrhoea; CT = *Chlamydia trachomatis*; TV= *trichomonas vaginalis*; HSV = herpes simplex virus; HPV = human papilloma virus; HbsAg = hepatitis B surface antigen; HIV = human immunodeficiency virus

Results from random household population-based surveys in urban[38] and rural[39] areas of Bangladesh are presented in Table 2. Corresponding figures from women in the same general populations (but not from the same households) are also presented. It can be seen that apart from syphilis in urban men, there were relatively low levels of infections found in both men and women in these two studies.

Table 2: STIs in men and women in surveys in rural Matlab and urban Dhaka, Bangladesh

Organism	Rural men (n=969)	Rural women (n=804)	Urban men (n=530)	Urban women (n=984)
Chlamydia trachomatis	0.5% (n=607)	0.5% (n=753)	0.2%	0.9%
Neisseria gonorrhoeae		0.5%	1.5%	1.8%
Trichomonas vaginalis		0.8% (n=661)	0% (n=42)	2.6% (n=145)
Current syphilis	0.5% (n=942)	0.7%	9.3%	4.4%
HIV	0% (n=444)	0% (n=458)	0% (n=530)	0% (n=470)
Herpes simplex 2 virus	5.6% (n=178)	5.9% (n=134)		
Hepatitis B surface antigen	9.9% (n=122)	5.6% (n=82)	5.7%	2.9%

The results presented in these two Tables highlight how little is known about the 'true' population-based burden of biomedically defined STIs in men in India and Bangladesh. We have here defined 'true' STIs as being diagnosed on laboratory analysis, since this is the only objective measure of the presence of STIs, and does not rely on self-reported morbidity or clinically diagnosed problems. Previous studies and reviews have highlighted the lack of correlation between self-reported morbidity in women and the presence of laboratory-defined infection.[40] Nonetheless, despite the lack of a comprehensive evidence base on the population levels of disease burden (and in the absence of any longitudinal data sets showing trends with time), programme managers are charged with designing programmes which are effective and epidemiologically appropriate. In this regard, attention is more often paid to target groups of men, such as those that seek care for symptoms of possible STIs.

Surveys undertaken among men seeking health care for STI symptoms in India reveal that, as expected, STI prevalence is much higher here than in the 'general' population - see Table 1. If men are encouraged to seek care for their STI symptoms, what services can be provided for them in resource-poor settings such as those found in Bangladesh and India?

The management of men with STIs in resource-poor settings

Traditionally the diagnosis and management of STIs has relied upon the clinical judgement of the individual practitioner or has been based upon the results of laboratory tests. In the absence of widespread laboratory facilities in most low-income countries, the World Health Organization (WHO) has developed a set of management guidelines specifically for low-income, low-resource settings: syndromic management algorithms.[41] These guidelines were developed with the aim of managing patients with symptomatic STIs. They are especially useful in countries which cannot afford widespread laboratory testing, but versions of syndromic management are used in high-income countries as well. It is advocated for use particularly in areas where laboratory facilities are absent or inadequate or where there may also be lack of trained staff and large distances between rural primary health care (PHC) centres and specialized/laboratory facilities. Aside from therapeutic drug regimens, counselling, education, condom use and partner notification are an integral part of this approach. Patients receive immediate treatment, thus increasing the potential for both compliance and the overall cure rate.

The most common STI-associated symptoms in men are genital ulcers and urethral discharge. The algorithm for genital ulcers works on the basic premise that the two commonest causes of such sign/symptoms are syphilis or/and chancroid, and recommends therapy for both conditions. The algorithm for urethral discharge assumes that the aetiology could be gonococcal and/or chlamydial and that therapy appropriate for both should be utilized.

A recent review of the costs of syndromic management in different epidemiological settings found four published evaluations undertaken among symptomatic men.[42] The prevalence of both gonorrhoea and Chlamydia combined (the two organisms most commonly associated with causing urethral discharge) among these men ranged from 45% to 75% in the different studies. By comparison, the prevalence of these two STIs in reviews looking at symptomatic women (not necessarily in the same geographical area) ranged from 0.9% to 19.5%. Cost analysis on the use of syndromic management in symptomatic men found this to be a highly cost-effective intervention. The cost *per man* treated was similar to that found in reviews of symptomatic women, but the cost *per true case* treated was much lower for men than for women - a reflection of both the high prevalence of STIs in symptomatic men, and the high sensitivity and specificity of the treatment algorithms.

Health care seeking among men

Effective management of men with STIs can only be assured if men present to trained health providers as soon after the onset of symptoms as possible. Surveys in Bangladesh and India show that most people with STI symptoms seek care in the unregulated (and predominantly untrained) private sector. The National AIDS Control Organisation in India, for example, estimates that only 5-10% of patients with STIs present to public sector care.[43] This is true not just for STIs, but for a wide range of curative services, and it is not only the economically wealthy who seek private medical care; the poor choose private providers for a variety of reasons as well.

Why do men seek care outside of the public sector? Treatment-seeking is determined by a number of contributing variables, among these are: perceived seriousness and causality of symptoms; availability of health care; costs (including opportunity costs) of treatment; perceived and actual quality of care (including confidentiality); accessibility of different types of care; and belief systems concerning the appropriate provider to consult. There is a strong and prevalent system of indigenous medical care in Bangladesh and India and a multitude of different providers in the formal and informal sectors. All of these factors contribute to where, when and why people seek care.

What would encourage men to seek care more frequently from public sector providers? In the next section we will explore the notion that one important (but often overlooked) variable influencing health care seeking, is the perception of the provider's interest not coinciding with the client's interest. We hypothesize that if a man does not perceive that a particular health care provider shares his own areas of health concern, he is unlikely to seek care from this provider. We further postulate that if men in Bangladesh and India are more concerned about issues other than STIs and seek care for these concerns in the private sector, they may be unlikely to seek care
from (trained) public sector providers even if they become infected with an STI as they will feel more familiar and more comfortable with the private sector that they are already using.

What are the sexual health concerns of men in South Asia?

The data presented here on male sexual health comes from two health intervention studies in South Asia. Each study is briefly outlined and then similarities in men's perceptions of sexual health are discussed. In Orissa, eastern India, a study was undertaken in the coastal districts to inform condom social marketing programmes: a qualitative study preceded a population-based survey among urban and rural men. In rural Bangladesh, a population-based survey of STI prevalence was undertaken among men in the Matlab area. The aim of the research was to inform decision-making around provision of STI management and control programmes.

Men's sexual health concerns in Orissa

As part of an extensive qualitative study identifying patterns of sexual behaviour [44], the cultural perceptions of men's sexual health problems were explored using in-depth interviews with key informants and case study informants. During these interviews, structured qualitative interviewing techniques were used: free-listing, pile-sorting and rating.[45] The subsequent structured survey undertaken to quantify the extent of sexual risk behaviour [44,46] included some questions on self-reported sexual morbidity. This survey covered a large population-based random sample (n=2087) of single and married men in urban and rural areas of the four coastal districts in Orissa.

The free lists compiled from 35 male informants in the qualitative study are given in Table 3 (only the 15 most frequent concerns are listed here, with the English interpretation of each condition in brackets). The salience of a problem (last column) is determined by the number of respondents mentioning it (frequency, second column) and by its average position on the list (third column). Informants were also asked to sort the items from this free list into categories (pile sorts) according to the similarities among the conditions. Most concerns on the list in Table 3 refer to symptoms rather than diseases. Medical terms used by lay men in the community, like *gonoriha* and *syphilis* should be understood as generic terms for conditions which are sexually transmitted, rather than translating into the specific medical diseases.

Table 3: Free list of sexual health problems among men in Orissa (N=35)

Sexual health problem *(translated)*	Frequency	Average rank	Salience
Dhatu Padiba *(white discharge)*	28	2.750	0.424
Jadu *(itching)*	22	4.636	0.195
Swapnadosh *(nocturnal emission)*	19	3.211	0.242
AIDS *(AIDS)*	17	2.529	0.353
Handling *(masturbation)*	14	5.000	0.106
Gonoriha *(gonorrhoea or generic term for STI)*	13	2.231	0.285
Linga-gha *(ulcer/sores on the penis)*	9	3.222	0.106
Parishra-poda *(burning during urination)*	9	3.333	0.095
Hernia *(hernia)*	7	4.714	0.093
Fileria *(swollen penis, scrotum, leg and foot)*	6	5.500	0.035
Hydrocele *(swollen scrotum)*	6	5.333	0.066
Katchu *(itching - scabies)*	6	3.667	0.090
Syphilis *(syphilis or generic term for STI)*	4	3.500	0.061
Bata *(rheumatism)*	4	3.250	0.040
Linga-ghimri *(eruptions on penis ~ herpes)*	3	1.000	0.086

The most important, most salient concern is *Dhatu Padiba*, the passage of whitish discharge with urine which men believe to be semen. Other related conditions were nocturnal emissions or *Swapnadosh* and masturbation or *Handling*, all concerns related to semen wastage and associated with fears over sexual and physical weakness. Men sorted these concerns with other 'psycho-sexual conditions', like worries over impotence and premature ejaculation. Another category combines the infectious conditions that indicate 'probably STIs': *gonoriha* and *syphilis,* ulcers/sores on the penis *(Linga-gha)* and herpes-like eruptions on penis *(Linga-ghimri).* AIDS was the second most salient concern and even though most informants grouped *AIDS* as a category of its own, it was otherwise included in this category of sexually transmitted illnesses. Other distinct categories combined rashes and itches in the groin most likely not sexually transmitted and a separate group of anal conditions. A last group are conditions not related to sex but affecting the sexual organs or groin area - *hernias and hydroceles* (swollen scrotum probably caused by filariasis).

The significance of involuntary semen loss, *Dhatu Padiba*, was clearly not limited to a small sample of informants in the qualitative study who could be considered as both more knowledgeable and more concerned about sexual issues. In the survey, 27.4% of all men reported personal experience of *Dhatu Padiba* while 52.3% reported problems with excessive nocturnal emissions. *Dhatu Padiba* is perceived to be caused by excessive heat in the stomach (*peta garam*), improper diet, strain due to hard physical labour, as well as excessive masturbation and prolonged sexual abstinence (excessive sexual heat). Masturbation is believed by them to lead to semen thinning and to widening of the urethral opening, thus making *Dhatu Padiba* more likely.

Men in this study did not associate *dhatu padiba* with sexual transmission, but another concern sometimes mentioned was *parishra-poda*, denoting a burning sensation during urination. Both conditions are believed to be caused by *peta garam* (heat in the stomach) as a result of excessive heat and cultural hot/cold belief systems underlie the physiology of leaking semen[47]However, since penile discharge together with painful urination form the syndromic diagnosis for gonorrhoea and chlamydia, there is potential for confounding semen loss with pus discharge, if clinical diagnosis is based on reports rather than the actual observation of a discharge. It is important to stress that the white discharge in *dhatu padiba* is usually not directly observed. Other studies confirm that most often the diagnosis is made indirectly on the basis of a set of complaints about weakness and persistent fatigue. Semen loss is thus implied rather than observed.[46,48]

Men's sexual health concerns in rural Bangladesh

In 1994, researchers from the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) initiated a research programme to look at the population-based prevalence of sexually transmitted infections and other reproductive tract infections (RTIs) in both women and men in the Matlab area of Bangladesh. Using demographic lists, a random selection of men were interviewed at home by specially-trained male interviewers who asked them a series of closed and open-ended questions relating to current and past symptoms, health care seeking patterns, and risk behaviour and protection, as well as more general questions on socio-demographics. Men were asked to provide a urine sample and a fingerprick blood sample. These were tested for the presence of *Chlamydia trachomatis* and syphilis, respectively.

Men were asked whether they had 'any problems with their sexual health'. The meaning of this phrase was outlined by the male interviewer: physical problems; worries over particular symptoms or feelings; any other sexual or reproductive health concerns. Their concerns were recorded in an open-ended question and coded at a later date. Men were then asked a series of closed questions relating to three defined symptoms: urethral discharge, genital ulcer

disease and pain passing urine. The presence of these symptoms was then correlated with the laboratory findings from diagnostic analysis of urine and serum samples.

One quarter of all men reported one or more current sexual health concerns. The most common group of complaints in these men were the psychosexual problems. Almost 17% of men (161/969) reported psychosexual problems on open questioning. The range of symptoms included: premature ejaculation; impotence; 'dissatisfaction' with sexual intercourse; difficulties in maintaining an erection; and 'night pollution' (a direct translation of the local terminology for nocturnal emissions).

Symptoms relating to a possible STI (urethral discharge, pain passing urine, genital ulcer disease) were reported by over ten per cent of men. The relationship between reporting of symptoms and the presence of a laboratory-diagnosed infection was good in the case of urethral discharge, but less good for the other symptoms. Men were asked about seeking health care for the three named symptoms: urethral discharge, pain passing urine and/or genital ulcer disease. Most men who had experienced such symptoms had sought care (60%, 57% and 84% for each of the three named symptoms, respectively), and the majority had done so in the private sector.

Coincident with the population-based survey of STI prevalence, male sexual health clinics were established in the pre-existing maternal and child health clinics run by ICDDR,B in Matlab.[49] During the first year of operation of these clinics, the most common presenting problems in the more than 600 men who came to the clinics were pain passing urine (41.8%) and psychosexual problems (41.5%). A slightly smaller number of men (37.8%) reported an abnormal urethral discharge.

DISCUSSION - COMMON FEATURES IN THE TWO STUDIES

These two studies show that psycho-sexual conditions are a major concern, both among men who present at sexual health clinics and among those interviewed in the community. These problems may have an organic/physical origin—for example, diabetes, neurological or vascular disorders, some psychiatric conditions and certain prescribed medications are all known to have side effects of sexual dysfunction. While some men in our surveys may indeed have been suffering from physical or organic problems, this is unlikely to account for the entire burden of reported morbidity.

Male anxiety about semen loss and associated weakness is widespread in South Asia and well described in the psychiatric literature as 'dhat syndrome'.[50,51,52] The anxiety is based on an age-old belief derived from ancient Ayurvedic texts that each coitus is equivalent to an energy expenditure of 24 hours of concentrated mental activity or 72 hours of hard physical labour.[53] There is a belief that consumption of 60 pounds of food is needed to replace the loss of semen in each ejaculation. Though all semen loss is thought weakening, it is believed to be more so when it takes place without sexual intercourse. Thus, masturbation is often seen at the root of several of the conditions related to sexual weakness. *Virya,* the Hindi word for semen, also means 'vigour'. Semen is thus viewed as a vital force, the source of physical as well as spiritual strength. The loss of virya through sexual acts or imagery is thought to be harmful both physically and spiritually.[54]

For these problems men do consult both Ayurvedic and folk healers who all share similar belief systems and who explicitly advertise their services in magazines, newspapers and display boards throughout South Asia. The common message is that semen loss is responsible for sexual dysfunction and weakness.[55] Complications of supposed consumption by semen loss are mental exhaustion with constant negative thoughts (or depression) and hypochondria, mainly due to the extreme anxieties a diagnosed patient suffers about his condition.[47] It can thus be understood as a somatic idiom of distress[56] and described as a culture-bound syndrome associated with neurotic depression and anxiety neurosis.[53] Dhat syndrome has recently been recognized internationally through inclusion in Annex 2 (culture-specific disorders) of the ICD-10 Diagnostic Criteria for Research.[57]

Results from the survey in Bangladesh (where approximately 80% of the population questioned were Muslims) suggest that this widespread set of cultural beliefs transcends religious barriers. Semen loss concerns are also well documented in Pakistan (Muslim) and Sri Lanka (Buddhist).[55,57] In the Bangladesh data, concerns about semen loss and 'nocturnal emissions' were volunteered by over 15% of the men questioned in the population-based survey. Other widely reported problems in these men concerned sexual performance: premature ejaculation and inability to maintain an erection. The prevalence of reported psychosexual anxieties among the men in these two studies is not dissimilar to that from other published reports in the literature. Analyses of large numbers of studies carried out in both Europe and the United States of America among community and clinic-based samples found a surprisingly consistent percentage of men who self-report psychosexual concerns of premature ejaculation (35–38%), male erectile dysfunction (4–9%), and inhibited male orgasm (4–10%).[58,59]

DISCUSSION – WHAT DO MEN WANT FROM SEXUAL HEALTH SERVICES?

In this paper we have highlighted that there is a broad picture of sexual health concerns among men in South Asia that can be grouped under the terminology of psychosexual concerns. We have seen that, while studies and research premised upon public health concerns (e.g. epidemiological analyses of the burden of disease, or the effectiveness of interventions) have detailed (to a limited degree) the extent of STIs in some populations of men in South Asia, and evaluated strategies for their control, these concerns do not necessarily fully coincide with the sexual health issues raised by men themselves. We have further outlined how men's concerns are predicated on deeply-held sociocultural belief systems which influence perceptions of well-being. Furthermore, these beliefs about the causes of symptoms and disease may directly influence the sufferer's choice of appropriate health care provider.

Though they are held up as objective measures, the burden estimates used in health care prioritization are in fact biased and based on ethnocentric (Western biomedical) calculations including only 'global' diseases. Dhat syndrome or semen loss anxiety is thus a specific example of a culture-bound syndrome that does seem to represent a large 'burden' of emotional distress in South Asia. Despite the 'international recognition' through classification in ICD-10, the burden of these kinds of conditions are by definition invisible in the World Bank/WHO burden estimates….

The research done to inform HIV/STI interventions have brought us to an existing literature in mental health and psychiatry and it is clear we need to challenge the categorical paradigms of sexual health in current programmes and clinical services.[60] What Patel and Oomman[61] point out for women '…health needs increasingly involve problems beyond reproduction, and it is our contention that mental health already is and will continue to grow to become a core health issue for women. The intersection of reproductive health and mental health provides an avenue for exploring these issues…' may be equally valid for men. Health needs of men go beyond prevention and treatment of infections, and addressing semen anxiety may provide the opportunity to discuss issues of sexuality and sexual behaviour.

The picture emerging from South Asian studies is one of unmet need for comprehensive male sexual health services rather than exclusive STI management services. Such an approach is complementary to that advanced for the expansion of services offered to women, i.e. a shift away from single issue services (family planning) and towards broad-based holistic care (comprehensive integrated reproductive and sexual health care). In the case of men in South Asia, such comprehensive services should include provision for the care and management of psychosexual complaints—which are common and of higher saliency on men's own health concern agendas. Failure to provide such services may be one reason why men do not seek care from public sector providers, but instead go to the private sector—a sector which more often responds to their own concerns, and where providers offer 'cures' and 'treatments' for all manner of psychosexual worries and disorders, but in an unregulated and often untrained setting.

We believe that if men were offered comprehensive sexual health care services, they would not only seek care more frequently from such services for their own sexual health worries, but they might also then be in a position to be more open to the idea of other sexual health interventions - such as male involvement to improve women's reproductive health outcomes, or male responsibility for safer sexual behaviours. Services which do not correspond to

men's own perceived sexual health needs are unlikely to attract men as clients, and thus remove many of the opportunities for male involvement in other aspects of reproductive and sexual health prevention and care.

We would further argue that given the cultural beliefs underlying the reported psychosexual concerns of men in South Asia, a more innovative approach to improving the quality of management and care received by these men would be to work directly with the providers that already 'treat' and manage these conditions. Improving the range and quality of services in the currently unregulated private sector may have a number of benefits, among these are high coverage, and working with existing patterns of health care seeking. Moreover, it may also be possible to work with private sector providers to encourage a more comprehensive approach to sexual and reproductive health care, namely one which not only manages the individual male client but also seeks to ensure better health outcomes for his sexual (and reproductive) partners. Nonetheless, we also recognize that working with the folk healers and Ayurvedic practitioners will present interesting challenges. For example, it may be argued that these practitioners have clear commercial benefit from continuing to fuel men's minds with worries about sexual performance based on semen loss theory.

What are the implications for programme managers?

Commitment to respond to men's own sexual health concerns in South Asia raises a number of programme-level concerns and questions. We highlight some of these:

1. The **costs** of such programmes have not been explored in low-income countries. Cost analysis of such an approach would have to take into account the potential cost-benefit of men seeking services in a trained and regulated sector, and potentially being amenable to other interventions that such a sector might offer—men's involvement in other aspects of women's reproductive health, for example.

2. **Indicators** for programme management and programme effectiveness would need to be carefully thought through. Management of psychosexual complaints is clearly more time-consuming and less amenable to direct 'success' measurements than, for example, treating STIs.

3. The **positive externalities** of comprehensive male sexual health services need to be articulated and measured—for example, can it be shown that men who come to such services are more likely to participate in other aspects of reproductive and sexual health care in the future?

4. Establishing comprehensive public sector sexual health services for men is one approach to the problems we have outlined. An alternative, or complementary approach is to **train and regulate the private sector** providers who currently see most men (with STIs or with other sexual health problems). The feasibility of this in many countries is not yet clear.

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2.4.3 Male participation in reproductive health - a Caribbean imperative

Dr Hugh H. Wynter and P.I. Hamilton

Abstract

In the English-speaking Caribbean countries, reproductive health services have traditionally targeted women. During the second half of the 1960's with the introduction of public family planning programmes and increased nongovernmental participation, there have been significant reductions in fertility, maternal mortality and infant mortality and increased contraceptive use.

Despite these achievements, there are major concerns around a number of critical issues that impact on and determine the reproductive health status of the population. These issues include the level of unmet need for family planning services, unplanned pregnancies, adolescent fertility, the prevalence of sexually transmitted infections (STIs) including HIV, substance abuse, sexual abuse and the quality of parenting. The traditional perspective of the West Indian family is that it is matriarchal, with men marginal to family life. This needs to be changed for men to exercise their acknowledged influence in reproductive health in a manner that will improve the health of both themselves and their partners. Men play important roles in contraceptive use, fertility desires and their achievement, partner exposure to sexually transmitted infections and sexual abuse, which can result in severe and negative outcomes for their partners. The consequences of these roles can either have positive or severe and negative outcomes for their partners.

The Caribbean's unequivocal dilemma rests on such facts as having the second highest rate of human immunodeficiency virus (HIV) infection in the world next to sub-Saharan Africa, and also high rates of early sexual activity, teenage fertility, unplanned pregnancies, female-headed households and substance abuse. These factors are manifested in a context of important changes in the region's demographic and epidemiological profile and in the economies, which have mainly experienced either limited growth or stagnation during the past several decades.

A multidisciplinary approach is needed to focus and address programmatically the critical issues that determine male participation in reproductive health. It is imperative that health service providers include men as partners in reproductive health by adopting a life-cycle approach which identifies and services their needs in a way that is both culture and gender sensitive. Major strategies to improve male participation in reproductive health must include education, training, promotion and service delivery. Men must be targeted through education and promotion to share sexual, contraceptive and parenting responsibilities and to plan their families. This educational and promotional thrust must be supported by the health professionals through adequate training in the counselling of men and couples, increased condom availability and provision of male-friendly services.

INTRODUCTION

The Caribbean, a diverse grouping of islands, is a mosaic of different ethnic groups and cultures brought from several continents and has colonial traditions that are English, Dutch, French and Spanish. In this paper, the use of the word "Caribbean" will be confined to the English-speaking Caribbean which reaches from Guyana across the eastern Caribbean to Jamaica in the North. The estimated population of the English-speaking Caribbean is 6.7 million, with wide variations in size, from Anguilla with a population of 8,960 to Jamaica with the largest population of 2.6 million. Males account for just under half (49.7%) of the population (Pan American Health Organization, 1998).

The population is experiencing demographic and epidemiological changes which are typical of societies in transition. These phenomena are manifested in the changing population patterns. The major population changes are influenced by the significant declines in the fertility and mortality rates, increased longevity, ageing of the population and high rates of urbanization and migration. The region's annual growth rate over the last twenty years has been between 1.0% and 1.3% and is a result of the dampening effect of the significant declines in fertility and high emigration to countries such as the Canada, the United Kingdom and the United States of America.

The total fertility rate for the region is approximately 2.6 and an estimated 52% of couples use a modern method of contraception (United Nations, 1998). In the period spanning the mid-1980's to the 1990's, life expectancy rose from 68.7 to 71.1 years in the Americas and the average life expectancy in the Caribbean is 74.3 years. The increased life expectancy is attributable to two main factors—the ageing population and the decreased mortality in the first years of life, particularly from communicable diseases.

The mortality pattern has experienced important changes with the decline in the number of deaths from non-communicable diseases. In Latin America and the Caribbean, non-communicable diseases are responsible for approximately two-thirds of all deaths. This epidemiological change in mortality includes an increase in the number of deaths from chronic and degenerative diseases; they outnumbered the deaths from infectious and parasitic diseases by five to one in 1985 and were projected to reach ten to one in the year 2000 (Pan American Health Organization, 1998).

The development of family planning programmes

Throughout the region, the initial efforts to address population growth were undertaken by nongovernmental organizations that sought to provide family planning services to women to improve the quality of their lives, which were exacerbated by frequent and unplanned childbearing. The focus of these efforts in reproductive health was on family planning and the principal target group was women in the reproductive years of 15–45. The thrust of the family planning programme was twofold. Firstly, to encourage women to space their children to improve their own health and that of their children and secondly, to reduce their fertility levels. In many of the Caribbean states, family planning associations provided the institutional framework through which external funds were accessed and services provided to a wide cross-section of communities.

Generally in the Caribbean, male involvement in reproductive health efforts has been marginal in that it has been mainly restricted to condom use. The narrow range of

contraceptives available for the exclusive use of men has resulted in little emphasis being placed on services to support their use. Both male and female sterilization is unpopular among males. In a survey of Jamaican men of 15–40 years, 94% approved of family planning but 93% would not consider sterilization for themselves after having achieved their desired family size (Bailey et al., 2000). Male sterilization services are not available in some countries, but even where they are available, the demand is almost non-existent.

With the intensifying debate about economic growth and development and strategies to promote them, Caribbean governments in the latter half of the sixties began to implement family planning programmes and supported nongovernmental efforts to reduce population growth. The containment of population growth was seen as an important measure to promote economic growth and social development in developing societies.

Governments accessed international funding from several bilateral and multilateral agencies to provide training, contraceptive and related supplies, research, equipment and technical assistance to develop and deliver family planning programmes. The Government of Jamaica was among the first of the English-speaking Caribbean states to establish, in 1968, a public institution, the National Family Planning Board, to administer and implement family life and family planning programmes. Other regional governments followed suit by allocating resources for family planning programmes through the family planning associations and their ministries of health.

The establishment of family planning programmes in the region posed many challenges that spanned sociocultural, religious, political, geographical and educational arenas. Some of these issues were thornier than others. The prevailing sociocultural and religious norms did not accommodate artificial control of fertility. The new socialization that fertility can and should be controlled to improve individual and national social and economic well-being runs counter to the belief that uncontrolled fertility is a given. It is also believed that one's social status can be improved through one's offspring as well as to provide social security in old age.

Initially, family planning programmes were organized and delivered as vertical programmes in single-purpose clinics. In many instances this mode of service delivery has been changed, as it is has been integrated into regular clinic services and is either included in or closely allied to maternal and child services. There still exists in some countries a mix of both vertical and integrated delivery modes for family planning.

Caribbean governments have sought through public information, education and communication programmes to create awareness in their populations about the benefits of family planning and to provide highly subsidized clinical and contraceptive services to women. Services for men were mainly limited to condom distribution, information and vasectomy. Over the decades, access to family planning services has increased significantly and several benefits have accrued which include reductions in the indices for fertility, infant mortality, maternal mortality and greater participation of women in the labour force. These improvements are reflected in the development indicators for the region according to which the total fertility rate in Latin America and the Caribbean declined from 3.7 to 2.4 children between 1970 and 1995, infant mortality from 51.7 to 24.0 per 1,000 live births and the female workforce increased from 28.0% in 1970 to 32% in 1995 (Pan American Health Organization, 1998).

Since the latter half of the 1970's, improvements in the quality and expansion of family planning services in the region have been facilitated by the University of the West Indies through the Advanced Training and Research in Fertility Management Unit in the Faculty of Medical Sciences. The Unit has provided training, research and clinical services for over

twenty years. This institution is a valuable regional resource and model for the integrated delivery of family planning utilizing holistic, interdisciplinary and multisectoral approaches in its programme. It has emphasized training and clinical service as critical factors for efficiency and reliability in family planning.

Major initiatives in reproductive health in the Caribbean

Major initiatives in the Caribbean to support reproductive health include the adoption in many countries of population and health policies that advocate the achievement of optimal levels of population growth, targeting special population groups and the provision of adequate health services. Population goals include fertility targets and the integration of family planning services into general health services to expand the service delivery network and increase access to all population groups.

In the 1980's, government efforts to deepen population planning included the development of explicit population policies, and the establishment of national population councils and population units and the development and review of health policies. Population policies included major fertility goals for specific time periods based on an analysis of current population trends and their projected performance. Jamaica led the way by developing the region's first population policy which projected a total fertility rate of two children per women by the late 1990's and a population of not more than 3 million by the year 2000. The policy was revised and adopted by the Jamaican Government in 1995. Preliminary population policy statements were been made in Dominica, Grenada and St Lucia in 1986, and the Grenadines and St Vincent in1987, but they have not yet been formally adopted. These policy initiatives form part of the regional process to institutionalize and integrate population concerns into national policy and development planning.

While the importance of men in the reproductive sphere has been known, as it relates to their own health and behaviour and that of women and children, it has not in the past received the direct attention of health care planners and providers. In the last decade there has been a significant increase in the acknowledgement of the role and importance of men in sexual and reproductive matters resulting in efforts to expand the original concept and focus of family planning programmes to the broader concept of reproductive health.

This wider concept was reflected at the 1994 International Conference on Population and Development (ICPD) in Cairo, which advocated efforts to ... "emphasize men's shared responsibility and to promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of STD's including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes." (UNFPA, 1994)

This emphasis was underscored in the 1995 World Conference on Women in which the statement was made that ... "shared responsibility between women and men in matters related to sexual and reproductive behaviour is also essential to improving women's health"(United Nations). The English-speaking Caribbean governments have been signatories to the agreements of both conferences to implement expanded reproductive health programmes in their respective countries. Since the last decade, efforts have been intensified to expand the traditional family planning programme in the region.

Family planning programmes throughout the region have been placing greater emphasis on adolescent reproductive health and the introduction of services for men. The findings of the

Caribbean Adolescent Survey 1997 point to the direct need for reproductive health services for young men and women. Among the sexually active adolescents in the survey, more than two had initiated sexual activity before the age of ten and 50 per cent reported non-use of contraceptives at last intercourse. The Caribbean Youth Summit in 1998 also placed actions on the agenda of regional governments to be undertaken with the participation of youths in programmes for information, education and communication and services to improve and protect the reproductive health and rights of adolescents. The focus on adolescents and young adults in the region is justified by the fact that approximately 54% of the population is under the age of 25 years.

Trinidad and Tobago has forged ahead in its provision of male reproductive services. The response to the service shows that men are interested in accessing a range of services and the original service concept had to be expanded beyond dealing with prostrate disorders to persistent requests for other genital and urinary problems. In Colombia, research findings among men showed that men wanted more than just information about health, but also wanted to know how to communicate with children and partners as well as foster new ideas about being gender-sensitive in a changing society. They were also concerned about the relationship between their sexual role and their behaviour. (Eschen et al., 1999).

There have been several programme efforts in the region funded from national and international sources to develop reproductive health programmes. A life-cycle approach is being adopted which segments the population into specific target groups to address their special circumstances and needs. Special emphasis has been placed on males and adolescents, while increased attention for education and services are being focused on older men, women, young girls and boys. Reproductive health programmes are being implemented across the region with the support of several international organizations including the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID).

Over the last two decades, the shift to broaden traditional family planning programmes to reproductive health was intensified. This shift in perspective has adopted a life-cycle approach to addressing the reproductive needs of men and women and is inclusive of reproductive rights which implies the right to decide when to have children and how many.

Data to determine the status of male reproductive health in the Caribbean are limited and this is a result of the focus that has been placed on females. Reproductive health surveys conducted every five years have begun to include men and so, over time, the database will become more comprehensive. Survey findings among men in Jamaica indicate that men are interested in fertility issues and would like to become more knowledgeable and involved in reproductive health. More research among men is needed to determine what they perceive their needs to be and the ways in which they would like to participate in reproductive health programmes. Research to inform male participation in reproductive health in the Caribbean must move beyond the current context of social problems and from the perspective of women to explore in-depth their attitudes towards reproduction and the factors that impact them. Research studies, principally in the form of reproductive health surveys, are routinely conducted to determine contraceptive prevalence, provide information on contraceptive knowledge, attitude and practice and unmet needs among men and women of 15–49 years of age.

Caribbean men have been profiled as being at best marginal to family life and in relation to their roles as partners and fathers (Smith, 1971; Wilson, 1973). Subsequent studies, however, have revealed that men value these roles and are not naturally irresponsible, but are constrained by their limited economic status which distorts their viability as good fathers and

partners (Chevannes, 1986; Bailey et al., 2000). While women suffer disproportionately from gender inequities, the gender role and expectations in relation to reproduction and sex in the Caribbean also have negative effects on men. The concept of masculinity is firmly rooted in their sexuality, which includes the ability to father children and to provide economic support for their children (Bailey et al., 2000). This concept needs to be modified to be consistent with the defined reproductive health tenets.

National, regional and international experiences in reproductive health programmes consistently show the need for male involvement to improve and protect their own health and that of their women and children. The AIDS pandemic has heightened the need for male involvement given that male attitudes about sexuality and their vulnerability put both themselves and their partners at risk. Next to sub-Saharan Africa, the Caribbean has the second-highest rate of HIV/AIDS infection (2% of its population). The prevalence of AIDS is in a ratio of two males to one female. The disease has evolved from the initial profile of homosexual and bisexual males towards mainly heterosexual transmission. There is also an increasing number of paediatric cases. AIDS cases are also mainly in the 25–34 age group (34%), followed by 26% in the 35–44 age group, which constitute the prime productive years (Camara, 1999). This situation is of major concern and requires very intensive application of programme interventions to address the problem at the individual, community, national and regional levels.

Several countries are at this time considering the development of a reproductive health policy. The adoption of such a policy will comprehensively address the most critical issues among which are the integration of males, reproductive rights, important gender considerations and the life-cycle approach to reproductive health. Regional collaboration is also being pursued through conferences and consultations to identify the critical elements including the legal framework and service delivery components.

Implications of the present status for male participation in reproductive health

The role of men in the reproductive decisions of their partners has always been recognized as a factor that could either promote or hinder women's participation in family planning programmes. In spite of the recognition, overt programmatic action has not been taken to find ways to encourage their involvement as partners in family programmes beyond the provision of condoms and information. In the 1980's the Jamaica family planning programme introduced a male responsibility component which targeted men for education, information and counselling. Other countries have in a variety of ways tried to target men, particularly since the advent of HIV/AIDS, which has contributed to dramatic increases in condom distribution and use.

Against the background of the improvements in aspects of reproductive health, its impact on longevity and the health of women and children, and changes in the epidemiological profile is the marked increase in the incidence of diseases of the male and female reproductive systems. Underlying the impact of these changes on the health status of the region is their individual economic capacity to effectively mobilize the various resources to meet the changing needs, which will ultimately determine the health outcomes. Reproductive health conditions, especially among women, already consume a large portion of institutional health resources.

Efforts to further improve the reproductive health status beyond the current achievements in the Caribbean will be difficult without the active and informed participation of men. The initial focus on women was strategic and necessary in the short to medium term to reduce fertility, given the social and economic urgency to address the problem of health and

development in developing countries. That strategy has run its course. Issues of unmet need for family planning, inconsistent use of contraceptives, unplanned pregnancies and STI transmission can only be significantly reduced with male participation. It will be difficult to further improve the reproductive health of the population without the planned inclusion of men.

The experience over the years in implementing family planning programmes has provided greater understanding of the male influence and gender relations and their implications for reproductive health in its broadest sense. A sound base has been laid in family planning for service, research, education, communication and training, which can facilitate changes to expand the programme to implement the wider concept of reproductive health involving men, institutionalizing gender, and implementing a couples' approach to reproductive and sexual matters.

Family planning programmes are now more challenged in the face of pervasive poverty in the region to reduce the level of unmet needs for family planning and unplanned pregnancies. In 1997, the incidence of poverty ranged between a low of five per cent and a high of 50 per cent for the various states, with the majority in the region of 8% - 15% (Pan American Health Organization, 1997). Greater integration of Caribbean men in reproductive health programmes is mandated by a variety of conditions that exist in all the territories and which adversely affect their reproductive health status. They are of major concern to national governments and regional institutions such as the Caribbean Community (CARICOM) that is charged with fostering the economic and social development of the region. The conditions include:

- the high incidence of STIs and HIV/AIDS and the higher risk of male–female transmission and its transmission to the newborn;
- early sexual initiation, which, several studies indicate, takes place between 10–12 years for boys and which impacts on fertility and sexual infections; (Powell et al., 1988; Morris et al., 1995; Jackson, et al., 1998);
- multiple sexual partners and the associated risks for STI/HIV transmission;
- high incidence of adolescent fertility, estimated at approximately 30% for the region. This rate needs to be significantly reduced to curtail the economic and social dis-investment among the most valuable part of the population for national development;
- incomplete and inaccurate knowledge and information on reproductive health;
- lower health-seeking behaviour among men compared to women;
- prevailing myths and misconceptions about fertility, sex and contraception which influence sexual and reproductive attitudes, practices and behaviour that are detrimental to both sexes;
- unfavourable and negative attitudes to contraception and male/female relationships;
- high rates of sexual violence against women and girls in the main, but also against men;
- issues of male sexual dysfunction, infertility (estimated at 40% for infertile couples in Jamaica) and diseases of the reproductive system;
- inconsistent condom use to prevent pregnancy and infections;
- insufficient support for women in relation to contraceptive use and during pregnancy, delivery and postpartum periods;
- high levels of unwanted, and mis-timed births.

These core issues are not exclusive to any one sex, but must be more directly addressed among the male population to create the platform to reach greater consensus on them as they define the context of men's reproductive lives. Research findings point to positive outcomes when men are involved in reproductive health. In India, the provision of antenatal education

to prospective fathers resulted in a significantly higher frequency of antenatal visits and lower perinatal mortality among women whose husbands had received the education (Bhalerao et al., 1984).

The importance of educating males is further emphasized by the finding that men who participate in antenatal education are more knowledgeable about family planning methods and are more concerned about their partner's nutritional needs during pregnancy. Male sexual behaviour heightens the risk faced by women for the contraction of STIs; married women's greatest risk factor for STIs is the sexual behaviour of their husbands (Hunter et al., 1994; Foreman 1999). The fact is that men are more likely to transmit HIV to women through unprotected sexual intercourse than vice versa and this increases their vulnerability to infection (Padian et al., 1997).

As for women, men experience changes in their reproductive health issues, concerns and needs as they pass through their life cycle. Reproductive health practices are part of cultural, social and medical practices and are initiated from birth, for example, the circumcision or non-circumcision of boys. It has been shown from research in developing countries that circumcision *can reduce the risk of HIV* infection by at least 50% (Best, 1998). Puberty and adolescence carry with them the most significant physiological and psychological changes that impact on sexual behaviour.

During the adolescent phase, issues such as risky sexual behaviour, sexual orientations, masturbation, sexual abuse and concerns about their sexual organ all need to be addressed through comprehensive education, information and counselling. While the adolescent young men do not face the direct consequences of unintended pregnancies, they nevertheless share concerns about contraception, its appropriateness, accessibility, and safety, and sexual infections. The gender differences on these issues need to be jointly explored and understood, and appropriate approaches and measures devised to deal with them. This can only be achieved through male participation fostered by the stakeholders and institutions involved in reproductive health.

Older men have problems such as prostate cancer and various types of sexual dysfunction. The intensity of some of the sexual illnesses among this age group are related to lifestyle which include smoking, alcoholism and certain chronic illnesses, for example, diabetes mellitus.

The way forward

What are the measures needed to improve the reproductive health of men in the Caribbean? Regional governments through CARICOM have taken several policy and programme initiatives to improve in the long term the quality of life for Caribbean peoples, including their reproductive health. Initiatives include health promotion, health and family life education, gender equity, drug abuse prevention and definition of the ideal Caribbean person. Some countries have initiated reproductive health programmes for men that go beyond condom distribution and the provision of information. The interventions for men include counselling, sexual and reproductive health education, reproductive services outreach to young mates and mass media programmes.

It is imperative that reproductive services be provided for men without diminishing those provided for women, so that the services become more comprehensive to meet the different needs of males and females. The model of family planning service delivery that includes training, research, clinical services, promotion, information and education and outreach services must be evaluated to determine the best practices for the integration of male services.

The pillars of male reproductive services in the Caribbean should include the following:

- targeting male needs according to their age, marital status, sexual orientation, health and family life, education and sociocultural orientation to reproductive health;
- promotion of condom use to provide dual protection against sexually transmitted infections and pregnancy;
- promotion of communication skills to improve cooperation between partners on sexual and reproductive matters;
- provision of comprehensive reproductive education and information;
- clinical services to address a range of services that include contraception, infertility, STIs/HIV/AIDS, sexual dysfunction, screening for prostate cancer, etc;
- counselling services for individual men and couples;
- promotion of lifestyle changes to prevent and protect against risks of reproductive health diseases and compromising sexual behaviour;
- outreach programmes for male youths;
- development of programmes to target men at the workplace, especially those that are male dominated, taking into consideration the peculiarities of their jobs;
- mass-media educational programmes to create awareness, interest and support;
- condom social marketing to improve variety and access;
- promotion of male sterilization;
- support mechanisms for the reproductive health of women and children.

The powerful influence of education as an agent of socialization to achieve desired attitudes and behaviour makes it one of the most important measures to be consistently used in the preschool and schooling years and into young adulthood for reinforcement. Health and Family Life Education (HFLE) is a strategy recommended by CARICOM to be implemented in the region's educational facilities using a comprehensive curriculum. HFLE should seek to do the following, which will create the framework for increased male participation in reproductive health:

- provide more in-depth education and information on substance abuse including the implications for reproductive health;
- intervene with families and care-givers to encourage critical support for the promotion and adoption of practices that reduce the propensity for risky behaviour, which includes substance abuse, early sexual involvement and pregnancy etc;
- emphasize the development of social skills that will mediate risky behaviour;
- identify high-risk children for referral for evaluation and treatment.

Schools are an important site where young males can be reached, but it has to be noted that in the Caribbean girls are more likely than boys to remain in school. Therefore, special emphasis is needed to reach males who are outside the school system and are in need of the HFLE. One approach is to target young males in sports and social clubs and community groups.

Male participation in reproductive health in the Caribbean must of necessity employ strategies that are collaborative and multisectoral. Research on men is needed to properly assess their needs and obtain their opinions and perspectives about their participation. Institutional coordination, especially in the provision of reproductive education and information, is necessary principally among the ministries of education, health, social services and the nongovernmental health and social agencies to reach a wide cross section of men of all ages with education and information. Health and family life education must be the vehicle through which comprehensive and scientific reproductive and sexual health education is provided both for in and out-of-school target groups. Training of human resources to meet the identified

needs will be required and as such, regional strategies should be devised to institutionalize and coordinate existing regional resources to standardize and certify the required training. Existing reproductive health services should be reviewed, strengthened and expanded to include services for men that are "user-friendly", of high quality, cost-effective, appropriate and accessible to all income levels and socioeconomic groups.

Regional governments are convinced of the need for male participation in reproductive health and their continuous support is vital. Efforts to make inroads into increasing male participation will be related to a number of issues, which include:

- continuous global advocacy for the expansion of reproductive health;
- pursuit of gender equity in reproductive health without reducing existing services for women;
- increased allocation of resources for reproductive health to support training, service delivery, education and promotion.

The English-speaking Caribbean will have to intensify its efforts in the short term to mobilize resources to increase the participation of its male population in reproductive health if it is to effectively stem the AIDS epidemic, achieve further reductions in population growth and substantially improve the quality of life by reducing poverty, gender inequities and ill-health in the population. The region's potential for growth and development will be stymied and gains to date compromised, if full partnership is not achieved between men and women in the reproductive aspect of their lives for which the responsibility is joint and inescapable.

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2.4.4 Capacity building in reproductive health programmes focusing on male involvement: a South-to-South framework

Dr M. Badrud Duza

Abstract

The issue of male involvement in reproductive health is enigmatic. It has traditionally been held that men's role and voice are decisive in the family building process and reproductive health outcomes of both males and females. At the same time, against the backdrop of recent and ongoing experience, men also have been characterized as the neglected half in the pertinent programmes, playing a tangential role relative to women. Within this general area, the present paper explores the opportunities for capacity building in reproductive health programmes, keeping in view some critical areas where male involvement appears to be especially relevant. The exercise is undertaken in light of lessons learned in the South-to-South framework of inter-country sharing and exchange of experience in the field. Possible institutional strengthening towards increased and effective male involvement is considered in order to address capacity-building needs at the level of policy makers, programme managers, service providers and clients.

CONTEXT AND OBJECTIVES

Are men important, as traditionally believed, with respect to a decisive role and voice in the family building process and the reproductive health of males and females? How relevant are they, compared to women, in these regards, given the growing array of women-focused communications, programmes and empowerment? Is there any reason for concern about the stipulation that men are the neglected half, playing a marginal role, in recent and contemporary reproductive heath interventions? Such enigmatic questions bear profound ramifications in the context of the continued search for new policy frontiers and programmatic strategies in the field, especially pronounced during and since the International Conference on Population and Development (ICPD), 1994. The present paper explores the opportunities for capacity building in reproductive health programmes, focusing on male involvement. This is done in light of the lessons learned in the South-to-South framework of inter-country sharing and exchange of pertinent knowledge, experience and expertise in the field. Possible institutional strengthening towards increased and effective male involvement is considered in order to address needs at the level of policy makers, programme managers, service providers and clients.

The ICPD Programme of Action (POA) points out (United Nations, 1995) that in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal family size decisions to policy and programme decisions at all levels of government. Thus, it emphasizes that changes in the knowledge, attitudes and behaviour of both men and women are necessary conditions for achieving a harmonious partnership of men and women. The POA calls for equal participation of the two sexes in all areas of family and household responsibilities, and underscores that:

- "special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention

of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes" (UNFPA, 1996);

- male responsibilities in family life must be included in the education of children from the earliest ages;

- special emphasis should be placed on the prevention of violence against women and children;

- governments should consider changes in law and policy to ensure men's responsibility to and financial support for their children and families;

- national and community leaders should promote the full involvement of men in family life and the full integration of women in community life;

- parents and schools should ensure that attitudes that are respectful of women and girls as equals are instilled in boys from the earliest possible age, along with an understanding of their shared responsibilities in all aspects of a safe, secure and harmonious family life;

- relevant programmes to reach boys before they become sexually active are urgently needed.

At ICPD+7, we are thus faced with a daunting and unfinished agenda on determining an optimal gender focus in reproductive health interventions and, in particular, exploring modalities for effective integration of males in the concerned efforts. One may not be able to appreciate the full significance of the underlying issues on the basis of generalizations on whether men play an overly important or unduly negligible role in reproductive health norms, behaviour or programmes. Indeed, use of concepts such as male responsibility, male involvement, and men's programmes may imply varied connotations and sensitivities and, more often than not, it is sometimes difficult to say much without being misunderstood. Does "male responsibility" suggest that men are irresponsible when it comes to sexuality, fertility and contraceptive norms and behaviour? Does more "male involvement" suggest an intent for even wider engagement of them than their already dominant position in the reproductive arena? Similarly, would "men's programmes" imply segregation of male and female services, possibly creating separate programmes for males in isolation from and apparent opposition to female programmes? Thus, one needs to identify where, how and to what extent male involvement may make a positive difference in reproductive health outcomes and interventions (Verme, Wegner & Jerzowski, 1996). Only against such a broader understanding would it be possible to adequately outline the implications of male involvement in reproductive health for capacity building—and South-to-South framework—in various operational areas at the family, community, and institutional settings. It would be important to bear in mind the linkage of the development process with ongoing reproductive health efforts as well as the interface of related programmes under governmental, nongovernmental, communities and broader civil society organizations.

DIRECT AND SUPPORTIVE ROLE OF MALES

In the present context, involvement of males would be critical in their (i) *direct role* in making positive family life decisions and reflecting a proactive personal behaviour towards their achievement as well as a broad spectrum of (ii) *supportive role* as sex partners. The first set would cover: adherence to the small family norm; acceptance of male methods of contraception; and diligent care of own sexual and reproductive health, including risk-free behaviour with respect to STDs and HIV/AIDS. Importantly, the second would encompass commitment to women's sexual and reproductive health; avoiding risk behaviour that could jeopardize the health and safety of the spouses; and compassionate support to spouses in the choice, acceptance and continuation of specific family planning methods (Piet-Pelon, Rob & Khan, 2000). Full male involvement would culminate in a focus on men and women as couples and partners, rather than separate entities and individuals, in reproductive health norms, behaviour and initiatives.

Inadequate male involvement along the above lines has been widely documented. Typically, this has been attributed to the cultural ethos of male dominance of traditional societies. As summed up by Pachauri (Pachauri, 1997; Pachauri, 2000), since gender inequalities favour men in patriarchal societies and sexual and reproductive health decisions are made by them, there is a growing realization that unless men are reached, programme efforts will have limited impact. Research on sexual negotiation for HIV prevention has highlighted the inadequacy of strategies that target only women.

Because of unequal gender-power relations, women are especially vulnerable as they are unable to negotiate changes in sexual behaviour to prevent unwanted pregnancy and to practice safer sex. Therefore, the involvement of men as responsible partners is essential. Besides, men too, have reproductive and sexual health needs that should be addressed.

In the traditional settings of the developing countries (UNFPA, 1996; Konings & Carael, 1997; Fathalla, 2000; Piet-Pelon, Rob & Khan 2000), men are believed to:

- leave the burden of modern contraceptives essentially to women, men themselves representing low acceptors of such methods all over the developing world;

- tolerate (in large parts of Africa), such harmful methods as female genital mutilation (FGM), and help perpetuate practices of "widow inheritance" by a deceased man's (eldest) brother and "ritual cleansing" of recent widows , whereby the widow has to have penetrative sex with her deceased husband's brother(s) in order to be cleansed from the negative effects of death—practices that are raising major alarms in the wake of the HIV/AIDS pandemic;

- enjoy far wider freedom and choice of pre-marital and extra-marital sexual networking, compared to women, with all the health hazards with which this is associated;

- in view of the lower status of women, allow them highly inequitable access to whatever limited facilities may exist, in terms of allocation of family resources or community health infrastructures for antenatal, and other safe motherhood and women's sexual and reproductive health services.

Insufficient male responsiveness is also deemed to be related to the state-of-the-art in modern contraceptives, most of them being female methods, with varied side effects. Paradoxically, certain well-conceived reproductive health programme features—women counsellors and service providers in female targeted and women-friendly outreach and clinic settings—sometimes may unleash a process of alienation and disempowerment of the previously dominant male-folk. They may find it awkward to seek counsel or assistance under the circumstances; may simply resign to the notion that the new program turf—be it family planning, immunization or safe motherhood—belongs to their female counterparts and is simply beyond them (Nag & Duza, 1988; Piet-Pelon, Rob & Khan, 2000).

Lack of full and supportive partnership of males in the family decision-making and behaviour change process remains a major challenge in post-ICPD reproductive health programmes. In narrow family planning terms, outright male opposition or lack of support is often associated with contraceptive non-acceptance or dropout by either spouse, especially by the female partner in case of side-effects. A good deal of unmet needs in family planning has also been linked to male opposition. Implications for broader reproductive health issues are more pervasive.

A major case in point is the phenomenal success of the 100% Condom Programme in Thailand, with a significant decline in STD prevalence and a plateauing of HIV infections. This achievement is to be attributed to institutional mobilization and behaviour change communication (BCC) at various levels, including the government and nongovernmental networks, the sex establishments, and the huge body of male clients. However, the slow pace of comprehensive behavioural change remains to be addressed. While safer sex is now practised more widely, the use of condoms is largely limited to sexual intercourse outside marriage (Pachauri, 2000; UNAIDS, 2000). The phenomenon calls for considerable remaining work to be done with men who tend to have the stigma of condom use with their spouses for negative connotations associating condoms and sex workers, and for other reasons. Women continue to be exposed to the risk of infection in case of multiple sex partners of their spouses.

Thus, the programmes would need to integrate men fully. Additionally, it would help avoid the programmatic mistakes of marginalizing men in family planning and reproductive health services. In relation to the emerging problems of STDs and HIV/AIDS, one would need to underscore how "ignoring men's needs would not only greatly increase their health risks but those of their partners also" (Piet-Pelon, Rob & Khan, 2000). Concerns for both adolescent and adult sexuality and sexual health would be of particular significance. In this area, the vulnerability of women is well known. However, a perceptive approach would also reveal the vulnerability of males themselves, calling for attention to them for their own sakes as well as for that of their female partners. Thus, while men's behaviour may be contributing substantially to the spread and impact of HIV, and may put men themselves on the "front line of risk," engaging men as partners in the effort against AIDS can be a most strategic means to change the course of the epidemic. How men make a difference may be appreciated in a gender-sensitive approach to the problem (UNAIDS, 2000):

> All over the world, women find themselves at special risk of HIV because of their lack of power to determine where, when and whether sex takes place. What is perhaps less often recognized is that cultural beliefs and expectations also heighten *men's* vulnerability. Men are less likely to seek health care than women, and are much more likely to engage in behaviours . . . that put their health at risk. Men are also less likely to pay attention to their sexual health and safety, and are more likely to inject drugs, risking infection from needles and syringes contaminated with HIV.

> All over the world, and on average, men have more sex partners than women. Moreover, HIV is more easily transmitted sexually from men to women than vice versa. In addition, HIV-positive injection drug users—who are mostly male—can transmit the virus to both their drug partners and sex partners. There are sound reasons, therefore, why men should be fully involved in the fight against AIDS. As politicians, as front-line workers, as fathers, as sons, as brothers and as friends, they have much to give ...

Obviously, capacity building in this field would call for interventions at all the above levels. Acceptable reproductive health outcomes of men as well as women are pivotal in this dynamic.

SOUTH-TO-SOUTH INITIATIVES

Partners in Population and Development *(Partners)*

Understanding of the myriad issues reflected above would be facilitated by the sharing of the pertinent knowledge among the developing countries. Related policy initiatives and program interventions would also benefit from the exchange of experience among them. Success stories, lessons learned and innovative approaches within the South-to-South framework would be most salient. In this context, alliances like Partners in Population and Development *(Partners)* would prove to be most helpful in capacity building for strategic communications and institutional support towards an expanded and viable role of males in the field of reproductive health.

In recognition of the fact that, during the past few decades, many developing countries have acquired the experience and expertise to create and implement innovative and successful population and health programmes, ICPD affirmed South-to-South collaboration as a key mechanism to ensure implementation of its demanding agenda. Accordingly, the Programme of Action (para. 14.16) urges: " . . . more attention should be given to South-South cooperation … particularly in partnership with nongovernmental organizations. The international community should … give higher priority to supporting direct South-South collaborative arrangements". (UNFPA, 1996)

However, as pointed out by Silla (2000), demonstrated expertise and achievements in reproductive health do not automatically translate to a successful transfer of the relevant approach and skills to others. For the timely and successful transfer of their unique reproductive health knowledge and skills beyond the limits of particular pilot areas or country boundaries, it would be critical to systematically build and institutionalize the pertinent capacity of Southern individuals and organizations. Thus, South-to-South collaboration would need to be part of an integrated strategy leading to lasting improvements in the ICPD priority focal areas. (For a detailed exposition of the underlying philosophy and approach, see Silla, 2000.)

There have been various efforts in support of the above-felt need and strategy. The inception of *Partners* during ICPD in 1994 is of particular significance in this vein. It is the "*only organization in the world solely dedicated to the promotion of South-to-South partnerships*" (Silla, 2000). An intergovernmental organization comprising sixteen developing countries, its global secretariat is located in Dhaka, Bangladesh. Six of its members are from Asia

(Bangladesh, China, India, Indonesia, Pakistan and Thailand); three from the Middle East and North Africa (MENA) region (Egypt, Morocco and Tunisia); five from Sub-Saharan Africa (Gambia, Kenya, Mali, Uganda and Zimbabwe); and two from Latin America (Colombia and Mexico). The African countries include both anglophone and francophone cultural and legal systems. The Governing Body of the agency consists of Ministers of Health and other senior officials of the member countries, thus providing strong political support to its efforts. The alliance, which continues to expand, already represents more than half the world population. It serves all developing countries needing help and collaboration in reproductive health. Beneficiaries of its varied programs have covered government, NGO and private sector agencies from more than sixty countries. Along with the prime South-to-South focus, it also has a complementary North-to-South agenda, and extensive collaboration with international and bilateral agencies and foundations in order to keep up with state-of-the-art developments, and to benefit from technical, financial and other forms of assistance from the development partners.

The mission of *Partners* is to "expand and improve South-to-South collaboration in the fields of family planning and reproductive health." Its unique mandate is pursued within the focal priorities of the ICPD, and is strongly endorsed in the ICPD+5 review of the Special Session of the United Nations General Assembly, June 1999 (paragraph 88):

> … promote and sustain the full potential of South-South co-operation, including the South-South initiative: 'Partners in Population and Development,' in order to bolster the sharing of relevant experiences, and the mobilization of technical expertise and other resources among developing countries (United Nations, 1999).

In short, the essence of *Partners'* work comprises of advancement of reproductive health goals and interventions in the developing world. The modality of its operation is also its unique feature and comparative advantage, with significant value added along several dimensions – identification of the salient success stories from around the South; cost-effective sustainable exchange of the relevant experience and expertise through networking among the Southern countries; and sustainable capacity building for the transfer of the positive lessons learned from one milieu to another and their effective absorption by the recipients. To these ends, *Partners* is "dedicated to forming partnerships between and among … individuals, organizations, and governments of developing countries" (Silla ,2000). Capacity building for male involvement in reproductive health innovations and interventions within the South-to-South framework would, thus, bear enormous opportunities and potentials.

CAPACITY BUILDING FOR MALE INVOLVEMENT

Opportunities through *Partners* initiatives

While addressing the issue of male involvement in reproductive health programmes, it would be important not to view men in isolation from women, even when a particular male focus may be called for. The direct as well as supportive roles of males vis-à-vis females and the linkages between the two sexes as spouses and partners, as discussed earlier, would need to be borne in mind. Building in gender sensitivity in various areas within reproductive health would be most crucial, calling for appropriate orientation and reorientation of all concerned, especially on the part of males. Different levels of interventions directed at men and women as individuals, as well as couples and partners, would be involved in the process. Capacity building for advocacy, counselling and skill enhancement for service providers, programme managers, and policy makers would also have to be approached in this holistic and synergic

context. The following points are illustrative of where one might wish to strengthen the gender focus and male perspective in the South-to-South framework of mutual sharing and exchange in the field.

Partners has identified four focal areas out of the vast ICPD agenda for priority attention and follow-up:

- integration of reproductive health and family planning services;
- reduction of maternal morbidity and mortality;
- promotion and integration of STD and HIV/AIDS prevention and care within reproductive health structures; and
- promotion and provision of adolescent sexual and reproductive health as part of regular reproductive health programmes.

These are in response to the new ICPD paradigm envisaged—away from the vertical programme thrust of the past, driven by demographic targets and towards an integrated package, with focus on comprehensive quality of care. This shift implies radical reorientation of adult and adolescent men and women as individual actors in reproductive health, and various programme functionaries. There have also arisen expanded opportunities to cement a pivotal gender sensitivity—especially reinforcing the role of males—in each of the four priority areas in the *Partners* framework. Pertinent capacity building is being pursued by *Partners* through its three substantive programmes, viz.: Documentation and Communication, Research and Policy Dialogue, and Training and Development.

Documentation and Communication

Under this programme, documentation of success stories, positive and negative lessons learned, and innovative approaches are being gleaned from various developing countries for possible sharing, dissemination and benefit for others. Several initiatives may be cited. Developing the East African Reproductive Health Network (EARHN), covering Kenya, Tanzania and Uganda, was one of the early activities, started in January 1997. Good practices offered in the three countries in various areas of reproductive health were identified. The gender focus was prominent in the mapping of selected programme areas—community-based distribution of contraceptives; youth services, including a programme for high-risk adolescents; AIDS prevention and home-based AIDS care; and safe motherhood, including emergency obstetric care (Silla, 2000).

Similarly, *Partners* undertook an extensive review and reflections on possible interventions in HIV/AIDS in several African (Kenya, South Africa, Uganda and Zimbabwe) and Asian (Cambodia, Laos, Thailand and Vietnam) countries. The resulting report, African and Asian Know-how to End AIDS (AAKEA) (Moyo, 2000), addresses the underlying issues from the perspective of males as well as females. Among others, it has identified a series of focused initiatives to transfer know-how about interventions that have proven to have an impact on the epidemic in one AAKEA country to another. These interventions include:

- voluntary HIV testing and counselling;
- pre-adolescent and adolescent sexual health education;
- care and support of people with HIV/AIDS;
- sex worker outreach programmes; and
- coordination of national AIDS programmes.

Other efforts for relevant documentation have been pursued concurrently. Annex 1 refers to a number of case studies presented in an intercountry workshop of government and non-government organizations, convened by *Partners* in Jinja, Uganda, in December 2000. The studies harped on critical issues in STD-HIV/AIDS and Adolescent Sexual and Reproductive Health (ASRH), and pointed out initiatives that deserve consideration for replication elsewhere. The topics ranged from diagnosis to advocacy and counselling and prevention, care and rehabilitation of the affected population. They focused on adolescents and/or adults, and were fully responsive to the gender issue, including male involvement. A few illustrations reflect the innovative coverage: "The Speak Out Teen Radio Show" of Naguru Teenage Information and Health Center (NTIHC), Kampala; Information Dissemination to Young People on Reproductive Health through The Straight Talk Foundation, Kampala; Community-based Care for HIV/AIDS Clients by The AIDS Support Organization (TASO), Kampala; Care for HIV/AIDS Patients by Mildmay International Study Center, Kampala; STD-HIV/AIDS Services to Young People by Marie Stopes International, Nairobi; Systemic Counselling Training under The Zimbabwe Institute of Systemic therapy (CONNECT), Harare; and Peri-urban and Rural Youth-Friendly Services under the Zimbabwe National Family Planning Council (ZNFPC). Lessons learned in the above programmes would bear special significance for skill enhancement of service providers and institutional strengthening in the South-to-South modality.

Research and Policy Dialogue

Partners looks for appropriate research findings from the developing countries for mutual sharing, policy dialogue and programme interventions. Annex 2(A) compiles a list of researches on various aspects of reproductive health, with several of them focusing on adolescents, which were facilitated by small grants from the organization. The results were shared among the concerned researchers and policy makers in a workshop held in Mexico in April 2000. Another set of studies (Annex 2(B)) currently under way, with support from DIFID and the European Commission (EC), cover a wide range of themes on Alternative Approaches to Sustained Improvements in Reproductive Health. This is being implemented in 17 countries of Africa, Asia and Latin America, involving many government and NGO agencies. Topics range from quality of care to adolescents, STD-HIV, and training of Muslim religious leaders. The involvement of religious leaders along with other persons—as in the case of community based AIDS education in Uganda through Imams (UNAIDS, 1998)—concerns male motivators and counsellors, largely aimed at male target groups. In conjunction with several national and international agencies, *Partners* is currently documenting the Malaysian milestones and success story in safe motherhood; and the Iranian success story in primary health care, including the mandatory pre-marriage counselling and blood testing of the prospective grooms and brides, holistic adolescent development of boys and girls, and meticulous operation of the rural health houses at the grass-roots level, covering male as well as female clients. Insights from these investigations in varied settings provide opportunities for informed policy dialogue and programme interventions in other parts of the developing world.

Training and Development

The input from the above two programme areas of *Partners* reinforces training and human resource development, under which a number of activities for capacity building are orchestrated. Global Leadership Development Programme (GLP) is the principal mechanism in this respect. With support from the Bill and Melinda Gates Foundation, GLP seeks to consolidate and strengthen the effort to create a new generation of planners, programme managers, technical experts, and service providers in population and development in the

developing countries. The task is being carried out through several dimensions of institutional linkage that *Partners* has pursued during the past seven years. These include: (i) building on an extensive network of international and national agencies and institutions in the developing countries that can catalyse South-to-South exchange in the field; (ii) initiating a number of collaborating training programmes in institutes located in the Partner Countries; and (iii) exploring the possibilities of continued enrichment of the operational programmes in the developing countries with transfer of state-of-the-art knowledge and know-how. The objective is to expand cost-effective and sustainable training programmes in selected institutions of the developing countries.

The *value added* in the process would be enormous:

- capacity enhancement of premier training institutions in about twelve Partner Countries, drawing essentially from human and technical resources and experience of the South;
- modules and case studies based on success stories and insights from programmes of various developing countries, to be incorporated in the curriculum of the individual training institutions—with key lessons learned in different contexts that will be accessible also through the electronic media;
- innovative training of some 1,000 persons over a three-year period—trainees coming from Partner as well as non-Partner Countries, representing public and private sectors, and civil society organizations;
- fellowships and internships for staff of development partners in the North;
- international resource persons bringing in state-of-the-art knowledge and methodology and regional experts sharing success stories amidst institutional, human and financial constraints in the developing countries;
- cost-sharing, cost-effective and sustainable training opportunities to be developed in the participating premier training institutions;
- optimization of training resources within a comprehensive framework of priority needs; and
- institutionalization of South-to-South as well as North-to-South collaboration, based on operational relevance and realities in the field and transfer of advanced and appropriate technology.

The participating institutions are expected to move towards a significant level of self-reliance by the end of the three-year programme period. It is also expected that the programme would help the training institutions involved to build up and strengthen their curricula and staff so that they may increasingly be in a position to offer advanced short-term and medium-term courses on their own on a competitive basis. Donors and resource institutions, including WHO/RHR, UNFPA, IPPF, and the Population Council are already providing substantive and technical support. Collaboration from other sources—specifically from the Johns Hopkins University, Columbia University and the University of California at Berkeley—is also envisaged.

Various programmes of professional competency development have been set up under GLP. Programmes implemented and planned already include special modules in ten major collaborating institutions in nine countries, as noted in Annex 3. Three to four more institutions are expected to join over the next few months. The trainees are drawn from among service providers, programme managers, technical experts, and policy makers of the region where a course is offered. About 300 graduates are expected to be produced by

December 2001, 750 by December 2002, and 1,000 in a total of about 40 rounds of courses by the programme closing date of June 2003. The graduates are likely to come from more than 50 developing countries; nearly 40 countries have already been represented in the courses offered, roughly ten countries per course. A unique feature of this programme is a series of modules based on multi-country based experience, offered by in-country, regional and international resource persons. Eventually, each participating institution would be able to offer the modules on its own, with a thrust on regional relevance and international level courses.

The short-term courses of two-to-three-weeks' duration covers the four substantive priority areas of *Partners* noted at the beginning of this section. The goal of the programme is to offer a basic *technical update* in terms of the state-of-the-art developments in the field, along with a good *programme update* needed for reproductive health interventions. Depending on regional salience and need, one of these areas may be offered as a special theme, and the others are included in the core module, which addresses the key concerns in the global population and development arena. The core module, which is common to all GLP institutions, covers the cross-cutting issues, such as, gender equity and management in reproductive health interventions. These cross-cutting issues also run through the special modules that entail about two-thirds of the course effort and duration. Thus, GLP offers considerable opportunities to bring in the *appropriate male focus in the courses being offered and for the programmes being focused on*. In terms of capacity building, *the collaborating training institutions are developing the needed expertise* in the area; and have begun to transmit the pertinent *orientation, knowledge and skills to their graduates that include technical experts and programme functionaries of various levels*. These are being pursued within the *South-to-South approach*, to which *Partners* is fully dedicated.

It may be noted that special modules offered and planned under GLP in various institutions—from China to Morocco and from Cairo to Harare—include the following themes:

- Design and implementation of integrated reproductive health
- Safe motherhood
- Quality of care in reproductive health
- Prevention and care of STDs-HIV/AIDS
- Adolescent sexual and reproductive health
- Strategic leadership and management of reproductive health
- Urban reproductive health issues (under formulation)
- Project cycle management in reproductive health programmes (under formulation)
- Strategic communications in reproductive health (under formulation)
- *Male involvement in reproductive health (under formulation)*

Each of the above, specialized modules would cover gender sensitivity, gender equity, and male involvement as a cross-cutting issue. The last module, however, would be entirely devoted to male involvement—the context, the rationale, the content, the approach, and the modality. It would address not only the integrated approach to reproductive health, including family planning, but would also examine the implications of both direct and supportive male involvement in all the above mentioned programme areas. In addition, it would reflect on the programmatic mistakes of marginalizing men in family planning and reproductive health services. In relation to the emerging problems of STIs and HIV/AIDS, it would underscore how “ignoring men’s needs would not only greatly increase their health risks but those of their partners also” (Piet-Pelon, Rob & Khan, 2000).

A good deal of programme development, coupled with training of managers and providers, would be needed to initiate appropriate behaviour change communication. Besides home,

school, community and clinic-based advocacy and counselling directed at men, women and opinion leaders, policy dialogue at the highest level of societal decision-making would be called for. Piet-Pelon, Rob & Khan (2000) suggest that the following principles should be applied to men's services, which would need to be incorporated in the male-focused course:

- Services and contraceptives for men should be well publicized. Emphasis should be placed on the benefits that men would gain from using methods, as well as how methods would enhance their health and well-being;
- Men should be counselled at health facilities on their reproductive responsibilities, including family planning;
- Counsellors for men should be men;
- Satisfied users should be enlisted to promote the use of methods and to counsel other men. This may be particularly important for vasectomy services;
- Service sites need to be established that cater to the needs of men. Men should be able to obtain the services they want in convenient locations and at appropriate hours;
- Services and supplies should be readily available near work places.

Needless to say, the above remarks would apply to other priority areas referred to in the preceding discussions, including capacity building at institutional and provider levels for STD-HIV/AIDS and adolescent services.

CONCLUDING NOTE

The foregoing deliberations highlight the importance of capacity building in reproductive health programmes, focusing on male involvement. This is pursued in light of the South-to-South framework, using illustrations from the ongoing and prospective activities of Partners in Population and Development *(Partners)*, a dedicated agency for exchange of pertinent success stories, lessons learned and innovative approaches among the developing countries. It is encouraging to note expanding opportunities for involving males in the field in the above context and framework. This would need to be done at various levels of advocacy, counselling, mobilization and training at various levels of interventions.

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Annex 1: Jinja workshop - innovative approaches in reproductive health

Partners in Population and Development (*Partners*)

Title	Implementation institution	Supporting institution
STD-HIV/AIDS Services to Young People	Marie Stopes International, Nairobi, Kenya	MSI, DFID (UK) European Commission. KFW (Germany)
Voluntary Testing and Counselling Services	The AIDS Information Center, Kampala, Uganda	USAID, DFID, CDC
Urban Youth Centers/Corners	City of Harare, Zimbabwe	City of Munich (Germany) UNICEF (Harare)
The Role of Research in Influencing Adolescent Reproductive Health Service Provision	Center for the Study of Adolescence, Nairobi, Kenya	Population Council, JHU/PCS, Rockefeller Foundation, Pacific Women's Institution, Terre des Hommes
Information Dissemination/IEC through a Radio Programme "The Speak Out Teen Radio Show"	Naguru Teenage Information and Health Center (NTIHC), Kampala, Uganda	UNICEF, MOH of Uganda (DISH), Radio Simba, Straight Talk Foundation, Family Planning Association of Uganda, RH/EC Working Group
Systemic Counselling Training	The Zimbabwe Institute of Systemic Therapy (CONNECT), Harare, Zimbabwe	
Syndromic Management of STDs	Bulawayo City Health,Zimbabwe	
STD Management Training Programme	Genito-urinary Center at Wilkins Hospital, City of Harare Health Department, Harare, Zimbabwe	University of Zimbabwe, Departments of Medicine and Obstetrics and Gynaecology, NACP-Ministry of Health
Peri-urban and Rural Youth-Friendly Services	Zimbabwe National Family Planning Council, Harare, Zimbabwe	Population Council, Rockefeller Foundation, JHU/PCS, GTZ, USAID, UNFPA
Organization of NGO Networks	Kenya AIDS NGOs Consortium (KANCO), Nairobi, Kenya	
Information Dissemination to Young People on Reproductive Health	The Straight Talk Foundation, Kampala, Uganda	DANIDA, DFID, DSW, EC, SIDA, Ford Foundation, UNICEF
HIV/AIDS Training	Mildway International Study Center, Kampala, Uganda	Ministry of Health of Uganda DFID, World Bank, CDC
Community-based Care for HIV/AIDS Clients	The AIDS Support Organization (TASO), Kampala, Uganda	DANIDA, SIDA, DFID, USAID, EC
A Pilot Implementation Project on VIA to Screen for Cervical Cancer in Two Selected Districts of Zimbabwe (Mutoko and Gwanda)	University of Zimbabwe, Department of Obstetrics and Gynaecology, Harare Zimbabwe	Ministry of Health, UNFPA, University of Zimbabwe
Youth-Friendly Urban Center	Naguru Teenage Information and Health Center, Kampala, Uganda	UNFPA, UNICEF, Ministry of Health, Population Secretariat, Local Government
Care for HIV/AIDS Patients	Mildway International Study Center, Kampala, Uganda	Ministry of Health, DFID, World Bank
100 % Condom Promotion	All National Consortium	

Annex 2(A): Mexico workshop - innovative approaches in reproductive health

Partners in Population and Development (*Partners*)

Title	Implementing institution	Supporting institution
Quality Evaluation as a Dynamic Process in Reproductive Health Programmes	Population Studies	
Process for Building a Sustainable Institution	Federación Mexicana de Associaciones Privadas de Salud y Desarollo Comunitari (FEMAP)	USAID
Access to Professional Obstetric Care: Maternal Hostels for High Risk Pregnant Women and Females from Remote and Difficult to Assess Areas	Instituto Mexicano del Seguro Social-Solidaridad (IMSS-Solidaridad)	Ministry of Health
The District Care Programme for Adolescents: Different Models for Sustainable Services within a Comprehensive Programme	PROFAMILIA	International Planned Parenthood Federation (IPPF)
The Adolescent Sexual and Reproductive Health care Model: A Public Programme of Modules for Medico-psychological Services	Dirección General de Salud Reproductiva (DGSR)	
The Model of Integrated Care for Marginal Urban Areas: Care Centers as Bases for Integrated Services for Rural Adolescents	Instituto Mexicano del Seguro Social-Solidaridad (IMSS-Solidaridad)	Ministry of Health
Reproductive Health Programme for Marginal Urban Areas	Instituto Mexicano del Seguro Social-Solidaridad (IMSS-Solidaridad)	Ministry of Health

Annex 2(B): Alternative approaches to sustained improvements in reproductive health

Partners in Population and Development (*Partners)*

Criteria	Project # 1	Project # 2	Project # 3	Project # 4	Project # 5
Programmatic focus - **Projects included focus on interventions in several ICPD priority areas, not just FP/RH**	**Reproductive Health** Improved utilization and quality of reproductive health services by strengthening organizational capacity to provide these services	**Adolescent Reproductive Health** Transfer of adolescent RH urban outreach strategy in 4 urban areas in LA	**Reproductive Health** Training for Muslim religious leaders in support of RH and FP	**RH and STD/HIV** Increased institutional capacity to offer high-quality integrated RH services	**STDs/HIV** Research and policy development among participating MOH's on STDs
Countries	Mexico Dominican Republic Honduras Peru	Colombia Ecuador Panama Venezuela	Bangladesh China India Thailand Egypt	Thailand Vietnam	Morocco Tunisia Algeria
Executing agency (contracting agency)	Dirección General de Salud Reproductiva (DGSR)	PROFAMILIA	Family Planning Association of Bangladesh (FPAB) International Islamic Center for Population Studies (Egypt)	Health Department of the Ministry of Public Health, Thailand	Ministère de la Santé publique/ Direction de la Population (Tunis) Ministère de la Santé Publique/ Direction de l'Epidémiologie (Morocco)

Annex 3: Global Leadership Development Programme

Partners in Population and Development (*Partners*)

COURSES COMPLETED AND PLANNED

Region	Institute & dates	Special focus
South Asia	Institute of Child and Mother Health, Dhaka (07 - 28 February 2001)	Safe Motherhood Approaches in Developing Countries
	Institute of Child and Mother Health, Dhaka (16 - 30 June 2001)	Safe Motherhood Approaches in Developing Countries
South-East Asia	Shanghai Institute of Planned Parenthood Research, Shanghai (01 - 17 November 2001)	Adolescent Sexual and Reproductive Health
	Shanghai Institute of Planned Parenthood Research, Shanghai, (31 March -16 April 2002)	Quality of Care in Reproductive Health
	Nanjing College for Population Programme Management, Nanjing (15 - 31 October 2001)	Strategic Leadership and Management in RH
	Nanjing College for Population Programme Management, Nanjing (31 March - 16 April 2002)	Project Cycle Management in Reproductive Health
	College of Population Studies, Chulalongkorn University, in collaboration with Ministry of Public Health, Thailand (14-28 January 2002)	STD and HIV/AIDs Prevention and Control
Francophone North Africa	Centre International de Formation, Office National de la Famille et de la Population (ONFP), Tunis, Tunisia (27 May -10 June 2001)	Management of Integrated Reproductive Health Programme
	Centre International de Formation, Office National de la Famille et de la Population (ONFP), Tunis, Tunisia (22 October - 07 Nov. 2001)	Cultural and Legal Constraints in RH Programme Interventions
Middle East & North Africa	Cairo Demographic Center, Cairo, Egypt (03 - 18 June 2001)	Quality of Care in Reproductive Health
	Cairo Demographic Center, Cairo, Egypt (14-29 October 2001)	Strategic Leadership and Management in RH
	Directorate of Population and National Institute for Health Administration, Ministry of Health, Kingdom of Morocco (17 - 28 September 2001)	Leadership in Safe Motherhood
Anglophone East Africa	Zimbabwe National Family Planning Council, Harare, Zimbabwe (23 July - 07 August 2001)	Adolescent Sexual and Reproductive Health in the context of STD and HIV/AIDS
	The Population Studies and Research Institute, University of Nairobi, Kenya (24 September - 05 October 2001)	Adolescent Sexual and Reproductive Health in the context of STD and HIV/AIDS
	Department of Population Studies, Institute of Statistics and Applied Economics, Makerere University, Kampala, Uganda (15 - 26 October 2001)	Adolescent Sexual and Reproductive Health in the context of STD and HIV/AIDS

2.5 Present lessons and future programmatic directions

2.5.1 Men's roles with multiple partners: challenges and opportunities

Dr Amy Ratcliffe

Abstract

Worldwide, men are often involved with multiple partners through serial or simultaneous relationships. These complex partnerships present a challenge to researchers and programmers eager to promote men's roles as responsible and supportive partners for women's health. Such partnerships encourage very different reproductive interests for men and women; divide men's time and resources across families; and may create networks of individuals with common disease risk. Work in the rural Gambia with polygyny is used to illustrate the impact of such multiple partner unions on fertility and sexually transmitted disease risk. Men's net fertility is one-and-a-half times greater than women's in this population. This fertility difference corresponds to the average of 1.6 women reported among the mothers of the men's children. Multiple partner unions may be an important proximate determinant of men's fertility worldwide. Models of herpes simplex virus (HSV-2) in this same population show that monogamy is protective. Modelling of HSV-2 is used to illustrate the difficulties and possibilities of studying multiple partner unions. Using samples that include multiple partner sets will allow for a better understanding of both fertility and disease risks in populations. Men's roles with multiple partners may also provide opportunities for health promotion. Programmes that acknowledge these roles may be more acceptable and effective.

INTRODUCTION

Men's roles with multiple partners present a considerable challenge to fertility awareness and reproductive health programmes around the world. While both men and women may be involved with multiple partners men's greater sexual freedom and broader rights in relationships make it more likely for men than women to have multiple partners. Indeed, in some cultures such relationships, both socially sanctioned and illicit, are the norm for men. Epidemiological studies of sexually transmitted diseases have shown increased risk with higher numbers of lifetime sexual partners and logically, multiple partners increase the force of transmission of such diseases. Beyond disease risk however men's multiple partner relationships and the diverse roles that men play in these relationships need to be taken into consideration in the design of research and programmes aimed at fertility awareness and reproductive health.

Multiple partner relationships promote different interests for the man and his partners where the man is often involved in decision-making with different, often conflicting, implications for each of his partners. This will hamper possibilities for transparent decision-making and negotiation of sexual, reproductive and family interests. Programmes that aim to encourage communication between partners must consider the paradox that this presents. Men and women may be negotiating their relationship as one of several, embedded in a complicated

network. In some cases, the wife or man's partner may not even be aware of the external relationships and their implications. Additionally, where a man is required to divide his resources across partners or families, constraints may make his contributions to each less than adequate.

There is a considerable range of the types of relationships that should be included among those classified as having multiple partners (Bennett, Bloom & Miller, 1995; Francovich 1998; Blanc & Gage,, 1999; Rendall et al., 1999). The West African polygyny that will be presented in this paper is an example of relationships that are truly concurrent both sexually and for men's roles as husbands and fathers. The serial monogamy that is increasing with divorce and remarriage in European cultures effectively spreads partners over time; while sexual relationships are not concurrent men's interests are still divided across families and their roles as ex-husbands and fathers continue for a lifetime. With increasing ages at first marriage and permissive sexual freedoms, concurrent dating relationships provide an example of concurrent sexual relationships that may range from casual to increasingly emotionally committed. In all of the above cases the relationships are socially sanctioned but illicit relationships are even more difficult to identify. For many reasons, illicit relationships are likely to be concealed and even denied by men. Even in these illicit relationships men may be committed to these relationships, devoting emotional and financial investment to them.

This paper will present the case of polygyny in a rural population in the Gambia as an example of the extent and implications of men's multiple partner relationships. Polygyny offers a relatively easy case for study because marriage events clearly define the start and end of relationships that are socially recognized and therefore easily reported. The lessons learned from the study of polygyny provide insight into the implications of such relationships elsewhere. To accurately address men's roles with multiple partners in fertility awareness and reproductive health programmes, culturally specific understanding of expectations for men and the possibilities of diverse partner sets will be required.

West African polygyny

The particular family formation strategies that are widespread within West Africa present very different options to men and women to achieve their reproduction. In a region where women's fertility levels are among the highest in the world, men are able to increase their personal fertility beyond that of any single wife through polygyny and remarriage following divorce or widowhood to younger wives. Understanding men's reproductive *behaviour* and the influence it has on their wives is important to the explanation of fertility and the possibilities to encourage improved reproductive health in the region (Adamchak & Adebyao, 1987).

Throughout the region, marriage is an alliance arranged and regulated by kin to support the primary goal of reproduction and to accord sexual and reproductive rights (Abu, 1983). Negotiations for the marriage are held between senior male kin with limited input from senior females, including the bride's mother. The payment of a bridewealth is characteristic of most West African marriages and most often coincides with transferring the claim on a woman's reproduction to the man's kin group (Abu, 1983). Early marriages are common for women with effective constraints on premarital sex and a large age difference between spouses is a key factor in the sustainability of polygyny in populations where the adult sex ratio is close to one (Pison, 1986; Caldwell, 1996).

Throughout a marriage, different rights are granted to the husband than to the wife and over time and circumstances the rights of both husband and wife may change (Abu, 1983).

Through marriage, men enjoy the benefits of women's reproduction and labour while women are granted access to land, paternity for their children, and the security of the men's kin group (Draper, 1989; Caldwell, 1996). While a man's rights in marriage are earned mostly through meeting the specific terms of a marriage agreement, a woman usually earns rights within her husband's kin group only after proving her labour and reproduction (Abu, 1983).

Sexual rights to a man are rarely reserved for his wife (Abu, 1983). The practice whereby men are able to marry up to four women is especially common in West Africa and is sanctioned by the *Sharia*, or Muslim law. Women are not usually given the opportunity to oppose a polygynous union for their husband (Lesthaeghe, Kaufman & Meekers, 1989). Within the Gambia, polygyny is widespread throughout the Muslim population. In a nationally representative survey conducted in 1990, 50% of women aged 15–49 and 36% of men aged 18 and above were in a polygynous union. This degree of polygyny is high even among populations in West Africa, often recognized as the region having the highest levels of polygyny (Speizer, 1995).

Polygyny has been associated with high fertility interests at the community level (Ezeh, 1997). Studies of the associations between polygyny and different levels of fertility for individual women have shown conflicting results (Bhatia, 1985; Garenne & Van der Walle, 1989). The difficulty in determining the polygyny-fertility relationship may be due to the manner in which polygyny is treated in many surveys and analyses. Most often, polygyny and monogamy are considered as a dichotomy based on an individual's current marriage state and rarely are marriage histories available for either men or women (for exceptions see Donadje, 1992). Treating polygyny and monogamy as a dichotomy fails to account for past marriages and future possibilities. Even in the most polygynous populations, all men begin their married lives monogamously but the potential for future relationships will shape expectations and behaviour (Speizer, 1995). As men marry additional wives or divorce their earlier wives, they may move from a varying degree of polygyny back to monogamy, creating complicated marriage histories. Women's fertility is not shaped through polygyny as obviously as men's fertility and the study of women's fertility will not allow for sex differences in the fertility experience that are created through polygynous unions. Previous work in polygynous populations has illustrated the disparate fertility achievements of men and women with total fertility rates (TFRs) for the men nearly twice that of women (Pison, 1982; Donadje, 1992).

The polygynous union creates separate spheres in which husbands and wives live in West Africa. Spouses rarely share the same living space. Each wife might have her own house or rooms and in some cases, wives live together in a common room separate from the husband's quarters (Dey, 1981; Draper, 1989). Men are supposed to maintain impartiality across their marriages which results in their remaining detached from their wives in many ways (Draper, 1989).

While a husband's lineage has control over land used by a wife, the wives are responsible for production of important subsistence crops that support the family, as well as most domestic tasks concerned with food processing and childcare (Draper, 1989). Separate budgets and even food stores are characteristic of West African marriages (Dey, 1981; Abu, 1983). Men are expected to provide for the family's needs but men's contributions are largely determined by the resources available and by the changing nature of the family's needs with a growing cash economy.

Women are responsible for the day-to-day maintenance of children and men provide for cost-related items such as education and health care from their cash earnings (Caldwell, 1992).

Strict gender divisions of labour make it impossible for men to do the work allocated to women. Women's labour is therefore essential for the maintenance of a family. Co-wives are expected to cooperate in labour and to substitute for each other in certain duties. Since investments in people are paid off through returns on their labour as long as a man's kin group has sufficient land and resources for bridewealth, the costs of adding a wife to the kin group are minimal (Draper, 1989). Further, as the woman's labour will support her children and their labour will eventually be devoted to communal production, the possibilities for the returns of her children's labour are great.

Across polygynous marriages, men must divide their resources between among wives and children. This essentially serves to limit the contribution that a man can make to any one wife. Competition for resources for children can easily lead to jealousy among co-wives. A man is expected to remain impartial and equitable while at the same time caring for the needs of everyone within his care, including his wives. To achieve this impartiality, a certain formality and discretion must be maintained that characterizes men's involvement with their families in rural West Africa (Draper, 1989).

Farafenni population and data sets

Demographic surveillance has been carried out by the UK Medical Research Council (MRC) in forty villages (population 16,000) near the town of Farafenni in the North Bank Division of the Gambia since 1981 (Ratcliffe et al., 2001). Three ethno-linguistic groups are represented: Mandinka, Wollof, and Fula. Villages are organized into compounds with thirty-eight people on average. Compounds usually include extended family, led by a male compound head. The population is almost exclusively Muslim. Subsistence farming is the primary occupation of nearly all men and women. Education levels in the population are low; 10% of the men and 3% of the women have ever received formal schooling.

In 1998, a marriage and fertility survey was conducted in twenty-one villages that were chosen to be representative of the forty surveillance villages (Ratcliffe, Hill & Walraven, 2000). All men aged 18+ and all women aged 15–54 resident in the 21 villages were eligible for interview. The survey obtained a response rate of 79% of the 1,699 eligible men and 87% of the 1,891 eligible women. The final samples included 1,315 men and 1,621 women, of which 844 were matched couples. Men and women were interviewed privately. Each was asked to report on all marriages and all pregnancies with which they were associated. The men's interview began by listing all wives the man had ever married in chronological order with marriage dates and other details. This list was then used to complete a pregnancy history for each wife in turn. The men were asked about extramarital births in a separate section.

In 1999, a reproductive morbidity survey was conducted in 20 villages which were mostly the same villages that had participated in the 1998 survey with some substitutions (Walraven et al., 2001). The survey obtained a response rate of 72% of 1,871 eligible women. One thousand three hundred and forty-eight women participated in the survey that included both interviews and gynaecological examinations. Clinics were held in the resident villages by two female
gynaecologists who conducted the examinations. The examination included testing of venous blood for herpes simplex virus 2, the results of which are reported here.

In 2000, a sub-sample of the 1998 male sample was re-approached and asked for participation in a rural to urban comparison of marriage and fertility histories. All men aged 35–65 were asked if they had urban resident brothers to identify those with brothers within the same age range living in the main urban area of the Gambia or in the close urban area of Farafenni town

and Soma town. One hundred and fourteen rural men and 102 urban resident brothers were interviewed using a questionnaire similar to the 1998 survey.

Consideration of men's polygyny experiences

Men interviewed in the 1998 survey were married for the first time at age 25 on average. Women were married for the first time at age 15 on average. Among the 929 married men who were interviewed in 1998, 40% were currently in a polygynous union (Table 1). The highest prevalence of polygyny was among the Mandinka with 49%, the Wollof followed with 43% and of the married Fula men, only 27% were married polygynously. On average, married men had 1.53 wives at interview and polygynous men had 2.36 wives at interview. Twenty-five per cent of the men's marriages had ended by interview either through divorce or widowhood. The average age at second marriage for men was 36 and the number of times married was highly correlated with age (Pearson's $r = .72$, $p = .000$); men aged 60 and above had been married three times on average. The age difference between spouses averaged 14 years but was correlated with men's marriage order (Pearson's $r = .498$, $p = .000$). The average age difference between spouses for men's first marriages was ten years, but in third marriages the average was 21 years. The married men had been married twice on average with a range of up to nine times.

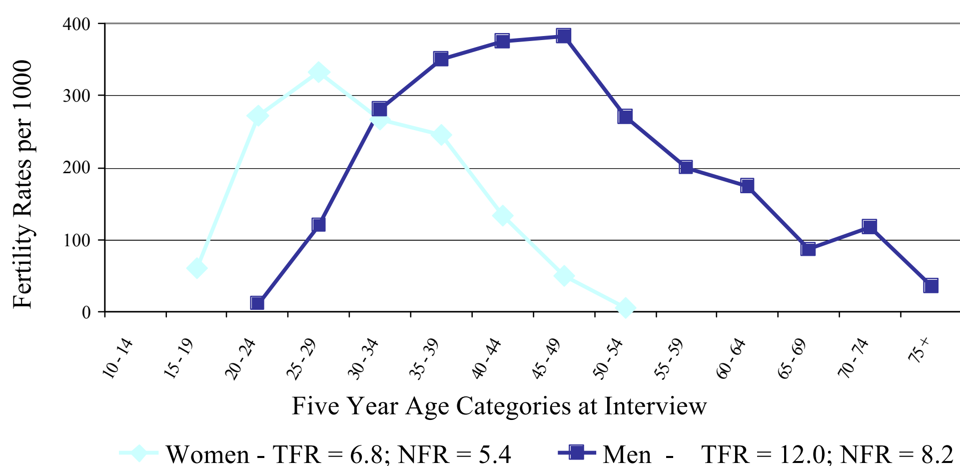
In 1998, all men were asked if they were interested in marrying or marrying again in the coming 12 months. Marriage interests were high with a large proportion of all men, 35%, interested in taking on a new marriage. There were no differences in the proportion of men reporting such interests by ethnicity. Single and married men in the population both had strong interests in marriage. In fact, interest in marriage was highest among monogamous men. Forty-three per cent of the monogamous men were interested in marrying, while only 25% of the polygynous men were. Among the rural men (N = 114) who participated in both the 1998 and 2000 survey, those who expressed interest in a coming marriage in 1998 were 5 times more likely than others to have taken on a new marriage by 2000.

The extent of polygyny can best be captured as a ratio of marriage intensity for the men. Of the total time spent married for men, the total woman-years married was calculated for each married man by summing the duration of each of his marriages. For all men, the average number of woman-years married was 30.9. The mean number of woman-years married is time- and age-dependent. In the ratio of intensity of marriage, the number of woman-years is standardized by time since first marriage for each man. This ratio of woman-years married to actual time since first marriage could range from a number close to zero in the case of an immediate divorce, to at least four in a case where a man had on-going marriages with four women for his entire married life. The ratio averaged 1.24 for all men, indicating an average man might have been married continuously to his first wife for ten years and an additional wife for a further 2.4 years. Interpreted in another way, we can say that through polygyny men are able to gain, on average, an additional 24% of the time that would have been possible through a monogamous marriage through additional marriages. Fula men have a lower average ratio of woman-years married to time since first marriage than Mandinka and Wollof men. The Fula men have a ratio of 1.13 woman-years to time since first marriage while the Mandinka have a ratio of 1.31 and the Wollof have a ratio of 1.28 (Table 1).

Table 1: Indicators of polygyny among married men (N = 929)
(1998 Marriage and Fertility Survey)

	Mandinka	Fula	Wollof
Proportion Polygynous	.49	.27	.43
Wives, current	1.67	1.24	1.52
Wives, ever-married	2.44	1.64	2.02
Wives, in pregnancy history	1.71	1.41	1.65
Interested in marrying again, next 12 months	.38	.36	.40
Woman-years married	36.51	24.25	28.85
Time since first marriage	25.24	20.58	20.75
Marriage intensity ratio	1.31	1.13	1.27

Figure 1: 1993–1997 age-specific fertility rates for men and women
(1998 Marriage and Fertility Survey)



Fertility and polygyny

Sex differences in fertility illustrate the effect of multiple partner unions on men's fertility. According to the age-specific fertility rates, men's fertility closely follows behind women's fertility with an apparent ten-year difference up to the men's thirties (Figure 1). By the men's late thirties, corresponding to the average age of polygynous men's second marriages, men's fertility surpasses women's fertility. Men achieve higher peak age-specific fertility rates than the women's peak rates and sustain these for fifteen years. Men's fertility extends into much older ages than is possible for women. The total fertility rate (TFR) is sensitive to the timing of fertility and the population age distribution and is therefore not the best index for comparison of male and female fertility. Total fertility rates of 12.2 for men and 6.8 for women reflect the experiences of individuals who survive through all the sampled age categories, but this does not reflect the average experience. The average experience of fertility for men in the population is better expressed after taking mortality into account.

The net fertility rates (NFR) for men and women have been constructed based on the age-specific rates for 1993–97 and the life table mortality rates for men and women in the surveillance population for the same period. The rates are simply the sum of the products of the age-specific fertility rates, B_X/P_X, and the life table survival rates, L_X/l_0, for the given period. Men's fertility is considerably higher than women's fertility even when adjusted for different mortality. The NFR for men is 8.21 while women's NFR is only 5.36. Men's net fertility is one-and-a-half times greater than women's in this population. Through serial and polygynous marriages, men in this population share their reproductive experience with several women and this fertility difference corresponds to the average of 1.6 women reported among the mother's of the men's children. Polygyny certainly creates unique male and female experiences with reproduction.

Disease risk and polygyny

Herpes simplex virus 2 (HSV2) has been shown to be an indicator of risky behaviour for sexually transmitted disease in a population. At the individual level, HSV2 has been found to be associated with number of lifetime sexual partners. The prevalence of HSV2 was determined to be 32% among the women who participated in the 1999 reproductive morbidity survey. In univariate analyses it was found that the prevalence of HSV2 was higher among women living in polygynous marriages at interview. Several research questions were raised based on this higher prevalence. The first was focused on the relationship between polygyny and disease risk based on a more thorough consideration of marriage histories rather than current polygyny status, since it would be unlikely that current marriage status would accurately reflect lifetime risk. Given that polygynous marriages create risk sets in which concurrent partners share common risk based on the behaviour of any one member, we also needed to know if HSV2 was a good marker of risky behaviour in polygynous populations. A matched data set was created to explore these research questions. The marriage history data available for the women from the 1998 survey was matched to the 1999 HSV2 data for all women who participated in both surveys. This data was then matched to the husband's marriage histories for all those women whose husbands had participated in the 1998 survey. Five hundred and thirteen women were included in this new data set. Logistic regression was used to explore the relationship between these marriages and HSV2.

A hierarchical model building approach was used to build a 'best' model predicting a positive HSV2 lab result for the 451 women who had complete data on all variables of interest. In the 'best' model, woman's age and ethnicity, and female genital cutting were included as

predictors of HSV2 lab results for the women. The effect of polygynous experiences in marriage was then considered in this model, using six different indicators. Only one indicator of polygynous experience, a true monogamous marriage or the only marriage for both husband and wife, was significant in the multivariate model using this approach. The following indicators of polygyny were not significant predictors of HSV2, controlling for age, ethnic group and genital cutting—current state in a polygynous marriage; number of man's current wives; number of man's lifetime wives; man's reporting any long-term extramarital partners; or the order of the marriage among the man's total marriages.

According to the final model that included woman's age, Mandinka and Fula ethnic groups compared to Wollof as the reference ethnic group, female genital cutting, and a true monogamous marriage, monogamy is associated with a decreased risk of HSV2 (Table 2). Monogamy was associated with an odds ratio of 0.41. All variables were significant at the level of $p < .05$. Risk increased slightly with woman's age with an odds ratio of 1.04. Mandinka and Fula were both more likely than Wollof to be HSV2 positive. The odds ratio for Mandinka was 2.7 and for Fula it was 1.9. Female genital cutting increased the risk of HSV2, with an odds ratio of 2.7.

The second research question can also be answered based on the model described. The comparisons between the ethnic sub-populations differences indicate that HSV2 is an indicator of risk even in this polygynous population. Anecdotal evidence suggests that the Wollof may be less permissive of extramarital relationships in the rural communities than both the Mandinka and Fula. If this is true, this may explain the reduced risk of Wollof even when controlling for circumcision and marriage histories.

Table 2: Logistic regression predicting HSV-2 positive laboratory results for 451 women

(1998 Marriage and Fertility Survey and 1999 Reproductive Morbidity Survey)

Independent variables	Odds ratio
Woman's age	1.04
Ethnicity (compared to Wollof)	
Mandinka	2.71
Fula	1.88
Female genital cutting	2.67
Only marriage for both partners	0.41

All independent variables significant at $p < .05$

DISCUSSION

The example of West African polygyny illustrates the challenges and opportunities presented by men's multiple partner unions. Polygynous unions are relatively easy to study because they are socially recognized with definite dates of marriage. Nonetheless, the challenges to capture the experience of polygyny and its implications to both fertility and disease risk are evident. Considering polygyny and monogamy as a dichotomous state cannot relay the history or future interests of men with their multiple partners. While it might not always be possible to collect full marriage histories, efforts can be made to consider the key information that might be useful from such histories and to direct questions to get this information. The example of fertility that has been presented shows that questions might focus on numbers of

children with different wives and the timing of such fertility to better understand an individual man's experiences and obligations. In counselling couples about fertility awareness and interests, basic information about children with other partners may be essential. Additionally, questions on marriage interests may be appropriate in polygynous populations and are likely to be predictive of future marriages. The increased likelihood of new marriages in the two years following the 1998 survey among men who stated an interest in a new marriage shows that men are making decisions about future marriages and acting on them. For determining disease risk, key information may also be collected. The modelling of HSV2 shows that such information might include questions about first and only marriages for an individual and his partner. Using concise and directed questions about relationships with other partners makes data collection more efficient, but only if the right questions are asked.

The challenge to study and address men's multiple partner unions appropriately and effectively requires a culturally specific understanding of gender and sexual norms. The rights and obligations that are accorded to men will vary across cultures, but also in different types of unions within a single population. Research should include an overview of the types of relationships that are possible for men as well as the diverse roles that they may take on with different partners. This type of research will require a primary focus on men, something that has not been fully embraced by researchers around the world.

Men's roles in multiple partner unions present a challenge to reproductive health and fertility awareness programmes. Counselling about risk reduction should consider the range of behaviours in which men engage and the risks that they carry across unions. Such consideration may not be possible when working with couples and may require individual counselling sessions with men and women. Encouraging the negotiation of sexual and reproductive behaviours should also take into the interests within a specific union as well as the competing or conflicting interests that may be introduced in men's other unions. Ignorance of multiple partner possibilities can jeopardize the effectiveness and acceptability of health messages directed both at men and their partners.

The study of men's roles with multiple partners also offers opportunities for the improvement of understanding fertility and reproductive health. In populations with high fertility, the determinants of male fertility may offer new insight into the supports for this high fertility and to the means to fertility reduction. The proximate determinants of fertility for women—marriage, contraception, lactation, and induced abortion— may be adapted for men's fertility by including an index that captures the degree of multiple partner unions. Risk of sexually transmitted disease can also be modelled more accurately with information on past and present multiple partner unions and the behaviours that are associated with them.

Including men's roles with multiple partners will improve the effectiveness of reproductive health programmes. While many programmes remain primarily focused on women, reproduction is centred on the relationships that women have with men. The diverse roles that men play in these relationships and the roles that men play in other important relationships in their lives will determine the possibilities for communication and negotiation between men and women and will ultimately determine sexual and reproductive choices. To improve programme effectiveness, health messages can be packaged to address these roles. Culturally appropriate health messages may be tailored to address men's diverse roles.

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2.5.2 Research on men and its implications on policy and programme development in reproductive health

Dr Charles Nzioka

Abstract

This paper examines the implications of social science research on men for policy and program development in reproductive health. The significance of enhancing male participation in reproductive health programs is recognized because by their risky sexual behaviour, men jeopardize their own heath as well as the health of their sexual partners. Social research, if well conducted, can provide valuable data and information for reproductive health programming and policy development. Much of the social research in the sub-Saharan Africa region has provided informative data on the factors which impede enhanced male involvement in reproductive health programmes within the region. However, while the findings of these studies have provided insights into ways of improving and strengthening reproductive health programmes targeted at men within the region, this paper recognizes the need for more research, especially on the factors perpetuating risky sexual and social practices, because it is these practices that undermine the success of male reproductive health programmes in the region. Programmatic research areas and methodological approaches which can facilitate a better understanding of men's sexual and reproductive health behaviour and enhance programme coverage and quality of services are identified. It is concluded that there is a need for more localized social research which feeds into local policy and programme development so as to produce more effective and meaningful reproductive health programmes for men.

INTRODUCTION

In the past, demographic research has primarily focused on women's reproductive health behaviour (Roudi & Ashford, 1996). The underlying assumption behind this approach seems to have been that reproductive health matters are primarily a concern for women, and that men are generally disinterested in reproductive health matters. In the 1990s, however, demographers and population specialists have turned their attention to men's reproductive health behaviour (Roudi & Ashford, 1996; Greene & Biddlecom, 2000). A number of reasons account for this growing interest in men. First, it is now recognized that the sexual and reproductive behaviour of men puts them at risk themselves, and also impacts on the health status of their sexual partners. Men are uninformed and irresponsible with regard to fertility control, they are barriers to women's contraceptive use, and are sexually promiscuous (Greene, 2000). Moreover, it is currently estimated that one-third of the world's couples are using a male dependant method such as condom, vasectomy, withdrawal, periodic abstinence or other traditional methods (Green, Cohen & Ghouayel, 1995). Male participation and cooperation is therefore important in the effective and sustained use of these methods. The HIV/AIDS scourge has also rendered increased involvement of men in reproductive health programmes and decision-making processes even more crucial. Against this background, this paper examines how reproductive health research on men can be used to inform reproductive health policy and programme development especially in sub-Saharan Africa.

THE IMPORTANCE OF REPRODUCTIVE HEALTH RESEARCH ON MEN

Increased male involvement and participation in reproductive health programmes can be achieved in the way men accept and indicate support to their partners needs, choices and rights, or in the way men modify their own sexual and reproductive, or through their active involvement in policy and programme formulation (Green, Cohen & Ghouayel, 1995). Recent studies in the sub-Saharan region have shown that where men have been involved in programme design and implementation, such programmes have recorded remarkable success (Population Council, 1998; Nzioka, 2000). To increase male involvement and participation in reproductive health efforts and launch successful programmes, there is need to gain in-depth knowledge and understanding of men's sexual and reproductive health perspectives, behaviour and practices, and the only way to obtain data and information on men would be through research. Data and information obtained through well-coordinated research can lead to the formulation, design and implementation of viable, cost-effective, acceptable and affordable reproductive health programmes.

For example, research can lead to a better understanding of the sexual and reproductive behaviours of people because such behaviours have their own social, cultural and biomedical origins (Jejeebhoy, 1999). Most settings are inherently different, hence the need to discover the uniqueness of each setting in order to design programmes that are appropriate and workable in each setting or environment. Research into new reproductive health technologies can also widen the range of choices available to the consumers of such services and also produce easily acceptable and affordable methods of fertility regulation.

The importance of reproductive health research in increasing the understanding of male behaviour in family planning and other reproductive health programmes has been aptly recognized. The 1994 ICPD conference in Cairo and the 1995 Fourth World Conference on Women in Beijing, whose consensus documents were endorsed by more than 180 governments, called for special efforts to promote men's active involvement in responsible parenthood and sexual and reproductive behaviour, including family planning; prenatal and maternal health; prevention of sexually transmitted diseases including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; recognition and promotion of equal value of children of both sexes (United Nations, 1994).

The consensus documents of the two conferences further recognize the need for research into new methods for regulation of fertility for men and also behavioural research into factors inhibiting male participation so as to find ways of enhancing male involvement and responsibility in family planning. The conference documents further identified research on sexually transmitted diseases, including HIV/AIDS, and infertility as a priority.

Research into fertility regulation methods

One of the major deterrents to greater male participation in reproductive health programmes is the limited contraceptive options men face. Apart from natural methods such as abstinence or withdrawal, vasectomy and condoms are the only contraceptive methods available to men. Research is therefore needed aimed at increasing the range of choices of fertility regulation methods available to men.

Research into sexual and reproductive health behaviour of men

Social science research in reproductive health has four major basic aims, namely (a) to establish the levels and patterns of behaviours, attitudes, or perceptions; (b) to explore factors underlying these behaviours, attitudes, and perceptions; (c) to explain programme and organizational impediments constraining the exercise of informed choices or acquisition of preventive and curative services; and (d) to monitor the extent to which interventions have been successful in modifying behaviours, attitudes or perceptions, and enable an understanding of the policy, social and legal arenas which impinge on the determinants and consequences of reproductive choice (Jeejebhoy, 1999). Social science must be part and parcel of the entire reproductive health programme planning process. It should precede the programming, accompany the design and implementation of programmes and follow up reproductive health programmes. We can therefore identify various forms of social researches which fit into each of the functions identified above:

Types of social science research needed in reproductive health programming

Exploratory/Descriptive Research

This type of research is particularly important in situations or contexts where there exists little or no information about men. Men are also not a homogeneous group of people with same needs in every situation or context. There are internal variations in male needs brought about by the fact that men belong to different age sets or different sociocultural and economic backgrounds. For example, the reproductive health needs of boys within certain cultures must inevitably be different from those of boys from different communities or even from those of older men in the same culture. The unique needs of each category, therefore, needs to be discovered through exploratory research if effective programmes to address these needs are to be effected. Thus exploratory research would describe the different programmatic needs, attitudes and perceptions of men.

Operations research

This type of research includes fact-finding formative research and testing of application of findings to practical problem solving with a view to improving the quality of action within a programme (Sarantakos, 1994). It is a form of research which is undertaken by programme managers and practitioners. Operations research has five basis steps, namely (1) problem identification and diagnosis (2) strategy selection (3) strategy experimentation and evaluation (4) information dissemination and (5) information utilization and implementation. Operations research is designed to increase the efficiency, effectiveness and quality of services delivered by service providers as well as the availability, accessibility and acceptability of services to consumers (Fisher et al., 1991). Operations research should therefore be incorporated into all major reproductive health programmes that involve men, so as to facilitate continuous feedback into the programme and enhanced effectiveness and quality of service.

Comparative research

Comparative research methodology aims at identifying similarities and/or differences in policies and programmes. It seeks to identify the programmes which work and/or do not work, across contexts with different types of men. For example, the programmes which work or do not work with men of certain ages, social class, educational levels or cultural orientations. Comparative research is particularly important especially when there is need for sharing information on project/policy experiences, best practices and lessons learned. This type of research can be

conducted across projects, countries and regions, and the results used to improve reproductive health programmes and policies that touch on men.

Participatory action research
Participatory Action Research (PAR) is a form of research characterized by a strong degree of involvement and participation by the beneficiaries. Rather than imposing reproductive health programmes, there is need to engage men in PAR by involving them in the formulation, design and implementation of reproductive health programmes or services that serve them. Participatory Action Research helps in enhancing the quality of services given to men, since they (men) are better placed to understand their needs and problems.

Evaluation research
Evaluation research seeks to systematically investigate the effectiveness of intervention programmes (Rossi, Freeman & Lipsey, 1999). Evaluation research can help in assessing the effectiveness, impact and efficiency of reproductive health policies and programmes targeted at men. Such research provides useful information and data on how to improve existing projects or on how to better implement new projects and programmes for men. Evaluations could be on-going (monitoring) or summative, depending on their aims, but at all times, their results form important inputs into male reproductive health programmes.

MEN IN REPRODUCTIVE HEALTH PROGRAMMES: AN OVERVIEW OF RESEARCH FINDINGS FROM SUB-SAHARAN AFRICA

Since the focus of this paper is sub-Saharan Africa, the following section provides an overview of the major findings of studies on male role and participation in reproductive health within this region. Much of the social science research on the male role in reproductive health within the sub-Saharan Africa region has tried to examine *inter alia* men's sexual and reproductive health behaviour, factors facilitating or inhibiting inter-partner communication, and the influence of men on the reproductive health policy environment. The major aim of these forms of research has been to enhance male involvement in reproductive health programmes in the region. Below we discuss some of the major social science research findings within the sub-Saharan Africa which have programmatic implications.

Research in the sub-Saharan Africa region has shown that male participation in fertility decision-making is critical to the wider acceptance of family planning, and improvement in sexual and reproductive health (Toure, 1996a; 1996b). Since gender power relations in much of Africa are skewed in favour of men and African men wield a lot of power in the home and within society, they are the key gatekeepers to decisions relating to contraceptive use and fertility control. In this region, it is basically men who decide when to have children, and how many children a couple should have (Nzioka, 2000). Too often these decisions are devoid of partner consultation.

The continued use or non-use of a family planning method is largely influenced by the man's decision (Khalifa, 1988; Mbizvo & Adamchak, 1991). When a man approves of his partner's use of contraception, it is most likely that there will be sustained use of contraception. Even where a man suffers from an STI, he may seek collaboration of the local doctor in packaging treatment for a more acceptable illness or even lie to the sexual partner to ensure that they all get treatment (Fapohunda & Rutenberg, 1999).

There is enormous untapped potential for using men as advocates of family planning due to existing assumptions that men are not interested in family planning. Despite this assumption, there is evidence that, historically, men in Africa practised periodic abstinence, withdrawal and rhythm methods with their sexual partners to avoid conception. Other practised passively as the result of postpartum separation from their spouses (Kim, 1996).

Involving men in inter-spousal communication has also been found to be critical in the sustained use of family planning methods. For example, Demographic and Health Survey data from 14 African countries show that the percentage of women using contraceptives is consistently higher in the group that discussed family planning with their husbands (Roudi & Ashford, 1996).

Men are also known to take sexual risks which occasionally render them vulnerable to sexually transmitted diseases including HIV/AIDS. This risk-taking behaviour certainly impacts directly on the sexual health of their female partners. It is therefore important to address factors underlying male sexual behaviour.

OBSTACLES TO MALE PARTICIPATION IN REPRODUCTIVE HEALTH PROGRAMMES

Despite the recognition that men can and do play an important role in reproductive health, research has clearly shown that there are certain bottlenecks to increased male participation in reproductive health programmes.

The range of family planning methods available to men at present is limited, and this inhibits men's capacity to participate in fertility regulation and reproductive health programmes effectively. For example, studies in some African countries such as Kenya and Zimbabwe show that lack of information and services on male methods such as vasectomy is a major hindrance to their use of family planning services (Wilkinson, 1989; Miller et al., 1991; Green, Cohen & Ghouayel, 1995; Kim, Marangwanda & Kols, 1996).

In much of Africa, there are ideological and pragmatic obstacles to men's participation as both clients and supportive partners in reproductive health programmes. These obstacles include long-cherished traditional practices.

Past research has shown that men hold certain traditional beliefs or misconceptions regarding modern contraception which act as barriers to men using these methods or even approving use by their sexual partners. For example, men have been found to think that family planning is a woman's business, and also to associate female contraception with increased promiscuity. Men also think that other methods make women unresponsive during intercourse (Fapohunda & Rutenberg, 1999). This suggests that men who subscribe to these notions may not approve of their partners' use of the same.

Poverty is a major bottleneck to male involvement in reproductive health programmes. Due to poverty, access to a radio or TV is a preserve of very few men. The situation is more acute in rural areas where the vast majority of the population in sub-Saharan Africa lives, yet where the infrastructure is poor and wanting. Lack of access to print and electronic media coupled with high illiteracy levels means that few men have access to quality reproductive health information. In these rural areas, clinics are also few and far between - limiting the extent to which reproductive health services can reach most men in these areas. In addition, roads are either poorly maintained and/or impassable, and even where means of transport are available,

the costs of transportation can be prohibitive for most men. Men who contract STIs often have to contend with concoctions or other traditional forms of treatment whose efficacy is highly doubtful. In places where clinics exist and are easily accessible, problems such as lack of privacy, comfort, convenience, confidentiality, and poor provider behaviour adversely affect men's capacity to use reproductive health services (Nzioka, 1997; Fapohunda & Rutenberg, 1999).

Studies have also shown that the absence of inter-spousal communication and discussions can inhibit men from using reproductive health services. Men have been found to face difficulties in broaching the subject of contraception use or even initiating discussions of STIs for fear of accusations of infidelity from their partners (Makomva, Falala & Johnston, 1991). These limitations inhibit men from taking appropriate reproductive health decisions even when the risks are apparent. There is, however, a strong association between inter-partner communication and contraceptive usage in many settings (Mbizvo & Bassett, 1996; Fapohunda, & Rutenberg, 1999). The need to devise more appropriate and acceptable communication strategies can therefore not be over-emphasized.

African men have also been found to hold onto certain beliefs which inhibit their active involvement in reproductive health programmes. For example, African men value women's quietness and silence in sexual issues because they see silence and sexual passivity as the attributes of a good woman. These beliefs are particularly stronger among less-educated men. Where such ideas and notions are pervasive, inter-spousal communication may be greatly impaired.

Men have also been found to have limited knowledge of certain methods of contraception. For example, it has been observed that some men are against vasectomy because they see it as a form of castration. Some men also resist the use of condom, arguing that condoms reduce sensation and sexual pleasure (Nzioka, 2000).

The foregoing is far from an exhaustive list of the major findings made on studies on the sexual and reproductive health behaviour of men in the sub-Saharan Africa. However, these findings do suggest much is known about men, but a lot more needs to be discovered about men in the region because, if family planning and reproductive health programmes are to reach out to more men, a better understanding of their reproductive health intentions is imperative.

PROGRAMMATIC RESEARCH ON MEN: GAPS AND THE WAY FORWARD

While past social science research has highlighted some of the gaps in our knowledge of reproductive health issues which involve men, we have less experience and information on programmatic issues and how such research can influence and improve programme design, implementation and service delivery. In the following section, we seek to identify some of the programmatic research gaps as well as what we see as strategies for improving service delivery for men in the sub-Saharan region.

Location, quality of service and service delivery

Research findings in Kenya show that men are concerned with the location of a facility, the quality of service and the calibre of the service provider (Fapohunda & Rutenberg, 1999; Nzioka, 2000). If a service is offered where privacy cannot be assured, men will shy away from that service. For instance, if men are to seek vasectomy, it is most unlikely that they will seek the service from a clinic which is physically located in the open or where a clinic is stigmatized as offering that particular service. Most men are breadwinners in their families, are pressed for time and may not be keen on spending lots of time in the clinics. If a clinic is known to have long queues (a common feature, especially in the public service) men will opt for private services, and where they cannot afford such care, they will opt for self-medication. This brings about problems of inaccurate diagnosis and low dosages with limited efficacy. Men will only also willingly seek attention from service providers who are known to be sensitive to their needs. For example, a study in Kenya found that men are very reluctant to go for condoms or STI treatment where the service provider is female for fear that she might disclose the man's problem to other women. More comparative clinic-based research is however needed to assess the calibre of service providers and the quality of service offered in these clinics.

Acceptability of existing contraceptive methods

The range of methods of family planning methods, preventing unwanted pregnancy and STIs for men at present are limited. While more research is needed to develop newer methods, there is also a need to conduct more research to establish which of these methods (modern and traditional) are more acceptable or not, why they are more acceptable or not, and what strategies could be used to promote acceptability of methods which are not very popular. This kind of research needs to be conducted across among men of different age sets and socioeconomic classes.

Cost-effectiveness of methods

Research needs to be done on the economics of male involvement in reproductive health programmes. There is, for example, a need to establish the linkage between the cost of male methods such as condoms and men's purchasing power. Our data from Kenya, for example, shows that young boys may not be able to purchase condoms of their preferred quality and choice for lack of funds, but at the same time hesitate to accept free condoms for fear that they may be laced with the HIV or are of low quality (Nzioka, 2001). There is a need also to establish the linkage between local treatment costs and men's purchasing power, given that such costs may hinder men from seeking treatment for STIs or other reproductive health services.

Impact of vertical and integrated male services

Research also needed to establish the level of acceptability of vertical as well as integrated reproductive services. In particular, such research should focus on the impact of vertical and integrated services on clinic caseload, attendance, level of male contraceptive use, and client satisfaction, client willingness to pay, as well as affordability. Such research can provide insights into ways of improving reproductive health service delivery systems for men.

Information and motivational appeals that meet men's needs and concerns

Despite evidence of increased male involvement in reproductive health programmes, current research has shown that some men still have low knowledge of certain methods. Other men hold negative views on specific methods such as vasectomy—occasionally equating it to vasectomy to castration and believing that it reduces men's sexual desire and physical strength (Nzioka, 2000). Research is therefore needed to explore how promotional messages on these methods such as vasectomy can be better designed and packaged to earn greater acceptance among men. Further research is needed to understand what needs to be done to increase male compliance with use of particular methods.

Benefits of spousal communication and social networks

Past research has shown that lack of inter-personal communication hinders acceptance of contraceptive use among partners even when the risks are apparent. There is need for more research into better ways of promoting inter-spousal and inter-partner communication on reproductive health matters. The possible use of peer groups or social networks can be explored further.

CONCLUSION

There can be no doubt that social research provides the basis for viable, effective and meaningful policies and programmes for men. The need for intensified social science research is, perhaps, more acute in the sub-Saharan Africa region for a number of reasons. First, the region is poor, a factor which makes prudent utilization of the available meagre resources necessary. Second, the region is characterized by huge ethnic and cultural differences among its people. This diversity suggests the need for more localized policies and programmes which take cognizance of the reproductive health problems and needs of men across classes, cultures, communities and regions. Perhaps as Green, Cohen & Ghouayel (1995) observe, meaningful reproductive health research should include analysing the local setting, assessing institutional capabilities, providing a baseline of the status quo against which to gauge changes, identifying and segmenting target audiences, determining suitable service outlets and communication channels, and testing messages and materials.

Researchers within the region should, through social research, strive to identify policies and programmes which are culturally sensitive and which appeal to and resonate with local practices. Only through research can programme planners and policy makers be able to produce socially sensitive, culturally meaningful, male-friendly programmes. In this way, it will be possible to reduce the high incidence of reproductive health problems facing both men and women in the sub-Saharan region, and in particular the problem of sexually transmitted diseases including HIV/AIDS, which has reached endemic proportions.

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2.5.3 Addressing gender imbalances to improve reproductive health

Ms Judith Helzner

Abstract

The two related hypotheses on which this paper is based are: (1) increases in gender equity can both help increase contraceptive use and decrease the spread of sexually-transmitted diseases; and (2) since gender imbalances are part of the context of clients' lives, attention to such issues as male identity, male-female partnership dynamics, and sexual practices can help improve the results of reproductive health programmes.

After a brief introduction highlighting the difference between "sex" and "gender," i.e. the biological basis of the former and the social construction of the latter, the first section of the paper reviews selected topics on male dominance in society, including references to hegemonic masculinity, power issues, and gender-based violence.

The second section analyses ways in which these themes play out in reproductive health institutions and programmes, describing the IPPF/WHR "Manual to Evaluate Quality of Care from a Gender Perspective" as well as referring to various forms of provider bias that perpetuate gender imbalance.

The third section offers examples of programmes supported by IPPF/WHR that have been designed to increase understanding of gender imbalances and to increase commitment and capacity to promote social change in this area. These include: meetings or symposia, work with young men, outreach to men beyond the service delivery facility, and work with men in both female and male clinics.

INTRODUCTION

The topic of programming for male involvement in reproductive health has been an interest of the population community in general, and the International Planned Parenthood Federation in particular, for decades (IPPF, 1981; Drennan, 1998). In recent years, emphasis has been placed on gender perspective as the context for work with men. While "sex" distinctions between males and females are biologically determined and permanent, "gender" differences are socially constructed and vary across time and place. The International Conference on Population and Development Programme of Action recognized the importance of setting conversations about men into a broad gender perspective: "… the objective is to promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles" (United Nations, 1994).

Key questions, worthy of consideration by the public and private sector alike, relate to gender equity. For example, how can increases in gender equity improve reproductive health? The hypothesis is that changes in male-female partnership dynamics can help to: (1) increase contraceptive use to prevent pregnancy, and (2) increase condom use to prevent disease.

These are the key objectives of reproductive health programmes. This paper attempts to demonstrate that more progress will be made towards improving reproductive health

outcomes if gender issues are taken into account, and results will be slower if gender imbalances are ignored or exacerbated.

GENDER IMBALANCE, MALE DOMINANCE, AND SEXUAL AND REPRODUCTIVE HEALTH

Gender imbalances are part of the lives of both providers and clients. They can be addressed at several levels: institutions can address the problem among their own staff and services, while programmes can address the gender roles of clients.

In October 1998, IPPF/WHR and Engender Health (then AVSC) cosponsored a Symposium on "Male involvement in Sexual and Reproductive Health: New Paradigms" in Oaxaca, Mexico (AVSC/IPPF-WHR, Literature Review, 1998; AVSC/IPPF-WHR, Case Studies, 1998). That Symposium came to conclusions (AVSC/IPPF-WHR, Report, 1998) about the linkages between men, masculinity, and reproductive health. For example, it pointed out that masculinity is socially constructed; a dominant, "hegemonic" model of masculinity results in inequality between the sexes, and is harmful to both men and women. Men need new models of masculinities to allow behaviors and emotions currently forbidden to them - tenderness, vulnerability, fear, etc. The hegemonic model of masculinity not only affects men's own sexuality, but also the way they view women's sexuality. Contraceptive use is clearly affected; condoms are seen as reducing male pleasure, and withdrawal is downplayed as an option (even for teens, who may not acknowledge their sexual activity early enough or responsibly enough to prepare for intercourse with contraception (Rogow & Horowitz, 1995).

Participants at the Oaxaca meeting recognized that violence is an integral part of male identity under the hegemonic stereotype. Recently, analyses of violence have broadened to a consideration of power issues (Blanc, 2001; Population Council, 2001). There are examples of important intellectual distinctions in the literature (e.g., power to do something versus power over someone else), as well as examples of how programmes can address issues of violence and power.

Another set of reflections in the Oaxaca Symposium was about fatherhood. In general, the hegemonic model of masculinity defines "father" as biological parent, financial provider, disciplinarian; strong, rational and distant from his children. But a new paradigm of fatherhood could enrich both men's and children's lives; alternative role models are needed to give men ideas, and permission, to be a different kind of father. One proposal is that allowing men to be present during delivery of their children could help reduce distance and increase connections among the father, mother, and new baby.

APPLYING GENDER ANALYSIS TO SERVICE DELIVERY INSTITUTIONS

Gender analysis is a tool that was created initially to be used on male-dominated sectors of development, such as agriculture. But over the years its value has been recognized for family planning and reproductive health. This type of analysis can be applied to many levels of programmes: staff, service facilities, service content, contraceptive methods, IEC efforts, and clients' dynamics with their partners (Helzner, 1996). Early on, the numbers of men and women at each level of a programme were analysed. In many cases, men dominated at senior

levels (policy makers, researchers, programme directors, doctors) while women were the majority in positions such as nurses, counsellors, and receptionists. But recent tools have yielded more nuanced investigations. For example, the IPPF/WHR "Manual to Evaluate Quality of Care from a Gender Perspective" was developed with the Latin American and Caribbean Women's Health Network beginning in 1995 (IPPF, 2000). It includes six tools (interview guides and observation guides), and represents a more complex analysis than counting numbers of men and women alone.

Among the data collected and analysed are the per cent of positions at each salary level held by men versus women; the budgetary responsibilities of men versus women in the organization to determine who controls resources; and the existence of policies on equal opportunity in hiring, sexual harassment, staff flexibility for personal problems such as child care, etc. The gender analysis proposed in the IPPF/WHR Manual also includes a review of any gender stereotypes in IEC materials (images, language); any gender bias in service policies (e.g., spousal consent required for women, but not for men, to receive a sterilization); and gender imbalance in client-provider interactions (e.g., providers addressing men's concerns with greater care than women's, when couples are present together).

Providers of services are part of the societies in which they live, so they are not immune to gender bias or stereotypes. The content of client-provider consultations can be observed and analysed to determine whether gender imbalances are being perpetuated or combated. For example, family planning providers have long been told that condoms are not as effective as other methods in preventing pregnancy. They may not like, or even have tried, condoms themselves. They may not know how to counsel women about negotiating condom use with their male partners. They may believe that men are in danger of losing erections. Providers, like others in society, may feel that men should not be asked to deal with whatever minimal reduction of sensation might occur with condom use. Often, such concerns about men's sexual pleasure or performance are not matched by any attention to women's sexual health—a "double standard" due in part to women's primary role in reproduction but also to gender stereotypes that often promote men's sexuality but ignore women's (USAID IGWG 2000).

PROGRAMME EXAMPLES FROM IPPF/WHR

Given the fact that gender imbalances exist, and are harmful to reproductive and sexual health, what can programmes do to address the problem? Two key objectives are: (1) to increase understanding of, and commitment to, the need to weaken dominant, hegemonic male identity stereotypes; and (2) to increase understanding of the links between these stereotypes and
reproductive health outcomes. IPPF/WHR has supported numerous activities designed to promote these objectives.

1. Meetings and Conferences: These have included (a) in Barbados in September 1997, a meeting for the English-speaking Caribbean called "Gender, Families and Sexual Health: Spotlight on Men"; (b) in Oaxaca, Mexico a "Symposium on Male involvement in Sexual and Reproductive Health: New Paradigms"; and (c) in Queretaro, Mexico, in March 2000, organized by IPPF's affiliate MEXFAM, a meeting on the needs on adolescent boys "Working with Young Men: Health, Sexuality, Gender and Preventing Violence" (Trabajando con Hombres Jóvenes: Salud, Sexualidad, Género y Prevención de Violencia; Marshall 1997; AVSC/IPPF-WHR 1998; Aguilar, Mayen 2000).

2. Educational Materials: These range from CD-ROMs such as “Rock and Male Roles” developed by IPPF’S affiliate in Chile, APROFA; to a series of workbooks with exercises designed to help young men consider their values, beliefs and emotions around violence, mental health, sexual and reproductive health, and fatherhood (APROFA, 2001).

3. Outreach to Men and Boys: Efforts can be community based, as were “rap” discussion groups in Barbados; or focused on a specific place where men or boys congregate, e.g., a Samba school in Rio de Janeiro (IPPF/WHR “Forum” 2001).

4. Reaching Men in Clinics: While male-only clinics do represent an option, the costs can be high and results mixed. While PROFAMILIA/Colombia has successfully maintained some clinics for men, other Family Planning Associations (FPAs) have opened and later closed such facilities (e.g., Ecuador, Mexico). A gender training approach by the Ecuador affiliate APROFE, has produced valuable lessons about policies to be implemented regarding inviting men into the consultation or counselling session with their partners. Specifically, an effort to systematically invite male partners into consultation or examination rooms was replaced by a policy that required the staff to ask the woman client, at each stage of her visit, whether she wanted her partner with her or not (Shepard, forthcoming 2002). Another approach to dealing with gender power dynamics—though not specifically with men themselves—is the programme on integrating systematic screening for Gender Based Violence (GBV) in family planning clinics. This is being done on a pilot comparative basis by the IPPF affiliates in Venezuela, Peru, and the Dominican Republic, with a similar programme in Brazil offering additional experiences (IPPF/WHR Newsletter “Basta!” issues of Spring 2000, Summer 2000, Winter 2001, and Summer 2001).

In conclusion, the Latin America and Caribbean region is a rich source of theoretical discourse, research, and programme examples; the region has made extensive efforts towards setting “male involvement” into a gender analysis framework, beyond family planning/reproductive health alone.

Experience in the region has shown that work towards gender equity, and work towards reproductive and sexual health and rights, clearly reinforce each other. Also, we know that both institutional and individual changes are possible, with the appropriate tools and resources.

IPPF/WHR is eager to have others use, and/or to collaborate in implementing, the tools it has helped to develop for these purposes.

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2.5.4 Lessons and future programmatic directions for involving men in reproductive health

Dr Margaret E. Greene

While working in a midwifery clinic in El Paso, Texas, I attended the labor and delivery of a woman whose husband did not want to be present during the birth. The husband was in and out of the room looking rather distressed as his wife's labor progressed. Although he was clearly devoted to her, he confessed that he was fearful of feeling ill, fainting, or otherwise being unable to hold himself together during the birth itself with its blood and pain. I persuaded him to take a seat in the doorway of the bathroom next door to where his wife was laboring. After he had sat there for a while, he felt comfortable moving his chair just inside her room. Twenty minutes later, he realized he could tolerate being a bit closer to the action. By the time he and his chair had migrated all the way to the bedside, the infant's head was crowning and his wife was delivering their wriggling, wet, little baby. He stepped forward out of his chair and dove, sobbing with joy, into his wife's arms.

INTRODUCTION

Not every aspect of reproductive health is as joyful and emotionally intense as birth. Nor is it appropriate in every setting for a man to be present during labor and delivery. My point in telling this story is that the Cairo ICPD made it *our job* to assist men and women alike in shifting or expanding their reproductive roles in ways that contribute to health and well-being.

The purpose of involving men in reproductive

Gender stereotypes structure reproductive health programmes in ways that prevent programmes from achieving the vision of the ICPD Programme of Action. Just as understandings of reproductive roles led programmes to focus entirely on women, similar perceptions now limit the ways that many programmes work with men. In order that our interventions not reinforce stereotyped differences between male and female sexuality and reproductive behaviour, our field needs to understand and question its taken-for-granted views of how men and women should and do behave.

The reproductive health field is not in agreement about *why* to involve men, and this, of course, makes converging on future directions rather more difficult. In earlier work at the Center for Health and Gender Equity, I developed this schematic outline that identifies the basic approaches to male involvement.

Approaches to Male Involvement in Reproductive Health

Framework	Assumptions	Purpose/strategy	Programmatic implications/*examples*
TRADITIONAL FAMILY PLANNING	Men are absent and problematic. Inclusion of men not necessary from an efficiency standpoint.	Increase contraceptive prevalence. Reduce fertility.	Contraceptive delivery to women only. *Provide family planning methods to women, in the context of maternal and child health.*
1994 --- CAIRO INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT ---------------			
MEN AND FAMILY PLANNING	Men stand in the way of women's contraceptive use. Men can be involved.	Increase contraceptive prevalence. Reduce fertility.	Contraceptive delivery to women and men. Men as clients & recruiters of women. Address men only as a practical consideration in pursuing other programme goals *Enlist men in the recruitment of female contraceptors.*
MALE EQUALITY **Men as Reproductive Health Clients**	Men have been neglected. Men's needs must be met.	Address men's reproductive health needs, much as women's have been addressed.	Extend same range of reproductive health services to male clients as to women Concern with male sexuality Male health workers *Expand services currently serving women to provide services for men as well.*
GENDER EQUITY **The ICPD Ideal**	Global gender inequity influences fertility desires and reproductive health. Addressing inequity requires the full participation and cooperation of men, who hold more power and constrain women's choices.	Promote gender equity. Promote women's and men's reproductive health through substantial male involvement.	Men as partners Men active in promoting gender equity Careful assessments need to be done re: the way we might want to involve men in different programmes and settings. Broader range of activities – multiple entrees to work with men as partners, fathers, and community members Male health workers *Encourage men to take their children to well-child clinics, and support them in developing parenting skills.*

Source: Margaret E. Greene (1999), Center for Health and Gender Equity, "The Benefits of Involving Men in Reproductive Health." Paper presented in November 1999 at meetings of the Association for Women in Development, APHA, and at USAID. Further developed in a working paper by Jodi L. Jacobson and Margaret E. Greene (2000), *Refining Male Involvement: Towards a Gender Equity Approach*.

- Before Cairo, an acceptance of women's total responsibility for childbearing and the desire to bring about fertility decline led *conventional family planning programmes* to concentrate on women's contraceptive use and reproductive health.

- The *men and family planning framework* involves men primarily to increase contraceptive use. Men are potential obstacles to women's contraceptive use and an untapped group of potential contraceptors.

- Cairo's call for gender equity has been misinterpreted by some as advocating a remedial focus on men who have been "excluded" from traditional family planning programmes. The *male equality framework* reflects this reaction in programmes that have been designed to serve men as reproductive health clients in much the same fashion as women have been served.

- The last approach to involving men, the *gender equity framework,* is the only one that closely reflects the spirit of the ICPD. It acknowledges the fundamental role men play in supporting women's reproductive health and in transforming the social roles that constrain reproductive health and rights.

Taken together, male involvement programmes show a singular lack of clarity about what it is they are trying to accomplish.

SUMMARY OF "TODAY'S LESSONS:" GENDER STEREOTYPES SHAPE REPRODUCTIVE HEALTH PROGRAMMES

Family planning programmes focused on women because they assumed that:

- women are responsible for reproduction;
- women make decisions on their own or in perfect agreement with their male partners;
- dealing with women only is therefore adequate.

It is much simpler to focus on women alone, both in research and programmes.

Programmes now involving men tend to reflect and reinforce several specific assumptions about them, which include the following: men are uninformed, promiscuous and irresponsible, and act as barriers to women's control of their own fertility; men's sexuality is more important than women's; men can't and won't change—and it's not in their interest to do so.

· *Men are uninformed, promiscuous and irresponsible, and act as barriers to women's control of their own fertility.*

Men play important roles in regulating women's access to health services through control of finances, women's mobility, means of transportation, and health-care decisions. This "gatekeeping" authority may be challenged or upheld by how reproductive health programmes respond to prevailing cultural beliefs about gender roles.

Programmes that focus on modern contraceptive methods for women without expanding men's existing roles inadvertently erode men's existing responsible participation in reproductive health. Periodic abstinence, prevalent in Peru, Bolivia, and Sri Lanka (Helzner, 1996a), has been disparaged in mainstream family planning circles (Institute for Reproductive Health, 1999). Postpartum abstinence during lactation was once widespread in sub-Saharan Africa, and contributed to lengthening intervals between births (Bledsoe, 1990), but it has declined significantly with the advent of "modern" birth control. Nor have family planning programmes shown much respect for coitus interruptus or withdrawal as a contraceptive method even where it has been widespread as in Turkey and Pakistan. By disregarding these low-tech, cooperative family planning efforts, programmes have potentially missed opportunities to build on the self-control and communication they imply.

By promoting condoms among men for HIV control without addressing gender and sexuality, many social marketing campaigns in sub-Saharan Africa, Latin America and Asia have been seen as sanctioning promiscuous sex outside marriage as long as condoms are used (Tipping, 1991; Tipping, 1993). In Thailand, the 100 per cent condom campaign provided condoms and penalized brothels where they weren't being used, but did not attempt to address men's extensive patronizing of commercial sex workers (Hanenberg et al., 1994). In Nepal, a nongovernmental organization likewise responded to the routine rape of women by landlords on whose land they were collecting fodder, by providing condoms (Population Council, 1998). Recent efforts to make the image of condoms more compatible with marital use and to address the sexual double standard that influences their use may be more effective in the long run.

- *Men's sexuality is more important than women's*

The basic acceptance of the sexual double standard for women and men has made reproductive health interventions for men less ambitious, and has focused attention on male sexuality in ways that have never been true of programmes for women. A programme established to address STDs in Orissa, India investigated men's sexual health concerns and found they were focused on semen loss and virility (Collumbien et al., 1999). This programme and the research arising from it reflect this concern with men's sexuality, when women's fertility continues to eclipse any consideration of their sexuality.

A widely accepted emphasis on male sexual performance has justified the divergent treatment of men and women in reproductive health programmes. In India, the failure to lay to rest concerns regarding male sexuality and strength (Khan, Khan & Mukerjee, 1997), and a backlash against forced vasectomy during the "Emergency" under Indira Gandhi's rule in the mid-1970s helped to maintain an emphasis on female sterilization. *That female sterilization, a far more invasive surgery than vasectomy, became the norm while male sterilization was viewed with suspicion is a clarifying moment of patriarchy.* If women are to generate the confidence to negotiate the use of condoms, then dominant cultural stereotypes of women as sexually passive must be countered.

- *Men can't change and it's not in their interest to do so*

The field's static view of men needs to give way to an approach that supports men in transforming some of the gender inequities that inhibit reproductive health. For decades we have looked to women to change, develop, liberate themselves, and be empowered, all the while taking for granted that these changes would be welcome. Apparently, we have also harboured the notion that male-female relations constitute a zero-sum game, in which women's gains are necessarily men's losses, making us do little about changing men's behaviour. A study of male attitudes in Gujarat, India, for example, found widespread sexual

violence and coercion; yet offered as the sole solution, “strong advocacy and major social changes which could empower the women” (Khan, 1997), disappointingly avoiding suggesting what *men* might do.

Efforts to strengthen men’s participation in parenting are conspicuously missing from most male involvement programmes (Barker, 1997). There are few examples of programmes that support men who take their children for health services—to what used always to be Maternal and Child health centers—or that assist them in developing the skills they need to be good fathers. Practices as varied as breastfeeding, involvement in child care, contraceptive use, children’s school attendance, and dedication of financial resources all increase when mothers and fathers are mutually supportive (Foumbi & Lovich, 1997).

IMPLICATIONS OF SOME OF THESE LESSONS FOR FUTURE PROGRAMMING

We are looking for ways to support men’s support of women, and to change negative attitudes towards sex, gender and power at a deep level. Reproductive health programmes can contribute incrementally to this process. I have a few suggestions for future programmatic directions that may reduce our reliance on these stereotypes and erode gender inequities. Some of these ideas arise from the lessons I’ve presented, and some reflect the values the reproductive health field has laid out for itself.

1. Be sure to clarify objective of involving men

The reasons for involving men and the approaches to doing so are closely intertwined and should be carefully articulated. Few programmes have taken the plunge to initiate work that erodes the gender inequities inhibiting reproductive health.

2. Anticipate the impact of programmes on gender relations

A greater sense of “doing no harm” is needed in programme development, and it must extend to the social implications of reproductive health programmes. By reflecting assumptions about sex roles (e.g., men’s detachment from child-rearing, the demands of their sexuality) women’s primary responsibility for children and therefore for fertility control) they reinforce those relations when they deal with clients.

3. Address masculinity and its negative effects on health

The nongovernmental organization Salud y Genero in Mexico has developed the concept of “masculinity as a risk factor” and has met with considerable success in getting men to question the impact of their own masculinity on their health (de Keijzer, 1999). Working with men of the police and military in promoting awareness and skills building can be fruitful (Toro Ocampo, 1998). UNFPA-funded projects with men in uniform in Nicaragua, Ecuador and Paraguay built upon these men’s potential for leadership in the community. The men are masculine role models, with positions of leadership in the community. The institutional organization of the forces is also an advantage: By training officers and enlisted men in techniques for reducing violence, for example, the programme is able to reach thousands of men.

4. Work with young boys to influence their attitudes towards women

Disturbing research on South Africa indicates the prevalence of violence and sexual coercion among young girls, describing it as "everyday love" (Wood & Jewkes, 1997). The prevalence of coercion in early sexual encounters has been documented in many other places as well. Mexico's IMIFAP has developed an innovative curriculum addressing gender issues and violence for boys and girls that has been used to support the campaign against gender violence in Ixtacalco (Fawcett, 1999). Using Freire's "pedagogy of the oppressed," in which the substance and methods of teaching are in harmony with one another, Servol's comprehensive Adolescent Development Programme in Trinidad and Tobago teaches boys and girls how to create healthy relationships with information and skills on communications, gender, and social justice. An important component of the programme is an extensive discussion of rape and violence, talk that unsettles everyone and generally continues for days after the class (Weber, 1994). These good programmes provide models for work in other programme areas. Working with boys and girls helps to develop a sense of justice and empathy for the experiences of the other sex.

5. Be optimistic that both men and women can contribute to changing how they coexist to everyone's benefit.

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3. ANNEXES

3.1 Meeting Agenda

Wednesday, 5 September

Overall Rapporteur for the meeting: Dr Amy Ratcliffe

OPENING OF THE MEETING

Chair: Dr Michael Mbizvo
Rapporteurs: Dr Amy Ratcliffe and Ms Vera Zlidar

09:00 Opening of the meeting and welcome remarks
(Dr George A. O. Alleyne, Regional Director, AMRO)

Introductions *(Dr Ernest Pate)*

Purpose and objectives of the meeting and adoption of the agenda
(Dr Michael Mbizvo)

SESSION 1: PROGRAMMES FOR MEN TOWARDS PREVENTION AND CARE FOR STIs/HIV

09:30 1.1 *Presentation 1*: **"Interventions targeted at STI control in heterosexual men - a systematic review** *(Dr Sarah Hawkes)*

10:00 1.2 *Presentation 2*: **"Male involvement in prevention of pregnancy and HIV"** *(Dr Edith Pantelides)*

10:30 Coffee

11:00 Panel discussion from the above presentations on key issues and their application within regional contexts:

AFRO: Drs Kosia/Bathija
AMRO: Drs Pate/Ezcurra
EMRO: Drs Mahaini/Bathija
EURO: Dr Brandrup-Lukanow
PATH: Dr Clark

12:30-1400 Lunch

SESSION 2: PROGRAMMING FOR MEN IN FAMILY PLANNING

14:00 **2.1** *Presentation 3*: **"Counselling and communicating with men to promote family planning in Kenya and Zimbabwe: findings, lessons learned and suggestions for programming"** *(Dr Young Mi Kim)*

15:00 Panel discussion from the above presentations on key issues and their application within regional contexts:

2.2 *Presentation 4*: **"Communicating with men to promote family planning: lessons learned and suggestions for programming"** *(Ms Manisha Mehta)*

SEARO: Drs Aliudin/Wang
WPRO: Drs Pang/Wang
USAID: Mr Spieler

15:30 Tea

16:00 Panel discussion from the above presentations on key issues and their application within regional contexts *(continued):*

SEARO: Drs Aliudin/Wang
WPRO: Drs Pang/Wang
USAID: Mr Spieler

17:00 End of first day

18:00 Reception

Thursday, 6 September

Chair **:** Dr Michael Mbizvo

SESSION 3: PROGRAMMING FOR MEN IN PROMOTING SAFE MOTHERHOOD

09:00 **3.1** *Presentation 5*: **"Involving men in safe motherhood: the issues"** *(Dr Alexis Ntabona)*

09:30 **3.2** *Presentation 6*: **"Involving men in safe motherhood: lessons learned from action projects"** *(Dr M.E. Khan)*

10:00 **3.3** *Presentation 7*: **"Field experiences in involving men in safe motherhood"** *(Dr Imtiaz Kamal)*

10:30 Coffee

11:00 Panel discussion from the above presentations on regional perspectives, and experiences with community-based interventions:

SEARO: Drs Aliudin/Wang
WPRO: Drs Pang/Wang
UNFPA: Dr Cohen

12:30-1400 Lunch

SESSION 4 TARGETING MEN FOR IMPROVING REPRODUCTIVE HEALTH FOR BOTH SELF AND PARTNER

14:00 4.1 *Presentation 8*: **"Opportunities and challenges for men's involvement: the Regional Reproductive Health Strategy"** *(Dr Andrew Kosia)*

14:30 Discussion

14:40 4.2 *Presentation 9:* **"What do men want from sexual health services - evidence on men's sexual health concerns from South Asia"** *(Dr Sarah Hawkes)*

15:10 Discussion

15:20 Tea

15:40 4.3 *Presentation 10:* **"Male participation in reproductive health - a Caribbean imperative"** *(Dr Hugh Wynter)*

16:10 Discussion

16:20 4.4 *Presentation 11*: **"Capacity building in reproductive health programmes focusing on male involvement: a South-to-South framework"** *(Dr Badrud Duza)*

16:50 Discussion

17:00 End of second day

Friday, 7 September

Chair: Dr Peter Fajans

SESSION 5 PRESENT LESSONS AND FUTURE PROGRAMMATIC DIRECTIONS

08:30 5.1 *Presentation 12*: **"Men's roles with multiple partners: challenges and opportunities"** *(Dr Amy Ratcliffe)*

09:00	**5.2**	*Presentation 13*:	**"The implications of research on men on policy and programme development in reproductive health"** *(Dr Charles Nzioka)*
9:30	**5.3**	*Presentation 14:*	**"Adolescent male involvement in sexual and reproductive health"** *(Dr Matilde Maddaleno)*
10:00		Discussion	
10:30		Coffee	
11:00	**5.4**	*Presentation 15:*	**"Addressing gender imbalances to improve reproductive health"** *(Ms Judith Helzner)*
11.30	**5.5**	*Presentation 16:*	**"Present lessons and future programmatic directions for involving men in reproductive health"** *(Dr Margaret Greene)*
12:00		Discussion and overall recommendations	
13:00		Lunch	
14:00		Business and administrative meeting of Regional Advisers and WHO/RHR staff	
16:30		End of meeting	