Technical Paper No. 3

PARTNERING:

A New Approach to Sexual and Reproductive Health

UNFPA
United Nations
Population Fund

Technical Paper N°. 3

Partnering: A New Approach to Sexual and Reproductive Health

Sylvie I. Cohen,
Chief, Advocacy and IEC Branch, Technical Support Division
and
Michèle Burger,
Consultant

UNFPA
United Nations Population Fund

December 2000

Technical Paper is a series of periodic publications of UNFPA that reports on important technical and policy issues of relevance for national and international population and reproductive health programmes.

UNFPA also currently publishes reports in the following series: **Evaluation Reports, Programme Advisory Notes, Technical Reports and Technical and Policy Papers.**

220 East 42nd street
New York, NY 10017
USA

ISBN: 0-89714-540-2

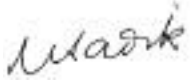
Notes: The views expressed and interpretations given in this Technical Paper are those of the authors alone and do not necessarily reflect those of the United Nations Population Fund.

The designation employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of the United Nations Population Fund (UNFPA) concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. The term "country" as used in the text of this report refers, as appropriate, to territories or areas. The designation of "developed" and "developing" countries are intended for convenience and do not necessarily express a judgement about the stage reached by a particular country or area in the development process.

Foreword

The International Conference on Population and Development (ICPD, Cairo, 1994) broke new ground in endorsing men's involvement in sexual and reproductive health, a realm that until then had overlooked their active role. In 1995, UNFPA published its first Technical Report on "Male Involvement in Reproductive Health, Including Family Planning and Sexual Health." Tremendous advancements over the last five years in research on men and masculinities, in the sense of urgency with the HIV/AIDS pandemic, in the visibility of gender-based violence, and in understanding the role that gender imbalances play in sexual relations and reproductive health have compelled us to reflect on new directions for working with men. A number of good practices from UNFPA and other organizations innovative programme interventions in these areas also deserve recognition and replication. This report attempts to capture such progress and recommend promising programming prospects in the areas of partnership with men, gender equity and engaging men to address such pressing issues as STDs and HIV/AIDS prevention, reduction of unwanted pregnancies, maternal mortality and morbidity, and gender-based violence, and in meeting their own reproductive health and educational needs. The growing consensus about focusing on young men, given the critical role their socialization and education play in determining the way they view women and their future sexual and reproductive behaviours, brings us hope. I strongly believe that early interventions with young men and boys constitute a great opportunity for promoting gender equity and reducing risk behaviours. It is essential to empower boys and young men with negotiation skills, supportive role models and networks, positive notions about sexuality and gender relations in schools and through community-based approaches, and to ensure adequate access to youth-friendly services. Similarly, enabling men to explore new family roles, to express their needs and seek help, to discuss such sensitive subjects as contraception, risk reduction and STD and HIV/AIDS prevention and reproductive intentions with their partners, and inviting them to make joint decisions on such matters require concerted efforts. This document reflects UNFPA's commitment to advocating and implementing such change, with support from other UN agencies, NGOs, political and religious leaders, activists, educators, employers, the media, husbands, partners, parents, male adolescents, community members, and service providers. I hope that it will serve as inspiration for stronger and tangible results in this complex but critical area.

Dr. Nadis Sadik



Executive Director, UNFPA

Acknowledgements

Many thanks to those who willingly shared their production in draft such as: Dr. Berit Autsveg, Gary Barker, Sam Clark, Margaret E. Greene, Paul Bloem, Ruth Hayward, and Michael Kaufman; to those who discussed and debated different sections of this paper at various stages of its development: Maria Jose Alcala, Delia Barcelona, Stan Bernstein, Dr. France Donnay, Dr. Nick Dodd, Dr. Lindsay Edouard, Riet Groenen, Dr. Carlo Laudari, Annemiecke de Los Santos, Wariara Mbugua, Luis Mora, Mohamed Nizamuddin, Dr N. Sadik, Mari Simonen, Kerstin Trone, and Marcela Villarreal; and to those who cooperatively shared recent literature that helped the document be current such as Patrick Friel, Judith Helzner, Shireen Jejeebhoy, Dirk Jena, Dr. Malika Ladjali, Ann Leonard, Dr. A. Olukoya, Julie Pulerwitz, Dr. Iqbal Shah, John Townsend, Mary Nell Wegner, and other members of the USAID Men and RH Sub-Committee.

Iram Batool, a UNFPA intern, prepared case studies of UNFPA programme experiences; Tarik Benbahmed, a UNFPA intern, organized the materials, made an overall literature search and prepared a specific literature review on male adolescents and HIV/AIDS; and Maria Holtsberg, a UNFPA intern, helped with research and case studies. Madeleine Sacco, UNFPA Technical Support Division, formatted the textboxes beyond her obligations.

Copy editing by Judith McCullough
Cover Design: Lynn Martin
Text Design/Typesetting: Andy Musilli

Table of Contents

List of Boxes

Introduction

Chapter One

Chapter Three

Chapter Four

Chapter Five

Chapter Six

Chapter Seven

List of Acronyms

AIDSCAP	AIDS Control and Prevention Project
APHA	American Public Health Association
APPROPOP/PF	Appui au Programme de Population/Planification Familiale
ARH/SH	Adolescent Reproductive Health and Sexual Health
AWID	Association for Women in Development
CBO	Community-based Organization
CDS	Center for Development and Health
CEDAW	Convention on Elimination of Discrimination Against Women
CEDPA	Centre for Development and Population Activities
CENEP	Centro De Estudios de Problacion
CST	Country Support Team (UNFPA)
DHS	Demographic and Health Surveys
FGM	Female Genital Mutilation
FHI	Family Health International
ECO	Economic Co-operation Organisation
FLACSO	Facultad Latino Americana de Ciencias Sociales
G/PHN	Government/Population, Health and Nutrition
HHRAA	Health and Human Resources Analysis for Africa
HIVAIDS	Human Immunodeficiency Virus/acquired Immune Deficiency Syndrome
HRP	Human Reproduction Programme (of WHO)
ICOMP	International Council on Management of Population Programmes
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IGWG	Interagency Gender Working Group
ILO	International Labour Organisation
INOPAL	Investigación Operativa y asistencia técnica en planificación familiar y salud materno-infantil en América Latina y el caribe
INPPARES	Instituto Peruano de Paternidad Responsible
IPPF	International Planned Parenthood Federation

IPPF/WHR	IPPF/Western Hemisphere Region
IUSSP	International Union for the Scientific Study of Population
JHU/CCP	Johns Hopkins University/Center for Communication Programs
JHU/PCS	JHU/Population Communication Services
JHU/PIP	JHU/Population Information Program
MAP	Men As Partners programme (initiated by AVSC International)
NGO	Non-governmental organization
PHC	Primary health clinic
Profamila/DR	Asociatión Dominicana Pro-Bienestar de la Familia/Dominican Republic
RFSU	Swedish Family Planning Association
SAARC	South Asia Association for Regional Co-operation
SIDA	Swedish International Development Agency
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
WHO	World Health Organization
WHO-EMRO	WHO-Europe and Middle East Regional Office
WHR	Western Hemisphere Region

Executive Summary

As its title suggests, the focus of this 2000 Technical Report and Policy Paper, "partnering: A New approach to Sexual and Reproductive Health", is on a gender perspective in sexual and reproductive health, and on finding constructive ways to build partnership between men and women. One way of achieving this is through a better understanding of manhood. The AIDS epidemic, ongoing efforts to empower women and achieve gender equity, the ICPD's mandate to meet the reproductive and sexual health needs of adolescents, and the growing international recognition of violence against women as a pandemic have combined to transform population into a field that epitomizes social transformation. Just as family planning and the pill were revolutionary 50 years ago, building partnerships with men in areas such as sexuality, reproductive intentions, new gender roles, fatherhood and conflict resolution is the revolution occurring at the start of the twenty-first century. This process has its roots in the ICPD Programme of Action, which links population and development with enabling conditions such as enhanced gender relations, reproductive choice and reproductive health, and which connects reproduction with sexuality. The ICPD "implies a positive approach to human sexuality" and mandates that sexual health care should be "the enhancement of life and personal relationships and not merely the counselling and care related to procreation or sexually transmitted diseases".[a] Future actions of the ICPD follow-up process also call for zero tolerance for harmful and discriminatory attitudes, discrimination and violence against the girl child, and all forms of violence against women.[b]

The new paradigm proposes three basic expectations: one relates to partnership in sexual and reproductive health, which leads to the second premise — a gender-equitable man; the third premise is men taking ownership of the problems and being part of the solution.

- Partnership between men and women would mean that they freely and deliberately join their forces and choices for achieving common sexual and reproductive goals. Other factors linked to the creation of a sustainable partnership are trust, respect, ownership of the decisions and their outcomes, and equality. Trust relates to communication and negotiation of safety from STDs/HIV/AIDS; respect involves relations free of violence; and

[a] United Nations, "Report of the International Conference on Population and Development" (Cairo, 5–13 September 1994), A/CONF.171/13, para. 7.2.

[b] "Key Actions for the Future Implementation of the Programme of Action of the International Conference on Population and Development", adopted by the 21st special session of the General Assembly, New York, 30 June–2 July 1999, para. 48.

ownership invites both partners to decide on matters of sexuality, pregnancy, family planning, post-pregnancy care and child-rearing.

- The notion of a gender-equitable man comes from a working definition by Barker on young men, as follows: young men who "are respectful in their relationships with women and seek relationships based on equality with their partner and intimacy rather than sexual conquest".[c]

- Finally, men taking ownership of issues related to unequal gender relations and feeling themselves to be part of the solution is the newest and most positive development we are witnessing, one that needs to be further nurtured. Never before have male researchers themselves striven to understand the context that reinforces stereotypic behaviour, and men and boys are increasingly mobilized to find alternative role models, address gender dimensions of all issues, and respect women's entitlements to sexual and reproductive health.

Recurring themes in this report are the influence of gender systems on men's identity formation and on gender relations, and the multiple expectations of and challenges to being a man; men's knowledge, attitudes and behaviour in the areas of sexuality and reproduction; the role men play in the HIV/AIDS epidemic; the urgency of dealing with the different kinds of sexual relationships men have, including same-sex behaviour and of finding ways for couples to negotiate safety and satisfaction in their sexual relations; what men's sexual and reproductive health needs are and how reproductive health services can better respond to them; the need to go beyond a health-needs and fertility-based approach, and to include legislation, advocacy and education to change cultures that condone violence and inhibit men and women's roles and choices; and the need to remove discriminatory practices, including son preference, early marriage, female genital mutilation (FGM) and gender-based violence, as interfering with social, couple and individual growth.

Couple decision-making and couple communication are also the focus of new research and interventions. Enabling factors such as support networks and education are keys to offering men and male adolescents abilities to resist pressure from peers and to experiment with new masculine roles. New models of masculinity are needed to reduce violence, and involve men in preventing maternal mortality and in alternative parenting and fathering. Fortunately, never before have governments and NGOs implemented so many initiatives that are becoming landmarks in this new field; men are also increasingly engaged in the debate and are mobilizing themselves in new networks.

This report not only provides new insights about the complexity of addressing men's and women's needs in an equitable fashion, but also underlines the importance of having well organ-

[c] G. Barker, "Exploratory Operational Definitions of Gender Equitable Behavior by Young Men" (notes from dissertation research, July 2000).

ized reproductive health services that integrate family planning with sexually transmitted infection (STI) prevention programmes, including HIV/AIDS. Trained service providers must be capable of considering the physical, emotional and social circumstances of male clients as partners and individuals. All health care professionals, including programme designers, managers, physicians and front line staff, must be able to offer men-friendly services, especially for counselling, answering men's queries, and promoting dual protection against unwanted pregnancies and STIs. They must manage potentially conflicting interests involving the reproductive intentions of men and women, consider the health implications, particularly for women, who bear the health risks of pregnancy and childbirth and are more vulnerable to STIs and STDs (sexually transmitted diseases), including HIV/AIDs. They must also be careful to build partnerships with men that ensure that the "locus of control" does not move from women to men.

As to male adolescents, offering them positive role models and providing them with conflict resolution and other life skills, sexuality education and reproductive health information and services, are key investments for the future. With access to these resources, younger male generations will evolve with a sense of comfort with their identity and with skills that foster equitable relationships with girls and women, and guide informed and safe sexual behaviour.

The report provides an overview of current theoretical and operational knowledge; it proposes programme directions, suggests programme indicators, discusses programming considerations, and informs about innovative approaches used in gender-sensitive reproductive health services and in communication interventions that aim to build partnerships with men. It provides both the rationale for comprehensive and more complex strategies and illustrates recent government, NGO and private sector initiatives. It also underlines the importance of using gender tools on a continuing basis to evaluate service and communication programmes.

The summary below captures key elements in each chapter

The introduction reviews the international consensus on the participation of men in reproductive and sexual health and defines basic concepts that provide the framework for programmes in population and development.

Chapters I and **II** provide the context and rationale for programmes that engage men as partners. **Chapter I** describes masculinity and explores some determinants and effects of the entrenched stereotypes of masculinity on both women and men with regard to sexual and reproductive health; it also emphasizes the need for social change. This chapter also discusses implications of recent research on masculinity in Latin America, Africa and South Asia for programme planners, particularly new angles such as the process of becoming a man and the cost of masculinity. An ecological perspective is proposed to include contextual factors, such as sexual culture and high-risk milieus, to situate the environment in which behaviour takes place. It provides examples of how men are changing and abandoning a model that is increasingly unsustainable in a world where the social norms are in flux.

Chapter II provides an overview of what is known of prevailing male attitudes and practices in regard to sexual and reproductive health, and men's unmet needs. Statistics confirm that men

play a critical role in spreading AIDS and conduce us to include men to help stem the spread of this epidemic. Men's vulnerability to sexual and reproductive health problems puts women and men at risk of spreading AIDS as well as other STDs. The data clearly support the need to educate men about safer sex and to take into account the multiple types of sexual relationships they have. Men are increasingly aware and supportive of family planning. Men are more likely to approve of family planning and to know about contraception than stereotypes about men suggest. In most countries, the reproductive preferences and attitudes of men and women towards family planning are similar. Some men may still identify family planning as a female responsibility, partly because of the extensive availability of female-centred contraceptives, and also because family planning programmes have tended to exclude men. Men require sexual and reproductive health services that are flexible, and respond to their sexual behaviours and changing needs throughout their life cycle. Men have their own health issues and concerns, independent of those of their partners. The spread of HIV and other sexually transmitted infections has brought an increase in awareness and use of condoms, but men are not always fully informed about HIV. Although men's knowledge of male condoms is extremely high worldwide, condom use is not as widespread as it could be. Condom use continues to be inconsistent and generally associated with occasional partners, including sex workers. Demographic and Health Surveys (DHS) studies also reveal a family planning "KAP gap" among men. Their contraceptive use is lower than might be expected, given their overall levels of approval and knowledge.

Chapter III analyses the series of frames of reference that guide population programmes to engage men; it suggests a gender-equitable framework for building partnerships between men and women. While the "men and family planning framework"[d] immediately followed Cairo, a "gender equity" framework, accompanied with educational and/or human rights approaches, is best suited to meet the ICPD mandate and implement gender-sensitive strategies. The gender-equity framework concerns itself with the sexual and reproductive health needs of men as equal partners of women (and of other men). It recognizes that gender inequity influences not only fertility behaviour, but also reproductive and sexual health risks and choices. Within this framework, the educational approach reaches men early in their lives by integrating a gender perspective into family life education, peer education and sexuality education. Its goal is to engender gender-equitable male adolescents and boys, who are aware of men's and women's sexual and reproductive health, gender inequalities, stereotypes and the implications of gender roles, and to equip them with tools to grow. To complement educational efforts, a human-rights approach promotes collective change. It calls for social justice and zero tolerance for gender-based violence and discriminatory practices, including son preference, FGM and early marriage, as violations of human rights. It calls for legal systems that protect reproductive rights, gender equality and the rights of the child, and provide safety nets.

Ethical issues, a life-cycle approach, resource allocation and research needs are the programme considerations described in **chapter IV**. Programmes that involve men in reproductive and sexual health have to address gender. An organization that is prepared to work on gender issues has to start by assessing itself in gender terms, and evaluate the impact it has based on its own gen-

[d] M. E. Greene, "Benefits of Involving Men in Reproductive Health" (paper presented at the Association of Women in Development (AWID) and USAID meeting, November 1999).

der relations. Managers must consider the resources they can allocate to a men's programme, and the cost of adding services not available in existing programmes. Expenditures need to be considered for training, promotion and possibly redesigning clinics to serve men. More research is needed, both theoretical research on masculinity and operational research to test and evaluate new approaches that reach men and couples.

Chapter V addresses key elements of communication programmes that work with men to change policies, social norms and behaviours. To incorporate a male-inclusive gender perspective in sexual and reproductive health and rights means that gender relations are not only carefully considered as time-invariable realities, but are also targets of change. In light of the ICPD mandate, population programmes are committed to promoting change. Two programme vehicles are at their disposal: advocacy communication to change policies and social norms, and behaviour-change communication (information, education and communication, or IEC) to change individual knowledge, attitudes, beliefs and behaviour. Experience in changing behaviours through a "social" approach, that is, advocacy, is growing; deep-rooted social change is the most difficult to achieve, but is being increasingly embraced by UNFPA and its partners to fight both the AIDS epidemic and violence. Lessons learned from existing experience and innovative approaches are presented, such as mobilizing men in grassroots advocacy against violence and involving religious leaders in reproductive health; and new methodologies are proposed, such as transactional analysis, conflict resolution, networking, couple communication and gender tools to analyse communication campaigns.

Chapter VI deals with service delivery for adult men. The three categories of services most commonly available to men are screening; clinical diagnosis and treatment; and information, education and counselling. However, programmes that serve men are experimenting in several areas. Providers are offering individual or group counselling; couple counselling is also provided if the woman consents to it. The AIDS epidemic is contributing to increased attention to STDs and HIV/AIDS prevention. Condoms and vasectomy continue to be the only effective male contraceptive methods, but new initiatives are promoting condoms as a dual protection method for the prevention of pregnancy and STDs, including HIV/AIDS. The syndromic management approach is used for managing reproductive tract infections and STDs. Training providers to work with men and incorporating a gender perspective into their training are critical steps in integrating services for men into existing programmes and in improving quality of care. Finally, distribution schemes such as community-based distribution, social marketing, and building partnerships with the private and public sectors to reach men where they convene, have become more mature and better evaluated. Organizations are also gaining experience in providing services at the workplace, including the military, and in emergency circumstances.

In **chapter VII**, the needs of adolescent males are highlighted. Young men go through a critical process of forming their self-identity. A variety of educational approaches, community-based, school-based and peer education, are informing young men about STDs and HIV/AIDS, and behaviours they can adopt to protect themselves. Innovative strategies including social marketing, hotlines and radio call-in programmes; the Internet and CD-ROMs; and entertainment-education programmes are providing adolescent males the confidential, timely and anonymous

counselling they tend to prefer. Also reviewed are the benefits of life-skills training, population education, family life education and sexuality education to teach young men the skills they need to negotiate healthy relationships, take responsibility for their lives, resist negative pressures and reduce their own vulnerability to infections and unintended pregnancies.

In conclusion, it is an exciting time for population programmes to embrace comprehensive and far-reaching strategies to engage men in equitable partnerships. The groundbreaking research on masculinity and sexual behaviour in some regions needs to be expanded to the rest of the world, and translated into programmes that not only address men but also are owned by men themselves.

Introduction

The role of men in reproductive and sexual health has never been so widely acknowledged. The AIDS crisis is largely responsible not only for the inclusion of men in current population and reproductive health policies and programmes, but also for motivating donors and providers to quickly develop AIDS prevention programmes for men and adolescents. The pandemic has also brought more attention to the connection between sexuality and gender, and has changed the implications of sexually transmitted diseases from a health to a social issue; it has also resulted in a global campaign to increase the use of condoms and barrier methods. In addition, in view of continuing inequality, the international movement to strengthen the rights of women has called for confronting gender-based violence and for changing men's views and behaviour in this area. A third trend is the relative acceptance of reproductive health in many developing countries and an increasing emphasis on maternal mortality, with greater attention to men as a logical next step.[1] While population programmes seem more committed than ever to positively engage men in sexual and reproductive health, country programmes are yet to reflect that commitment in a coherent package of interventions that balance health and gender-equity concerns with long-term and short-term goals.

The purpose of this document is to take stock of recent research findings and policy debates, and to shed some light on new priorities. While initially intended to update a previous technical report, "Male Involvement in Reproductive Health",[2] issued immediately after the Cairo conference, it became clear that, to revisit the issues, a new paradigm was needed. The paradigm proposed here rests on three basic expectations: first, partnership in sexual and reproductive health; which leads to the second — a gender-equitable man; third is men taking ownership of the problems and being part of the solutions.

- Partnership between men and women would mean that they freely and deliberately join their forces and choices for achieving common sexual and reproductive goals. Other factors linked to the creation of a sustainable partnership are trust, respect, ownership of the decisions and their outcomes, and equality. Trust relates to communication and negotiation of safety from STDs/HIV/AIDS; respect involves relations free of violence; and

[1] S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes", report for the Royal Ministry of Foreign Affairs, Oslo, Norway, 21 February 1999.

[2] C. P. Green et al., "Male Involvement in Reproductive Health, Including Family Planning and Sexual Health", *Technical Report* 28, UNFPA, New York, 1995, p. 104.

ownership invites both partners to decide on matters of sexuality, pregnancy, family planning, post-pregnancy care and child-rearing.

- The notion of a gender-equitable man comes from a working definition by Barker on young men: young men who "are respectful in their relationships with women and seek relationships based on equality with their partner and intimacy rather than sexual conquest".[3]
- Finally, men taking ownership of issues related to unequal gender relations and feeling part of the solutions is the newest and most positive development we are witnessing and should further nurture. Never before have male researchers themselves striven to understand the context that reinforces stereotyped behaviour, and men and boys are increasingly mobilized to find alternative role models, address gender dimensions of all issues, and respect women's entitlements to sexual and reproductive health.

The "new men" already exist; courageous and committed men are showing the way, questioning cultural values and norms, and intervening publicly and privately. However, it remains important to learn more about, recognize and work with what prevents partnership between men and women from being fully realized. In doing so, it would be counterproductive to adopt a moralizing stance or to stigmatize men into fitting rigid stereotypes.

The audience for this discussion paper is quite wide. It includes UNFPA's intercountry, regional and national programme constituencies, that is, practitioners, researchers, regional advisory teams, planners and managers, advocates, government officials and international and national NGOs, that are interested in assisting countries' efforts to design and implement comprehensive strategies that engage men as partners. To this effect, recent literature and case studies are combined, as well as directions, indicators and lessons learned from programmes, in an ensemble that is hoped to be helpful for future programme planning and evaluation. Since situation analyses are always region or country specific, it is risky to generalize on trends; but the choice of including region- and country-specific data is based on the expectation that doing so will inspire future operations research and needs assessments. As to the regional balance, most of the qualitative data on male identity, for instance, originated from Northern and Latin American researchers, with a few exceptions, from South Asia and Eastern Africa. On the other hand, surveys such as DHS questionnaires on men have mostly been applied in Africa; therefore, comparative data reflect this situation. The report cannot claim to be exhaustive and geographically representative, but mention of preliminary data allows to understand the roots of male behaviour, the context of pressures on them, and the potential for change. Similarly, innovative programmes, such as new legislation on paternity leave or violence, male networks, men's campaigns against violence against women, sexuality education and special skills for boys, may not been implemented in a large number of countries in the South; it does not prevent them for being relevant, and worth acknowledging and diffusing.

[3] G. Barker, "Exploratory Operational Definitions of Gender Equitable Behavior by Young Men", notes from dissertation research, July 2000.

The field is new and evolving very fast. Different perspectives from macro-economists (who emphasize poverty, support systems and education as root causes of most issues, including male roles), demographers (who tended in the past to limit men and other social groups as contexts to fertility), public health thinkers (who focus on risk prevention to ill health), psycho-sociologists (who zero in on factors related to socialisation processes, values and beliefs formation sytems), and activists (who seek social justice) still need to be assimilated to converge into a single institutional viewpoint. The discussion is meant to shed light on sensitive issues and to highlight promising yet pilot efforts.[4] To that effect, literature and programme experiences emanate not only from UNFPA but from many other institutions and sectors. The attempt is to reunite data on root causes of status quo with the range of strategies to address and engage men and boys for social change, with emphasis on sexual and reproductive health. In this endeavour, UNFPA benefited from the exceptional co-operation from the Men and Reproductive Health Subcommittee of the USAID-sponsored Interagency Gender Working Group, the Norway Ministry of Foreign Affairs, AVSC, IPPF/WHR, Population Council, UNAIDS, UNICEF and WHO, which released their latest yet unpublished data to enrich the debate.

A STRONGER INTERNATIONAL CONSENSUS ON THE PARTICIPATION OF MEN IN GENDER EQUALITY, SEXUALITY AND REPRODUCTION

The commitment to include men in reproductive and sexual health has never been so clearly reaffirmed since Cairo, Beijing, and their follow-up processes.

The Cairo and Beijing mandates: a rights-based and gender-equity orientation

The Programme of Action adopted by consensus at the 1994 International Conference on Population and Development (ICPD) shifted from a purely demographic approach to family planning to a more holistic, reproductive-health framework that links health to gender equality and sustainable development. it abandons traditional thinking, which isolates women's fertility and ignores factors that contribute to it, in favour of a model that considers men's active role in women's health and their own health and responsibilities in child-bearing. The ICPD also makes a clearer connection between reproduction, power relations and sexuality, and is a strong advocate for gender equality and women's empowerment as a means of achieving the goals of sustainable development. There was agreement in Cairo:

> *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 of family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children.*[5]

[4] Some of the language and concepts are still new, and working definitions are inserted when needed, although they are for clarification only.

[5] United Nations, "Report of the International Conference on Population and Development" (Cairo, 5–13 September 1994), 18 October 1994, para. 4.27.

A year later, the Beijing Platform of Action went further by advocating that "women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men".[6]

In Beijing, it was agreed:

> *The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality…free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.*[7]

The ICPD and the FWCW clearly stated the reasons for involving men in sexual and reproductive health programmes. Fundamentally, they called attention to the ways social contexts shape the use of family planning and other reproductive health services, and they promoted the notion of creating enabling conditions for women to be able to exercise their rights. Indeed, a rights orientation obliges one to recognize the importance of social contexts that constrain people's choices; this led to an emphasis on gender equity as an underlying objective of population and development programmes.[8]

The interest in male involvement peaked in 1998, four years after Cairo, a year before the Cairo+5 review. A combination of factors, including the familiarity of women activists and progressive men with the Programme of Action, the AIDS crisis, and the requirement to show initiatives undertaken in the five-year review processes, contributed to intense activities in male involvement undertaken between 1998 and 2000.

The review process validated the ICPD goals and appraised progress made. ICPD+5 keeps the momentum going in terms of women's rights, but it also invites men as partners in efforts to reduce maternal mortality and morbidity by emphasizing their role as advocates for women in eliminating harmful practices, including violence, and in supporting women's access to health care. It concluded that urgent action is needed to address the sexual and reproductive health needs of youth; prevent HIV/AIDS; and provide reproductive health care to women and youth in emergencies. Among key gender-related actions recommended by the ICPD+5 review were:

- meeting men's reproductive and sexual health needs without prejudicing reproductive and sexual health services for women;
- fostering zero tolerance for harmful attitudes like son preference;
- promoting positive male role models.

---

[6] United Nations, "Report of the Fourth World Conference on Women" (Beijing, 4–15 September 1995), 17 October 1995, para. 92.

[7] United Nations, "Report on Fourth World Conference on Women".

[8] M. E. Greene, "The Benefits of Involving Men in Reproductive Health" (paper presented at AWID and USAID, November 1999).

To achieve these goals, it clarified the roles and responsibilities of men as follows:

- Promote men's understanding of their roles and responsibilities with regard to respecting the human rights of women;
- protecting women's health, including supporting their partner's access to sexual and reproductive health services;
- preventing unwanted pregnancy and sexually transmitted diseases, including HIV/AIDS; sharing household and child-rearing responsibilities;
- and promoting the elimination of harmful practices, such as female genital mutilation and sexual and other gender-based violence, ensuring that girls and women are free from coercion and violence.[9]

The Beijing+5 review went beyond the Beijing Platform of Action in provisions related to reproductive health, by emphasizing the gender aspects of the HIV/AIDS pandemic and STDs. The review strengthened commitments to address gender-based violence by calling for zero tolerance campaigns condemning violence against women, requiring laws and other measures to address negative traditional practices, including honour crimes, and recommending gender-sensitive training of health workers to recognize and properly address gender-based violence. It called for stronger legislation against all forms of domestic violence, including marital rape and sexual abuse, and against violence towards women and girls as a human rights violation; and for programmes "to encourage and enable men to adopt safe and responsible sexual and reproductive behaviour, and to effectively use methods to prevent unwanted pregnancies and sexually transmitted infections, including HIV/AIDS".[10]

Progress in implementation of partnership with men in sexual and reproductive health and rights, while difficulties remain

The interest in partnership with men in sexual and reproductive health is reflected in greater donor awareness and support for government and NGO initiatives. Many multilateral and bilateral agencies have made new efforts to implement "partnering". Apart from UNFPA, other organisations have recognized the need to include men in maternal and child health-related activities. Most of the Nordic countries have supported important initiatives in this area. UNDP has formed a UN Men's Group for Gender Equality, and in the fall of 1997, USAID formed a Men in Reproductive Health Subcommittee under USAID's Interagency Gender Working Group.[11] Most countries have seen increases in awareness and in tangible activities both among International Planned Parenthood Federation (IPPF) affiliates and NGOs and within government-run programmes.[12]

---

[9] United Nations, "Key Actions for the Further Implementation of the Programme of Action of the ICPD", I July 1999, chapter IV, 52(g).

[10] United Nations, Division of Women, "Preliminary Analysis of the Beijing+5 Outcome Document", www.un.org/Womenwatch/daw/followup/analysis.html.

[11] S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes".

[12] Ibid.

Over the past five years, a series of important resources and materials has also emerged. To name just a few, these include: Nordic country initiatives such as Sweden's Male Networks and Young Men's Clinic;[13] the Men As Partners (MAP) programme, initiated by AVSC International; and the IPPF Western Hemisphere Male Involvement programme, both of which have sponsored the development of a wide range of programme- and training-related materials; the Population Council's Horizons project; and the Human Reproduction Programme (HRP) of the World Health Organization (WHO).

There has also been an unprecedented advance in the knowledge base regarding men's reproductive health behaviour, which will lead to new insights on how to improve reproductive health for men, women and children. We now have more representative quantitative survey data on men's reproductive health, and qualitative data on them as well. Progress is being made to find ways to use information on men, such as measures of unmet need, to develop improved strategies for reproductive health, and a new and more sophisticated men's questionnaire is being developed for inclusion in the third series of Demographic and Health Surveys (DHS). The new qualitative studies on masculinities, such as new work under way by the Facultad Latino Americana de Ciencias Sociales (FLACSO), the International Reproductive Rights Research Group (IRRAAG) described by Petchesky (1999), and recent work by Barker (1998), have a potential to provide insights that would be unlikely to arise from quantitative data and will probably result in more innovative and effective programmes. FLACSO, in Chile, recently published a well-received book on masculinities[14] and continues to dedicate itself to research on men as partners. Compendiums of resources[15] and electronic libraries, such as a CD-ROM, "HIM", and the Frontiers CD-ROM, Summaries of Operations Research projects; an informative newsletter, "Toward a New Partnership: Encouraging the Positive Involvement of Men as Supportive Partners in Reproductive Health", published by the Population Council, increase programmes' abilities to avail themselves of such knowledge.

There have also been an unprecedented number of conferences on male involvement in RH (see table on the next page). The few programmes under way, and literature available on masculinity, socialization of boys, sexuality, gender-based violence and fatherhood, were common themes shared and discussed at regional conferences in Africa, Eastern Europe, the Islamic World and Latin America. These conferences helped stimulate country programmes, contributed to re-emphasizing the gender perspective of male involvement programmes, identified research priorities, and facilitated the creation of countrywide, regional and international networks of professionals, primarily academicians, interested in providing the knowledge that will contribute to realizing the ICPD agenda.

---

[13] S. Laack et al., Report on the RFSU Young Men's Clinic, Swedish Family Planning Association (RFSU), Stockholm, 1997.

[14] T. Valdés and J. Olvarríra, eds, "Masculinidades y equidad de genéro en America Latina", FLACSO, UNFPA, Santiago, 1998.

[15] For example, see materials by UNFPA (Green et al., 1995), IPPF (*Planned Parenthood Challenges*, vol. 2, 1996) USAID (Danforth and Greene, 1997), PATH (Khorram and Wells in *Outlook*, vol. 4, no. 3, January 1997), Family Health International (*Network* 18, no. 3, 1998) and Johns Hopkins University Population Information Program *Population Reports* (Drennan et al., 1998).

Recent Conferences on Male Involvement in Sexual and Reproductive Health

1996

- *Male Involvement in Family Planning: A Challenge for the National Programme Workshop*. The Population Council, AVSC International, National Institute of Population Research and Training, Deutsche Gesellchaft Für Technische Zusammenarbeit. Dhaka , Bangladesh, June 1996. (National)

1997

- *Men as Partners in Reproductive Health*. AVSC International. Mombassa, Kenya, May 1997. (International)
- *Better Together: African Regional Conference on Men's Participation in Reproductive Health*. Johns Hopkins University/ Population Communication Services (PCS), Zimbabwe National Family Planning Council, IPPF Africa. Harare, Zimbabwe, April 1997. (Regional)
- *Male Involvement in Reproductive Heath and Mainstreaming Gender in Population and Development Programmes*. UNFPA, CST Addis Ababa, Ethiopia, October 1997. (Regional)

1998

- *Seminar on Family Men, Family Formation and Reproduction*. International Union for the Scientific Study of Population (IUSSP). Buenos Aires, Argentina, May 1998. (International)
- *Male Participation in Reproductive Health: New Paradigms*. AVSC International and International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR). Oaxaca, Mexico, October 1998. (International)
- *Thematic Workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services*. UNFPA, Technical Support Services (TSS), Rome, Italy, November 1998. (International)
- *First Conference of French Speaking African Countries on Men's Participation in Reproductive Health*. Johns Hopkins University/PCS. Ouagadougou, Burkina Faso, April 1998. (Regional)
- *Men as Supportive Partners in Reproductive and Sexual Health*. Population Council, Kathmandu, Nepal, Summer 1998. (Regional)
- *The Role of men in Reproductive Health Programmes*. UNFPA and Economic Co-operation Organization (ECO). Baku, Azerbaijan, September 1998. (Regional)
- *Seminar on Male Involvement in Reproductive Health: Summary of Research Findings and Future Directions*. Population Council, Asia and Near East Operations Research and Technical Assistance Project, Alexandria, Egypt, May 1998. (National)

1999

- *How Can Men Gain from Improved Gender Equality? Sexuality, Fatherhood and Male Identity in a Changing Society*. Swedish Ministry for Foreign Affairs. Lusaka, Zambia, January 1999. (International)
- *Men as Supportive Partners, Consultation for ICPD+5. Population Council*. New Delhi, India, January 1999. (National)

2000

- *Inter-Country Workshop Adolescent Reproductive Health for East and South East Asia and the Pacific Island Countries*. UNFPA, CST Bangkok, Pattaya, May 2000. (Regional)
- *Meeting on the Health and Development Needs of Male Adolescents and Young. UNAIDS and WHO*. Pretoria, South Africa, September 2000. (Regional)

However, the challenge in implementing this knowledge, and these mandates and directives, has been to translate them into comprehensive strategies and measurable changes in policies and programmes while maintaining a gender perspective. In addition to noting that a lack of institutional memory and inter-agency communication hamper progress in programming, a review paper commissioned by Norway identified the following unresolved issues: unsustained initiatives; policy-makers' prejudice against condoms; unanticipated backlashes from misoriented communication campaigns and from men concerned about keeping their prerogatives; lack of consensus on language for programmes; how to balance the reproductive health needs of men and the needs for couple strategies without subtracting from resources for women's health; and how to increase men's attendance in sexuality and gender training.[16]

Without pretending to resolve these outstanding matters, this paper aims to highlight future programme directions and stimulate further discussion to reach a consensus on priorities. To do this, a global update on recent research results, as well as trends in programme efforts to increase communication strategies, service delivery and special programmes to reach young men, are provided.

BASIC CONCEPTS THAT GUIDE PROGRAMMES CONCERNED WITH PARTNERSHIP WITH MEN IN SRH

To ensure our common understanding, the document starts with a compilation of the basic concepts that are involved in achieving goals. The concepts defined in this chapter include reproductive health, reproductive rights, sexuality and sexual health, sexual rights, gender, gender equity, gender roles, gender relations, masculinity and partnership.

Reproductive Health

The World Health Organization has proposed a definition of reproductive health, derived from the definition of health in general, as: "A condition in which the reproductive process is complemented by a state of complete physical, mental and social well-being and not just the absence of disease or problems in the reproductive process". This implies that people "have the ability to reproduce, regulate their fertility and engage in and enjoy their sexual relations, and that women may go through the process of pregnancy and childbirth without complications, fertility regulation may be achieved without problems for health, and that people may feel secure when they have sexual relations".[17]

Implicit are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth, and will provide couples with the best chance of having a healthy infant.[18] Reproductive health is both rights and health oriented. It includes:

---

[16] S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes".

[17] M. Fathalla, "Reproductive Health: A Global Overview", *Annals of the New York Academy of Sciences*, 28 June 1991, p. 1.

[18] United Nations, "Report of the International Conference on Population and Development", para. 7.2.

> *family planning, counselling, information, education, communication and services; education and services for prenatal care, safe delivery and postnatal care, especially breastfeeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood.*[19]

These concepts agreed to in Cairo and Beijing place men in a very different position from one they have been accustomed to for centuries. They give women and men equal rights in decisions involving reproduction and sexuality, and place the responsibility of safe pregnancies, childbirth and the health of offspring on both men and women. The sexual health criteria also challenge health providers' skills by broadening the scope of services beyond fertility. The ICPD rejects the previous demographic model used to identify factors that affect reproduction, which takes women as the unit of analysis; where men end up is another independent factor; they are seen either as facilitators or obstacles in the decisions women make regarding their fertility.[20]

Reproductive Rights

These rights are defined as the human rights of women and men to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. The Platform of Action of the FWCW strengthens the connection between sexuality, reproduction and gender equality by agreeing that:

> *"Reproductive rights imply equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."*[21]

Sexuality

Sexuality is intricately linked to gender. It is a social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behaviour, and it is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, influence an individual's sexuality.[22] Damien Rwegera, a Rwandan commentator, points out that sexuality involves:

---

[19] Ibid., para. 7.6.

[20] J. G. Figueroa, "Some Reflections on the Presence of Males in the Reproductive Processes" (forthcoming, in "Male Sexuality and Reproduction", El Colegio de Mexico, Union Internacional para el Estudio Cientifico de la Poblacion y Sociedad Mexicana de Demografia), p. 3.

[21] United Nations, "Report on Fourth World Conference on Women", para. 96.

[22] G. R. Gupta, "Gender, Sexuality and HIV/AIDS".

> *The pursuit of pleasure, desire for intimacy, expression of love, definition of self, procreation, domination, violence or any combination of the above. How people relate sexually may be linked to self-esteem, self-respect, respect for others, hope, joy, pain. In different contexts, sex is viewed as a commodity, a right or a biological imperative.*[23]

Post-Cairo reproductive health addresses sexuality, a sensitive and intimate aspect of reproduction, beyond an exclusive focus on risks of pregnancy and disease; it also considers questions of sexual enjoyment and confronts ideologies of men's entitlement that threaten women's sexual and reproductive rights and health.[24] The International Center for Research on Women has identified four components of sexuality: practices, partners, pleasure/pressure/pain and procreation. The center has also determined that "each component of sexuality is closely related to the other, but that the balance of power in a sexual interaction determines its outcome".[25] Ruth Dixon-Mueller identifies four additional dimensions of sexuality and sexual behaviour: "What people do sexually with others or with themselves, how they present themselves sexually, how they talk and act". She also discusses how gender intersects with and shapes each of these aspects.[26]

Sexuality is important to male identity in different cultures. Yet, men's expression of sexuality can cover a wide range. Power relations, in which men have the dominant role, are present in sexuality, since it is an essential arena for where gender relations take place.[27]

Sexual Health

"Human sexuality and gender relations are closely interrelated and affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives."[28] A universal definition of sexual health is difficult to arrive at because human sexuality is varied, diverse and dynamic. ICPD addressed sexual health as a notion that "implies a positive approach to human sexuality, and the purposes of sexual health care should be the enhancement of life and personal relationships, and not merely the counselling and care related to procreation or sexually transmitted diseases".[29] The definition used by the World Health Organization delves further into the complexity and multiple dimensions of self-identity and social interaction that affect sexual health. WHO defines sexual health as "the integration of the somatic, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication, and love".[30] Health professionals need to increasingly

---

[23] M. Foreman, ed., *AIDS and Men: Taking Risks or Taking Responsibility?* (London: The Panos Institute and Zed Books, 1998), p. 2.

[24] R. Dixon-Mueller, "The Sexuality Connection on Reproductive Health", *Studies of Family Planning* 24, no. 5 (September–October 1993): 269–82.

[25] G. R. Gupta, "Gender, Sexuality and HIV/AIDS: The What, the Why and the How", plenary address, XIIth International AIDS Conference, Durban, South Africa, 12 July 2000, p. 2.

[26] R. Dixon-Mueller, "The Sexuality Connection on Reproductive Health".

[27] M. Villarreal, "Construction of Masculinity(ies): Implications for Sexual and Reproductive Health" (paper presented at the Male Involvement in Reproductive and Sexual Health Programmes and Services workshop, FAO/WHO/UNFPA, Rome, November 1998), p. 7.

[28] United Nations, "Report of the International Conference on Population and Development", para. 7.34.

[29] United Nations, "Report of the International Conference on Population and Development", para. 7.1.

[30] WHO, "Definitions and Indicators in Family Planning, Maternal & Child Health and Reproductive Health Used in the Regional Office for Europe", March 1999.

integrate gender awareness into their programmes, realizing that gender, gender roles and gender inequalities are factors that affect fertility and sexual health.

Sexual health also involves satisfaction, an aspect of sexuality that is seen more as men's entitlement than women's in many societies. A satisfying sexual life and sexual health also imply consensual acts. In fact, pleasure is a central aspect of male sexuality, but it often comes at a price for both men and women. Men's sexual pleasure is often seen as more important, by men and by women, than women's concerns about becoming pregnant or acquiring an STD. Often, performance is another key aspect to men's sexuality. Many societies reinforce the perception that men's sexual ability is part of what defines them as "real men".[31] Besides the obvious issue of safe sex, men's concerns with performance, commonly referred to as sexual dysfunctions or psychosexual problems, provide opportunities for working with men and raising their awareness about the myths that may be contributing to their concerns.

Gender

"Gender refers to widely shared ideas and expectations (norms) about women and men in a given society. These ideas and expectations are learned from families, friends, opinion leaders, religious and cultural institutions, schools, the workplace and the media; they define typically feminine and masculine characteristics, abilities and behaviours in various situations; and they reflect and influence the different roles, health and social status, economic and political, of women and men in a society"[32].

The concept of gender posits that the differences between men and women are socially constructed, changeable over time, and have wide variations within and between cultures. Gender is a socio-economic and political variable with which to analyse roles, responsibilities, constraints and opportunities of people; it considers both men and women and their power relations. Through the cultural stamp of gender, individuals absorb and reproduce what is permitted and prohibited; gender marks their perceptions and their sense of responsibility with respect to all the social facets of life.[33] Neither gender and sex, nor gender and women are synonymous. Gender refers to roles; sex refers to the biological state of being female or male.[34] In this context, masculinity is the social construct that identifies males as men.

> *"Gender is a fundamental context for work on men as partners — in the way it affects men's role as clients and in the influence men exert on their partners' lives. Gender shapes how partners communicate and how they make decisions, earn and spend money, gain access to formal education and raise their children. All of these are related to health care."*[35]

---

[31] M. Villarreal, "Construction of Masculinity(ies): Implications for Sexual and Reproductive Health" (paper presented at the Male Involvement in Reproductive and Sexual Health Programmes and Services workshop, FAO/WHO/UNFPA, Rome, November 1998), pp. 7, 9.

[32] UNAIDS, "Report of a workshop on Planning for Gender and AIDS Mainstreaming" (Geneva, 14–17 June 1999), p. 8.

[33] M. I. Matalama, "Gender-Related Indicators for the Evaluation of Quality of Care in Reproductive Health Services", *Reproductive Health Matters* 6, no. 11 (1998): 11.

[34] C. Laudari, "Gender Equity in Reproductive and Sexual Health" (paper presented at UNFPA TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, Rome, 9–13 November 1998), p. 1.

[35] AVSC International, "Men as Partners in Reproductive Health" (workshop report, Mombassa, Kenya, May 1997), p. 5.

Gender Equity

Gender equity considers women's subordination in most societies, and the discrimination against girls and women that is exemplified by low levels of investments in their health, nutrition and education; their suffering of violence; and laws that that keep land, money and other economic resources out of women's hands (Greene 1999,[36] Das Gupta, 1987,[37] Leslie, Ciemins and Essama 1997,[38] Leach 1998,[39] Heise 1995.[40] Agarwal 1994[41]). This calls into question gender-based divisions, and addresses the discrimination that has arisen from these divisions and includes affirmative action. Equal rights and opportunities are its main goal.[42] The concept of gender equity conflicts directly with the conventional male gender model that relies heavily on male power and superiority, and its dominance over social relations in the production and reproduction spheres.

Gender equity is supported by the Convention on Elimination of Discrimination Against Women (CEDAW), adopted by the United Nations General Assembly in 1979. CEDAW provides the basis for realizing equality between women and men through ensuring women's equal access to and equal opportunities in health, education and employment, as well as in political and public life.[43]

Gender Roles

Gender roles are attributed to men and women because of their sex. In the patriarchal system, men's role is predominantly in the public sphere of production and politics, while women's is in the domestic one, household and child-rearing.[44] The confinement of women to household and child-care responsibilities contributes to men's reluctance to share them. "Household responsibilities" has several negative connotations that impinge on men's willingness to undertake them. Domestic work is unpaid or low-paying; it is unskilled, and women have always done it. Cleaning the house, changing diapers and preparing food are tasks that women are "supposed" to do. Performing them may threaten some men's sense of manhood.

---

36 M. E. Greene, "The Benefits of Involving Men in Reproductive Health" (paper presented at AWID and USAID, November 1999).

37 M. Das Gupta, "Selective Discrimination against Female Children in Rural Punjab, India", *Population Review* 13, no. 1 (1987): 77–100.

38 J. Leslie et al., "Female Nutritional Status across the Life-Span in Sub-Saharan Africa: Prevalence Patterns", *Food and Nutrition Bulletin* 18, no. 1 (1997): 20–43.

39 F. Leach, "Gender Education and Training: An International Perspective", *Gender and Development* 6, no. 2 (1998): 9–18.

40 L. L. Heisi, "Violence, Sexuality and Women's Lives", in *Conceiving Sexuality: Approaches to Sex Research in a Postmodern World* (New York: Routledge, 1995), chap. 7.

41 B. Agarwal, "Gender and Command over Property: A Critical Gap in Economic Analysis and Policy in South Asia", *World Development* 22, no. 110 (1994): 1455–78.

42 C. Laudari, "Gender Equity in Reproductive and Sexual Health", p. 1.

43 www.un.org/womenwatch/daw/cedaw/cedaw.htm.

44 M. Silberschmidt, "Rethinking Men and Gender Relations: An Investigation of Men, Their Changing Roles within the Households and the Implications for Gender Relations in Kissii District, West Kenya", *CDR Report*, no. 16 (Centre for Development Research, Copenhagen, 1991), p. 12.

Gender Relations

Gender relations are not biological givens, but are largely products of social and cultural processes. As such, they are not universal and a-historical. They are dynamic and changeable.[45] Power and dominance are critical elements in gender relations. "In the realm of reproductive health, power is about relationships between women and men and the stakes they have in one another's health. It is about who controls whose fertility. It is also about who makes decisions about programmes and who manages them — and how precious resources are allocated."[46] Men often attain or maintain their position of power by resorting to verbal, emotional or physical violence involving their partners, other men and, in extreme cases, themselves.[47] The role that power plays in gender relations has implications for men's role in reproduction and their sexuality. The challenge is to address and redirect men's use of power to improve their and their partner's health and men's relationships with their partners, children and other members of their community.

Masculinity

Male identity is socially constructed, that is, it is an expression of the social image men have of themselves in relation to women and other men, and a a set of characteristics and behaviours that are expected from men in a given culture. An important part of male identity in societies that rely heavily on male dominant status is men's ability to control women.[48] For example, research in a country hard hit by HIV/AIDS showed that male identity is very much linked to sexual performance: men feel pressured to have many feminine conquests to "prove" their masculinity. Safer sex, which entails a reduction in the number of possible partners, avoiding "one night stands" and greater selectivity in sexual partnership may therefore be felt as a threat to masculinity. At the same time, women find it difficult to negotiate safer sex because being assertive goes against the compliance expected from them. This means that gender equality involves change in both male and female identities.[49]

Partnership: the way forward

In conclusion, it is increasingly understood that partnership between women and men is the basis for strong families and viable societies in a rapidly changing world.[50] In this report, the term "partnership with men in reproductive and sexual health and rights" (PMSRH) is used to capture the scope of future programme directions. Partnership, a popular concept in the international development community, is mostly used to refer to relationships between the public and private sectors. It is regarded as a form of relationship between individuals or groups for the realization of common objectives. Other factors linked to the creation of a sustainable partnership are trust, respect, ownership of the decisions and their outcomes, and equality. Without trust between people, partnership is impossible. Trust is a product of experiences of people living and working together, of mutual expectations and of sharing common values and commitment. "Respect has something to do with the acknowledgement of something of value in the other

---

45 H. Moore, *Identity: Personal and Socio-Cultural* (Stockholm: Almquist & Wiksell International, 1988).

46 C. Steele et al., "The Language of Male Involvement: What Do You Mean by That?" *Populi* (November 1996), p. 11.

47 AVSC International and IPPF/WHR, "Male Participation in Sexual and Reproductive Health", Symposium Report, p. 8.

48 M. Villarreal, "Construction of Masculinity(ies)", p. 8.

49 A. Wouters, trip report from Zambia, UNFPA CST Harare, 15 January 1999.

50 UNFPA, "Lives Together, Worlds Apart: Men and Women in a Time of Change", *The State of World Population* 2000, p. 2.

person. Respect does not necessarily mean agreement. One can respect [another's] political views or religious commitment without necessarily sharing or agreeing with them.... Ownership refers to the degree to which the parties effectively participate in making decisions and are held responsible and accountable for all that is done in the partnership. If ownership is lacking or perceived to be lacking it will be very difficult for a partnership to sustain itself.... Finally, there has to be real and substantive equality between partners."[51]

With regard to men and women and their sexual and reproductive health, partnership between men and women would mean that they freely and deliberately join their forces and choices for achieving common sexual and reproductive goals. Trust would relate to communication and negotiation of safety from STDs/HIV/AIDS; respect involves relations free of violence; and ownership invites both partners to decide freely and responsibly on matters of sexuality, pregnancy, family planning, post-pregnancy care and child-rearing.

Structure of the document

This document is structured to mimic a "logframe": i.e., its starts with a situation analysis in the first two chapters. A discussion of desired outputs of programme interventions follows in chapter three; this chapter also provides possible indicators for each output. Chapter four discusses common principles and assumptions planners should keep in mind. Chapters Five, Six and Seven indicate programme strategies, activities and lessons from successful experiences throughout the world, in the areas of: communication, health services, and male adolescents and boys

[51] Adapted from A. Mohiddin, "Partnership: A New Buzz-word or Realistic Relationship?" Society for International Development, www.sidint.org/publications/development/vol41/no4/41-4b.htm.

Chapter 1

The Masculinity Equation

The intent of this chapter is to set the contexts in which male roles and behaviour occur, and to understand what shapes men's sense of identity. Knowledge about male identity is important for sexual and reproductive health programmes, because sexuality is exercised within the context of norms and values of the prevailing gender system, and gender relations determine to a large extent the health and social outcome. If adequate programmes are to be set up to improve the sexual and reproductive health of all the people (not only of one sex), we need to know much more about the gender system, and in particular about the male side of gender.[52] Gender and current power imbalances among men and women are indeed key considerations in reproductive health programmes. An emerging body of literature effectively analyses the existence of unequal power relations, the dominant prescribed roles, the diversity of male and female responses, and their effects on social, institutional and individual sexual and reproductive health matters. Perhaps because such analysis started in certain regions more than others (for example, Northern Europe and Latin America), it has not yet been adequately popularized, and it may have been underutilized in programme efforts. Evidently, gender roles and responses differ by country and culture, and it is counterproductive to generalize. In addition, the analysis of reproduction and sexuality may be undertaken at different levels across regions: in Latin America, focus tends to be on the psycho-social dimensions; while in Africa, researchers have adopted more demographic and macro-level perspectives.[53] Yet, similar threads about male identity are noticeable around the world. At the same time, as researchers obtain more information, stereotypes are giving way to a more factual portrait of men. Also, recent research about men demonstrates that most men are striving to differ from such stereotypes. The stock of existing knowledge, however limited it may be, is helpful to inspire future situation analysis. By examining issues related to male identity, the case is made for better understanding of men's viewpoints as a matter of urgency.

Understanding the content of pressure on men

When attempting to understand men's gender-based behaviour, it is important to adopt what some theorists call an "ecological" perspective. Such a perspective views behaviour as a function

[52] J. du Guerny et al., "The Male Side of Gender throughout the Life Cycle" (paper presented at the UNFPA Technical Support Services (TSS) thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, Rome, 9–13 November 1998), p.17.

[53] W. Mbugua, personal communication, 20 October 2000.

of cultural and socio-economic circumstances, that is, of the political, social and economic barriers and contexts that help or hinder the spread of harmful or desired practices throughout any sector of the population. This approach recognizes the context of men's (and women's) lives, addresses their fears and desires, and encourages responsibility, communication with partners, and respect for others and oneself. In searching for contextual factors of sexual and reproductive health (see also chapter V on communication frameworks), Herdt[54] suggests two useful notions: "sexual culture" and "cultural risk milieus", to guide the inquiry into men's context and risk-taking practices.

The sexual cultures and risk-taking milieus

Every culture postulates a desired and admired form of human conduct, not only for the present, but also across the entire course of life. "A sexual culture' is a consensual model of cultural ideals about sexual behaviour in a group. Such a cognitive model involves a worldview of norms, values, beliefs and meanings regarding the nature and purpose of sexual encounters. It also involves an affective model of emotional and moral guidelines to institutionalize what is felt to be normal, natural, necessary or approved' in a community of actors. Gender also mediates these norms, since customary patterns of the expression of masculinity and femininity in society, through roles, task assignment, social status and exchange systems, influence the expression of sexual practices. . . . Sexual cultures may allow for a dominant ideal to create a dialectical reaction in covert sexual forms within the same group, as happens, for example, in the allowance of a double standard' of monogamy for women and extramarital relations for their husbands... However, sexual cultures alone cannot ultimately predict a person's sexual behaviour. Risk-taking is contingent upon many factors, including cultural competence in negotiating multiple contexts or risk milieus".[55]

For instance, Barker finds that "during adolescence, boys spend even more time outside the home and unsupervised. In studies from five developing countries, boys were more likely to work outside the home than adolescent girls. Time outside the home represents freedom for boys, but it also means that boys are exposed to the behaviours of the male peer group. This can include male peers who encourage substance use and unprotected sex and sexist versions of manhood — that is, they encourage boys to believe that women are inferior to men, that women are sex objects, and that men have the right' to dominate women's lives".[56]

Herdt[57] goes further with the identification of two types of milieu: the cultural risk milieu and the positive milieu.

> By *"cultural risk milieu" is meant a sexual subculture circumscribed as the behavioural context of engaging in sex and sexual risk-taking; that is, it involves the social learning and attitudes of actors in specific milieus that motivate them to take risks and give*

---

[54] G. Herdt, "Sexual Cultures and Population Movement, Implications for AIDS/STDs", in *Sexual Cultures and Migration in the Era of AIDS: Anthropological and Demographic Perspectives* (Oxford: Clarendon Press, 1997).

[55] Ibid., p. 16.

[56] G. Barker, "Boys, Men and HIV/AIDS", UNAIDS briefing paper (second draft, Instituto Promundo, Rio de Janeiro Brazil, January 2000).

[57] G. Herdt, "Sexual Cultures and Population Movement", p. 16.

> *meanings to the kinds of sexual risk that they take.... First are milieus which promote the taking of risk and diminish the capacity of individuals to avoid taking risks. The recklessness of street gangs of young people, daring each other to acts of bravado or demonstrations of their loyalty to the group, is one such risk-enhancing milieu.*[58]

Examples of high-risk milieus abound. "Millions of men are in prison and jail — at rates far higher than women. Prison conditions in much of the world include sex between prisoners and guards — both forced and consensual — as well as unprotected sex, or sex in degrading conditions with the men's female partners or female commercial sex workers. In addition to these specific risk groups, poverty and unemployment may also increase men's sexual risk-taking. Research in some rural areas in Tanzania and Kenya finds that when men become unemployed and hence lose their status as providers, they are more likely to have sex with sex workers or other outside partners to feel "more like men". When their principal form of status — being providers and having meaningful employment — is gone, sexual activity with numerous partners becomes a way to compensate for their perceived "loss of manhood.... While this does not justify men's violence against women, men's violence tends to happen when men have few other things that give them meaningful roles in their families and communities".[59]

Learned stereotypes of male identity

Although there is a prototypical model of masculinity, the notion of one uniform masculinity is problematic for various reasons: first, masculinity is not homogeneous, because different groups of men have different definitions of masculinity, and few men can live up to the ideal model.[60] The model is not static, it varies from one culture to another, in any one culture over time, within any culture across socio-economic lines, and throughout any man's life cycle. Second, it does not exist as such: it is constructed within cultures and contexts, over time, and is based on interactions and power relations with other men (from different social classes and ethnic groups) and with women.[61]

Nevertheless, while there are diverse socio-economic, political and cultural settings, literature on masculinity indicates lots of common ground in sexual cultures.[62] Several studies confirm a normative, or hegemonic, model of masculinity accepted by men and women that determines unequal relationships between the genders. This prototypical model defines a man as active, productive, competitive and outwardly oriented. Such men have strong bodies capable of hard physical labour and able to fight wars. The model also assumes that men have power over women and over men who are considered inferior. Popular but harmful slogans such as "men don't cry" are directly derived from this model.[63]

---

58 Ibid.

59 G. Barker, "Boys, Men and HIV/AIDS".

60 M. Kimmel, "Working towards Gender Equality: Where Are the Men?" (presentation made to Men and Gender Equality Working Group at UNDP, New York, 12 August 1999), p.1.

61 Ibid.

62 B. Shepard, "Masculinity and the Male Role in Sexual Health", in *Planned Parenthood Challenges 2* (1996): 11–12.

63 AVSC International and IPPF/WHR, "Male Participation in Sexual and Reproductive Health: New Paradigms" (Symposium Report, Oaxaca, Mexico, October 1998), p. 8.

Several studies that seek to identify the building blocks of male identity recognize two main axes: sexuality and work.[64] The importance of sexuality for male identity is a common trait throughout different cultures, although the construction of sexuality varies widely throughout the life cycle and between social and ethnic groups.[65] The other building block of male identity, work, is related to demonstrating the ability to provide for oneself and one's family. Men's lives are thought to take place in the public spheres of production; in contrast, women's lives are thought to take place in the domestic spheres. However, growing unemployment, economic crises and women's attainment of improved work positions weakens this aspect of perceived male prerogatives. When the economic role that gives men status is taken away from them, then their sexuality, including having multiple sexual conquests and committing domestic violence, may become an important alternative to the creation of an identity.[66]

Other idealized traits include the "importance of being important", or superior to women and others. Men are often reported to strive for more power, in spite of the fact that they have historically exercised physical, political and economic power over women.[67] One of the reasons men are often so resistant to gender equality is their underlying belief that they are entitled to power, and fear that they may lose the power to which they feel entitled.[68] A project that addressed masculinities in workshops with men in Latin America found that these notions of superiority prevail, and that participants resist changing traditional male positions of power because they perceive themselves as losing privileges. Even men conscious of women's oppression resist gender equity because they cannot perceive it as pleasurable or possible.[69]

Commonly Learned Expectations of What Men Are Supposed to Do in the Area of Sexuality and Gender Roles

- Men are not expected to be able to control their desires, and therefore are not expected to be monogamous, or "faithful", within a stable relationship.
- Men are expected to dominate women, and often are ridiculed if they don't.

[64] T. Valdés and J. Olavarría, "Ser hombre en Santiago de Chile: a pesar de todo, un mismo modelo" in *Masculinidades y equidad de género en América Latina*, T. Valdés and J. Olavarría, eds. (FLACSO, UNFPA, Santiago, Chile, 1998).

[65] M. Villarreal, "Construction of Masculinity (ies): Implications for Sexual and Reproductive Health" (paper presented at the Male Involvement in Reproductive and Sexual Health Programmes and Services workshop, FAO/WHO/UNFPA, Rome, November 1998).

[66] M. Silberschmidt, "Rethinking Gender Relations: An Investigation of Men, Their Changing Roles within the Households and the Implications for Gender Relations in Kissii District, West Kenya", *CDR Report*, no. 16 (Centre for Development Research, Copenhagen, 1991), p. 80.

[67] AVSC International and IPPF/WHR, "Male Participation in Sexual and Reproductive Health", p. 8.

[68] M. Kimmel, "Working towards Gender Equality", p. 2.

[69] D. Cazes, "Work among Men in Latin America: Investigation and Practices, Results and Experiences" (paper presented at Seminar on Men, Family Formation and Reproduction, ISSUP, Buenos Aires, Argentina, 13–15 May 1998).

- Men are expected to be possessive and jealous, and in some contexts are expected to react violently to restore their "honour" if their partner is unfaithful.
- Men are expected to be strong. They are discouraged from expressing fear, pain, insecurity, sadness or other emotions that might make them appear weak, leading to artificiality and/or lack of communication in relationships.
- Men exert pressure on each other to drink alcohol together to create a shared social space, a practice often associated in the literature with unsafe sex practices. One reason is that normally proscribed behaviour from men, like crying and expressing hurt and anxiety, is allowed when drunk.
- Male sexual desire is expected to be separated from affection and emotions, so that many men feel humiliated when they can't "perform", even when feeling anxious or unconnected to their partner.
- Men are expected to be sexually experienced, leading some men to seek this experience at all costs, regardless of whether they feel affection or respect for their partners.
- Men who openly express affection and tenderness with their male friends are often subjected to ridicule and gay-baiting. They should not feel sexual desire for other men, or act on such desires.
- Men are expected to always take the initiative sexually. They should always be active, and never passive, with the corollary that women should not express desire. These behavioural expectations play an important role in certain instances of sexual coercion, especially within the context of courtship or dating.
- "Real men" are expected to be less receptive to messages regarding safer sex..[70]

Some implications of studies of masculinities for future programmes

Recent findings on masculinities offer interesting insights into evolving attitudes and behaviour in areas of identity formation, sexuality, and attitudes towards family planning and HIV/AIDS. Overall, what we learn from research on masculinities is that the process of becoming a man is a hectic one that does not facilitate men's sense of comfort with themselves. In contrast to women, men have to "become" men, and in order to do so they have to prove their masculinity. This is not a one-time-only affair. Masculinity has to be continuously proven vis- -vis women, as well as vis- -vis other men. Masculinity is perpetually questioned and is thus unachievable as a state of being.[71] What Latin American studies show, for instance, is that the male role seems to be even tighter and a more rigid straightjacket than the female role in these modern times. Boys are offered limited alternatives: to be either a "man" or a "faggot".[72] Machismo, a popular concept developed in this region, is defined as the cult of virility charac-

[70] B. Shepard, "Masculinity and the Male Role in Sexual Health".

[71] M. Villarreal, "Construction of Masculinity(ies): Implications for Sexual and Reproductive Health" (paper presented at the TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, UNFPA, Rome, 9–13 November 1998), p. 4.

[72] B. Shepard, "Masculinity and the Male Role in Sexual Health".

terized by aggressiveness and intransigence in male-to-male interpersonal relationships, and by arrogance and aggression in male-to-female relationships.[73]

Men, too, can be or feel disempowered

"In spite of ideologies favouring men, their lives are often filled with dilemmas and paradoxes, which are of another character than those that women are faced with. Men have often been viewed as the winners and women as the losers in the process of social economic change that has taken place during the last century....Under social economic change, traditional notions of gender identity and relations as well as norms and values are in a period of transition and do not fit with present realities. Research findings in Kisii District, Western Kenya, indicate that few men are winners'. Former male activities legitimizing their role as heads of household have disappeared. Many have abandoned their family obligations and their role as household head seems to be legitimized only by the patriarchal ideology. Unable to fulfil the obligations required of them, many men seem to experience a loss of identity, often in the form of alcoholism and domestic violence. The majority have difficulties in pursuing present demands as breadwinners and as responsible husbands and fathers. This is a major problem for many men, which they hide under a surface of superiority often reinforced by violence against wives and children and through the search for sexual gratification."[74] However, the male identity crisis may offer an opportunity for a redefinition of male identity towards more equality.

Masculinity has its costs

Studies on masculinities reveal that the hegemonic model can be detrimental to men who try to conquer it. It forces them to renounce emotions and feelings like empathy, receptiveness, tenderness. This painful process leads to damaging consequences such as alcoholism, suicide and other behaviours that contribute to men's vulnerability.[75] In addition to risk-taking behaviour related to identity issues, countless fears are associated with not being able to live up to "male" standards.[76] They begin with the sometimes traumatic process of separation and differentiation from one's mother. Other fears are related to losing power and privileges, not being a "real man" if one exhibits caring, "feminine" behaviour, and losing virility (such fear may be associated with male contraceptive methods such as vasectomy). Consequently, we must devise ways to address men's concerns without neglecting women's problems, and help men find benefits from stepping out of their usual roles, responsibilities and harmful behaviours.

We need to construct alternative models of masculinities

By learning about codes of conduct that play a decisive role in defining the identity and self-respect of both men and women. These codes establish the expectations of gender behaviour and, more importantly, create and consolidate feelings of inferiority, uncertainty and frustration when individuals can no longer give in to the unwritten norms and rules of behaviour.[77] Fortunately, norms and values are not static and unchangeable. They originate in the real world

---

[73] K. Stölen, "Gender Sexuality and Violence in Ecuador" (paper presented at Nordic Symposium on Gender and Social Change in the Third World, Granavolden, Norway, 1990).

[74] M. Silberschmidt, "Rethinking Gender Relations", pp. 13, 17, 80.

[75] M. Kaufman, "Las experiencias contradictorias del poder entre los hombres", *ISIS International*, 1997, pp. 63–81.

[76] M. Villarreal, "Construction of Masculinity(ies)".

[77] M. Silberschmidt, "Rethinking Gender Relations", p. 9.

and are hence historical, social and cultural constructs.[78] Research will allow us to devise ways of constructing alternative models of masculinity, whereby virility is promoted by the exercise of more egalitarian, caring, sharing relations. For example, it is important to break common male identity formation aspects such as to be macho = to be violent; man = dominant/authoritarian; hero = not to take care of one's health. Communications need to promote positive masculinity traits commonly associated with adulthood, such as responsibility, among adolescents.[79] New research on masculinity and fatherhood observes the emergence of a "family man" who embraces a "good masculinity"; he is heterosexual, non-violent and responsible, in contrast to "dangerous masculinities" exemplified by the *bon vivant*, the *womanizer*, the *alcoholic*.[80]

Examining masculinity as a concept helps us adopt a constructive approach in which men are not simply the problem in relation to women's sexual and reproductive health. It helps us understand men's motives and concerns. We need to create spaces for men to converse among themselves, grapple with their conflicting and/or unmet needs, and assume responsibility for their behaviour, including violence.[81]

We need to find adequate entry points to address gender relations

Such entry points can consist of making gender visible to men, by highlighting their privileges, entitlements and existing power, in order to trigger a discussion about their roles and accountability. Masculinity is one way to open the door to discussion about issues of power and gender relations.

In Nicaragua, the NGO CANTERA offers workshops on masculinity and sexuality; gender, power and violence; unlearning machismo; and communication skills. During a 1997 evaluation, many men reported that CANTERA's courses had changed their lives; two-thirds reported that they had a different self-image, and over two-thirds said they were less violent. Nearly half the women said their partners were significantly less violent after their training, and an additional 21 per cent said that they were a little less violent. Both men and women reported that the men were significantly more responsible sexually.[82]

Other opportunities include reaching men at an early age (see chapter VII) and promoting the role of men as caring fathers. For instance, men are more likely to control their fertility and cooperate with their partners to use contraception when they feel connected to and invested in the children they already have. Studies with men who seek vasectomies in Latin America have consistently found that such men demonstrate a higher-than-average connection to their families and their children.[83]

---

78 S. Le Vine, "Mothers and Wives in Gusii", in *Women of East Africa*, Chicago & London: University of Chicago Press, 1979.

79 B. Shepard, "Masculinity and the Male Role in Sexual Health", pp. 11–12.

80 E. D. Bilac et al., "The 'Family Man': Conjugality and Fatherhood among Middle-class Brazilian Men in the 1990s", WHO/Human Reproduction Programme, January 2000, p. 13.

81 J. C. Figueroa, personal communication, Geneva, August 2000.

82 See V. Norori Muñoz and J. Muñoz Lopez, "Conceptualizing Masculinity through a Gender-Based Approach", *Sexual Health Exchange* 1998, no. 2, pp. 3–6.

83 T. Valdés and J. Olvarríra, eds, "Masculinidades y equidad de genéro en America Latina".

It is important to recognize the various kinds of men's sexual relationships and the existence of men having sex with men (MSM)

Use of the plural "masculinities" is helpful to stress the diversity of men and increase social tolerance for more feminine traits in men. Homophobia is usually an expression of violence against anything that looks feminine in men. There is evidence that "prejudice, hostility, denial and misconceptions towards men who have sex with men, and with men who define themselves as homosexual, are directly responsible for inadequate HIV prevention measures. Engaging men in HIV prevention and adequately responding to the challenge of HIV require confronting widespread examples of prejudice and discrimination against MSM. Widespread prejudice towards MSM in most societies serves to keep homosexual behaviour and young men of homosexual or bisexual orientation hidden, hindering prevention, but also serves as a way to reinforce rigid views about manhood for heterosexual men".[84]

ENTRENCHED SEXUAL STEREOTYPES RAISE RISKS AND VULNERABILITY OF BOTH MEN AND WOMEN

Researchers and women activists are uncovering the critical role power plays in sexuality. In the context of gender inequalities, men's sexual pleasure may be seen as more important (by men and by women) than women's concerns about becoming pregnant or acquiring a sexually transmitted disease (STD). This cultural norm may lead to forced sex, and may exclude the use of a condom or any negotiation for safer sex. Furthermore, through marriage, males are in control of women's sexuality. For instance, researchers have found that, traditionally, the honour of a man is involved in the sexual purity of his mother, wife, daughters and sisters, not his own. From this point of view, female sexuality is an active and threatening power to men, because men's honour is intimately bound to the behaviour of their wives.[85]

Sexuality is very important to male identity regardless of cultural, ethnic and social influences. Men (and women) associate high levels of sexual activity with masculinity and believe the myth that men cannot control their sexual desire. "Sexual urge and pleasure are associated with male sexuality while women's pleasure is experienced only as a function of male pleasure."[86] Unfounded myths, such as the belief that it is better for men's health to go to a commercial sex worker than to masturbate and "waste" their semen,[87] affect their health. The notion of consent is absent from this view, which values competition, power and overall superiority. Such a view makes women vulnerable to men's sexual urges and demands, as exemplified in the following statement:

> *If a woman is not experiencing her menses and is not sick, she has no right to refuse sex, because we marry her to have children, and that is how we can get children. We don't marry women for their cooking. So if she refuses to have sex, why won't I want to beat her? I will beat her.*[88]

---

84 G. Barker, "Boys, Men and HIV/AIDS".

85 M. Silberschmidt, "Rethinking Gender Relations", p. 17.

86 M. Villareal, "Construction of Masculinity(ies)", p. 7.

87 S. Raju and A. Leonard, eds., *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality* (Population Council South and East Asia Regional Office, 2000), p. 57.

88 A. Bawah et al., "Women's Fears and Men's Anxieties: The Impact of Family Planning on Gender Relations in Northern Ghana", *Studies in Family Planning* 30, no. 1 (1999): 57.

These stereotypical male gender roles tend to rigidly define what is acceptable male and female behaviour and thus limit the notion of partnership. They also harm men's as well as women's health by encouraging men's risky sexual behaviour. Men are more likely than women to use alcohol and other substances that lead to unsafe sex and increase the risk of HIV transmission, and men are more likely to inject drugs, risking infection from needles and syringes contaminated with HIV. In many cultures, the concept of machismo encourages men to have extra-marital or multiple sexual relationships to prove their masculinity.[89] Such male gender roles can contribute to their contracting STDs and passing them on to their wives or girlfriends. Male gender roles also contribute to men's vulnerability in other ways, a fact that is evident in many national health statistics. In Mexico, for example, the top three causes of death for men are accidents, homicides and cirrhosis of the liver.[90] Finally, the existence of different rules for the home and the street, and the experience of harmful and humiliating rites of passage for boys, as in juvenile gangs, create spaces where sexuality is governed by social networks and peer-induced motivations.

In this context, women are vulnerable, because their gender, social and economic status, traditional customs and religious beliefs limit their ability to control their lives, including their sexual lives. In many cultures, women continue to be expected to be ignorant about sex and passive in sexual relations.[91] In a study in Rwanda, 20 per cent of HIV positive women interviewed had only one partner, and 45 per cent contracted the virus from their husbands.[92] Gender inequality prevents many women from using condoms or even discussing their use with a sex partner. A woman who asks her husband to use a condom risks being accused of having extra-marital relationships, and is considered to be stepping beyond her boundaries by being more assertive than the cultural norms allow.[93] "There is no way that the woman can suggest they [men] use condoms. There is bound to be fighting between them. The woman can only get protection secretly as the doctor would advise. She cannot blatantly confront her husband."[94] Consequently, many women's decisions on contraceptive use are shaped by fear of violence from disapproving male partners. According to Family Planning International Assistance, women in Kenya are reported to have forged their partners' signatures rather than risk violence or abandonment by requesting permission to use family planning services. Focus-group discussions on sexuality with women in Mexico and Peru confirm that women feared violence, desertion or accusations of infidelity if they proposed family planning.[95]

---

89 G. Barker, "The Misunderstood Gender: Male Involvement in the Family and in Reproductive and Sexual Health in Latin America and the Caribbean" (Chicago: John D. and Catherine T. MacArthur Foundation, January 1996), p. 53.

90 Ibid.

91 G. R. Gupta, "Gender, Sexuality and HIV/AIDS: The What, the Why and the How", plenary address, XIIth International AIDS Conference, Durban, South Africa, 12 July 2000, p. 3.

92"AIDS and the World II", eds. Jonathan M. Mann and Daniel J.M. Tarantola, Oxford University Press, 1996

93 John Hopkins University School of Public Heath, "Closing the Condom Gap", *Population Reports*, series H, no. 9, April 1999, p. 8.

94 E. K. Bauni and B. O. Jarabi, "Family Planning and Sexual Behavior in the Era of HIV/AIDS: The Case of Nakuru District, Kenya", *Studies in Family Planning* (March 2000): 73.

95 N. Yinger, "Unmet Need for Family Planning: Reflecting Women's Perceptions", in *Reproductive Health Effects of Gender-Based Violence Policy and Programme Implications*, technical report, UNFPA, New York, 1998, p. 19.

Reflections from a CANTERA Workshop on Sexuality and Masculinity[96]

- We lack knowledge of our own bodies…. They say, and it has been proved, that the biggest sexual organ we have is the skin, and we don't take advantage of this. We do not caress. Then, after ejaculating, we sleep. We believe that our sexual relations are only the physical act of penetration…. So I say that we do not fully enjoy it.
- The way we perceive and practice our sexuality is often possessive…and we often reflect power relations during the sexual act. Often we feel sure about completing the sexual act, but we have not discovered the affectionate and emotional side of our sexuality; this is very destructive.
- Sexuality is often associated with guilt, sin, taboos, fears, anxiety…. But it even exists outside couple relationships, because you can be sexual even if you are alone.
- The way we are educated — with a lack of true information but with prejudice, taboos and lies about sexuality — distorts us and reduces our capacity to be really human. It dehumanizes us completely and is responsible for much of the sexual abuse that occurs daily. That is why we need the right to develop a healthy sexuality without prejudice, so that we can become more sensitive and less macho as men.
- Sexual relations are not the only part of sexuality; they are one of the parts of sexuality. Unfortunately, we all believe that sexuality only consists of sexual relations; it is basically associated with the genitals.

Few men are encouraged to acknowledge their vulnerability

Masculinity defined in such rigid terms contributes to men's vulnerability, because it projects that men are all-knowing and thus stops men from seeking the information they need to protect themselves.[97] Men are at risk when their gender roles lead them to believe that they are invincible and not liable to become infected.[98]

Being able to talk about one's problems and seeking support are protective factors against substance abuse, unsafe sexual practices and involvement in violence. However, men's struggles, often painful, remain well-kept secrets, because men are not encouraged and often are not allowed to talk about such private matters, a forbidden activity within the masculine framework. Women talk and express their feelings. Men do not. They risk ridicule and expulsion from the brotherhood if they dare question its requirements.[99] Boys are generally raised to be self-reliant, not to worry about their health and not to seek help when they face stress. A study in Germany with boys aged 14 16 found that in times of trouble, 36 per cent would prefer to be alone and 11 per cent said they needed no help.[100]

---

96 V. Norori Muñoz and J. Muñoz Lopez, "Conceptualizing Masculinity through a Gender-Based Approach", p. 3.

97 G. R. Gupta, "Gender, Sexuality and HIV/AIDS", p. 5.

98 G. Barker, "Boys, Men and HIV/AIDS".

99 AVSC International and IPPF/WHR, "Male Participation in Sexual and Reproductive Heath", p. 8.

100 G. Barker, "Boys, Men and HIV/AIDS".

Changing gender roles may cause further stress

Little is known about "men's changing role within the household or the changing relations between genders from men's point of view. Men's problems, struggles, their qualms and anxieties about changing rights and obligations of fatherhood are not dealt with".[101] Families have experienced tremendous structural change in the past decade due to such circumstances as poverty, war and emergencies, including droughts, floods, earthquakes and the effects of the AIDS pandemic. Globalization is affecting family structures by employing large numbers of women in low-paying jobs, while men are finding it increasingly difficult to find jobs in an economy that demands higher-level and more specialized skills. Many men find themselves living in migrant communities, far from their families, in order to make a living. The dislocation of vast numbers of people due to wars and famines, and their extended stays in refugee camps, have also forced health professionals and policy-makers to address sexual and reproductive health issues in emergencies. In these settings, STDs and HIV/AIDS can spread rapidly, and violence against women, including rape, occurs on a regular basis.

The fruition of women's access to education is also changing family dynamics and affecting traditional gender roles. Some women are gaining access to high-ranking, well-paid positions. One of the consequences is that they have less time to take care of domestic responsibilities traditionally expected of them: for example, child care, purchasing and preparing food, carrying firewood and water, cleaning and washing. Another is that earning an income empowers them to negotiate sharing these responsibilities with their partners. Furthermore, as the world population ages, men and women are facing the task of caring for aging parents. A job traditionally assumed by women now demands the attention of men as well.

Shifting gender dynamics are forcing men to re-evaluate their roles — even their identity. What does it mean to be a man if he is no longer defined as the economic provider, but insists on ruling his family with an iron fist? Men are learning to negotiate, as partners, with what they have been raised to believe is the weaker sex.

New models of fatherhood and child-rearing are needed

At the root of male identity is a process of socialization in which boys learn to become men, though they often define themselves negatively as not being girls.[102] Fathers have a fundamental role in initiating their boys into the masculine world.[103] However, children do not necessarily benefit from their father's presence in the family. Men who buy into the stereotypical model of masculinity tend to be authoritarian and disciplinarian, and to have a greater tendency to be violent towards their children, sometimes because of frustration at not being able to meet the expectations placed on them as providers. They also tend to control their emotions, because they think they are expected to be rational and restrained.[104] Fathers can be present, absent, involved, passive, distant and ideal. The same man can exhibit several contrasting behaviours towards his chil-

[101] M. Silberschmidt, "Rethinking Gender Relations", p. 12.
[102] M. Villarreal, "Construction of Masculinity(ies)", pp. 3–4.
[103] E. D. Bilac et al., "The 'Family Man' ", p. 13.
[104] AVSC International and IPPF/WHR, "Male Participation in Sexual and Reproductive Health", pp. 25–27.

dren. For instance, some men care for and love the children they live with, while rejecting and neglecting those they fathered with other women.[105] Fathers, grandfathers, religious, traditional, political and community leader role models may reinforce a sense of "power and privilege based on exclusion".[106]

A critical step in boys' forming their identity is an early separation from their mother and rejection of everything female. Very young boys, pre-school age, exhibit caring and affectionate behaviour in their play.[107] But as they grow up and are socialized, these attitudes tend to be frowned upon, as boys are encouraged to exhibit behaviours that are not "female", such as rough-and-tumble play and competitive games. Boys are required to restrict their emotions, especially affectionate behaviour, and deny injuries and health problems or overcome them on their own. The concepts of manhood developed during childhood tend to emphasize male dominance, power and authority. By the time boys enter adolescence, their physiological sex drives are incorporated and conditioned by their culture, peers, community and family. This socialization process tends to force them to define themselves as everything that is non-feminine; it assumes that masculinity is better and more powerful, and conditions men to "view women and homosexuals as the despised other".[108] Fortunately, such damaging upbringing is evolving, and more and more parents question these cultural values. Men who intervene publicly against gender stereotypes have talked about their own early life and how they have been inspired by their mother's or sister's words and examples, or by the injustices women faced compared to men in the family.[109]

Research confirms that how boys are raised has direct consequences for their health and sexual behaviour. Boys who observe fathers and other men being violent towards women, or treating women as sex objects, may believe that this is normal male behaviour. In observing their families, boys may believe that domestic tasks and taking care of others is "women's work". Boys who lack positive male role models in their families may exaggerate what they think is required of them to be "real boys", based on images from the media. A national survey of adolescent males aged 15 19 in the US found that young men who had sexist or traditional views of manhood were more likely to report substance use, involvement in violence and delinquency, and unsafe sexual practices than were adolescent boys with more flexible views about what "real men" can do.[110] Similarly, young men who believe strongly in male stereotypes have more sexual partners, a lower level of intimacy with partners, a higher level of adversarial sexual beliefs, lower consistency of condom use and a higher concern about condoms reducing male pleasure. They also put less value on their partner's appreciation of condom use, feel a lower level of responsibility for preventing pregnancy and have a greater belief that pregnancy validates masculinity.[111]

---

[105] Ibid.

[106] UNFPA and ECO, "The Role of Men in Population and Reproductive Health Programmes" (Baku, Azerbaijan, 21–24 September 1998), *Conference Report*, June 1999, p. 50.

[107] AVSC International and IPPF/WHR, "Male Participation in Sexual and Reproductive Health", p. 7.

[108] B. Shephard, "Masculinity and the Male Role in Sexual Health", p. 13.

[109] R. F. Hayward, "Needed: A New Model of Masculinity to Stop Violence against Girls and Women" (paper presented at the WHO Global Symposium on Violence and Health, Kobe, Japan, 12–15 October, 1999).

[110] G. Barker, "Boys, Men and HIV/AIDS".

[111] F. Coeytaux, "Celebrating Mother and Child on the Fortieth Day: The Sfax, Tunisia, Postpartum Program", *Quality/Calidad/Qualite*, 1989, no. 1 (New York: Population Council).

In contrast, research on progressive and caring young men found that the assistance and nurturing of family or other meaningful adults and peers, such as uncles, stepfathers, fathers, male teachers and women (mothers, aunts, grandmothers), who often modelled or questioned traditional gender roles was required. Providing mentoring and connecting boys to other men who can provide positive role models can be effective.[112]

The research available on fatherhood is meagre, but provides insight into the multiple elements that define "father" and the role gender plays in determining men's perception of themselves as fathers. Similar to masculinity and sexuality, the concept of "fatherhood" is related to social and cultural expectations of what it means to be a father. Thus, there is not a single model of fatherhood, but rather three basic perspectives: the father as symbolic function, the father as a legal institution and the father as a biological fact. The first refers to the psychological, traditional, cultural and historical references attributed to fatherhood; and the second to men's legal relationship to children.[113] Cultural factors are perhaps paramount. In many societies, fathers' limited participation in child care is strongly linked to beliefs that close father-child relations are not appropriate.[114]

The involvement of men in child-rearing became part of the agenda of building equitable partnerships for several reasons. First of all, fathers' contributions to the direct care of their children, particularly when children are very young, is critical. Second, early results from research on fathers and daughters shows that fathers who are close to and have high expectations of their daughters may be contributing to building gender-equitable societies. Research shows that women who were their father's favorite, for whom the father often broke "rules" about what girls should get and be, prompted them to free themselves from a subordinate role later in their lives.[115] Such early relationships may also later motivate women to take bold measures against customs and traditions such as early marriage.[116] Nonetheless, a review of research in 186 societies found that fathers have "regular, close relationships" with their children during infancy in only 2 per cent of these societies. Fathers spend about a third as much time as mothers in providing direct child care.[117]

As increasingly sophisticated economic data have pointed to the impoverishment of women, due partly to men's failure to contribute adequately to household and child-related expenses, policy-makers and government officials have become more convinced that men are not carrying their share of reproductive responsibilities. Studies show that women contribute a larger share of their earned income than do men to buying food and clothing and to providing for the basic needs

---

112 G. Barker, "Boys in the Hood, Boys in the Barrio: Exploratory Research on Masculinity, Fatherhood and Attitudes toward Women among Low Income Young Men in Chicago, USA, and Rio de Janeiro, Brazil" (paper presented at Seminar on Family Men, Family Formation and Reproduction, Buenos Aires, 13–15 May 1998).

113 M. Muzskat et al., "When Three Is Better Than Two", WHO/HRP, January 2000, p. 9.

114 M. Drennan et al., "New Perspectives on Men's Participation", *Population Reports*, series J, no. 46 (Johns Hopkins University School of Public Health, October 1998).

115 R. F. Hayward, "Needed: A New Model of Masculinity".

116 H. Makhlouf and F. Abdel Kader Ahmed, "Husband's Role in Reproductive Health Survey", Cairo Demographic Center, Cairo, Egypt, 1996.

117 M. Drennan et al., "New Perspectives on Men's Participation".

of their children. This has been found to be true in many societies despite the fact that men earn more and tend to control family finances. Health care providers, with the help of researchers, have pointed out that children tend to be healthier when the father participates financially and personally in their rearing.[118] Women, exhausted from the double burden of working in and outside the home, are increasingly aware that gender equity cannot be achieved without men sharing domestic responsibilities more equally.

In the six years since Cairo, abrupt changes in family and gender roles are giving added impetus to addressing issues of fatherhood. AIDS is forcing men who have lost their wives and sisters to step in and parent the children left behind. Unemployment and under-employment of men, combined with the growing number of women entering the workforce, are also forcing men to take on more parental responsibilities. Privatization and the reduction of social welfare programmes are placing additional burdens on families that are expected to care for the sick and for an aging population. These factors, along with women becoming increasingly assertive in their relationships with men, are requiring men to look at themselves as fathers.

Male participation in traditional female job enclaves and social reproduction (that is, child care and housework) requires courage on the part of men and support from women in the face of possible and likely ridicule and stigma from other men and women in the community. The adoption of such roles is a powerful signal for change in gender ideology and gender relations.[120] For

Contrast between Hegemonic Model of Masculinity and New Paradigms of Fatherhood[119]

Old Paradigm: Masculinity	New Paradigm: Fatherhood
Primary and sole financial provider Authoritarian disciplinarian	Shares financial-provider role with partner Supportive and understanding of his children's emotional and educational needs
Unemotional, distant, restrained	Emotional, present, involved in all aspects of child-rearing

instance, a study of fathers in Brazil found that men between the ages of 40 and 59 are changing their behaviour in attempts to come closer to their children and in domestic-related tasks related to child care. Their motivation has been to differentiate themselves from their fathers, but has also been due to what they reported as "enormous pressure" exerted by their female companions. Another finding in the same study that merits further consideration is the fact that

[118] UNICEF, "Men in Families", 1995, pp. 8, 18.

[119] AVSC International and IPPF/WHR, "Male Participation in Sexual and Reproductive Health", p. 25.

[120] M. Kisekka, "Addressing Gender Based Issues", p. 17.

these men lack a father model to which they can refer, so they mirror the maternal model.[121] References to the "new father" in the literature still "mirror the mother for the simple reason that he now shares domestic tasks and participates more directly in taking care of the offspring". However, this model reveals: (1) a fundamental inability to imagine a father who is different from the "traditional model of *paterfamilias* without being confused with mother"; (2) the confusion between child-rearing tasks and the desire to have a child; and (3) a trend towards reducing the notion of a father to one that performs certain tasks.[122]

Society is yet to provide a new model for those men looking for alternative ways to care for their children. Such models are emerging in Nordic countries, where paternal leave is legalized and considered normal, household chores are shared by all, and men are publicly encouraged to care as fathers and husbands.

Gender-based violence and men

Violence is receiving increasing attention as a public health problem and a threat to women and men. Violence against women also takes a steep toll on women's rights. The World Bank tells us that the "health burden from gender-based victimization among women aged 15 to 44 is comparable to that posed by other risk factors and diseases high on the world agenda, including the human immuno-deficiency virus (HIV), tuberculosis, sepsis during childbirth, cancer and cardiovascular disease".[123]

The International Conference on Population and Development (ICPD) embraced "eliminating violence against women" as a necessary step to empower women and eradicate gender inequalities.[124] "Violence against women" and "gender-based violence" are used interchangeably in the literature to address domestic violence, rape and harmful practices that are meant to control women's sexuality. Women face gender-based violence throughout their lives.

> *Gender-based violence is violence involving men and women, in which the female is usually the victim and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual and psychological harm (including intimidation, suffering, coercion, and/or deprivation of liberty within the family or within the general community). It includes violence which is perpetrated or condoned by the State.*[125]

Recent research on masculinities reveals more factors in the origins of violence than what is familiar in feminist analysis and it helps in promoting empathy with men and going beyond a "blame the perpetrators approach". Traditionally, men's violence is viewed as a result of men's

---

121 M. Muszkat et al., "When Three Is Better Than Two", p. 2.

122 Ibid., p. 15.

123 L. Heise et al., "Violence against Women: The Hidden Health Burden," *World Bank Discussion Papers*, no. 255, 1994, p. 17.

124 United Nations, "Report of the International Conference on Population and Development" (Cairo, September 1994), para. 4.4(e).

125 UNFPA, "Reproductive Health Effects of Gender-Based Violence Policy and Programme Implications", 1998, p. 5.

power and the submission of women; men's sense of entitlement to privilege; and the social permission we have given to violence. The next four factors, however, offer a different explanation. They are aspects of what Kaufman has referred to as "men's contradictory experiences of power",[126] as follows:

a) the impossibility of meeting the multiple demands of manhood and the use of violence as a compensatory mechanism;

b) the psychological armouring, which keeps some men who commit violence from being in touch with the feelings and the pain of those around them and of their own pain;

c) the crippling prohibition of the expression of a range of emotions by men in most cultures, which buries feelings such as hurt, terror and fear, and channels them into forms of emotional expression that are permitted: anger and aggression, which can flare up as violence;

d) past experiences as witnesses to violence against their mothers, experiences witnessing violence against others, and experiences as boys or young men in which violence was directed against them.[127]

The study of men's violence is also providing information on its detrimental effects on men, who have "painful experiences, which are expressed in insecurities, fears, and emotional disconnection".[128] Examples of male self-inflicted violence include criminal behaviour, drug dealing and addiction, accidents, injuries and excessive work.[129]

Data on men's attitudes on violence against women are scarce; these are cited for illustration purposes. In the Sudan, men were asked about three types of violence: female genital mutilation (FGM), wife battering and early marriage. The majority (73 per cent) felt strongly that they did not want their wives to be mutilated, although fewer (32 per cent) said that FGM would be a reason to cancel their marriage. Most men preferred women over 20 years old as marriage partners, because they could better manage household responsibilities. Almost all the men (91 per cent) disapproved of wife battering. Noticeably, most of the respondents were relatively young and unmarried.[130]

---

126 M. Kaufman, "Men, Feminism and Men's Contradictory Experiences of Power," in *Theorizing Masculinities*, eds. H. Brod and M. Kaufman (Thousand Oaks: Sage Publications, 1994), pp. 142–63; and M. Kaufman, *Cracking the Armour: Power, Pain and the Lives of Men* (Toronto: Penguin/Viking, 1993), chap. 2 and passim.

127 M. Kaufman, "Involving Men and Boys: A Necessary Step in Ending Violence against Women and Girls", in "Ending Gender Violence and Reaching Other Goals: What Do Men and Violence Have to Do With It?" UNICEF workshop report, New York, 23–24 March 2000.

128 AVSC International and IPPF/WHR, "Male Participation in Sexual and Reproductive Health", p. 21.

129 Ibid., p. 22.

130 S. Osama, "Addressing the Gender Dimension Involving Men with Special Reference to Sudan", in "Operationalizing Reproductive Health Programmes: Report of Workshop, Regional Consultation Arab States", UNFPA, Rabat, Morocco, 24–28 November 1997, pp. 20–21.

Attitudes may also be aggravated by stressful circumstances. In Rwanda, an orientation workshop gathered victims of violence, including men.[131] Although armed conflicts affect the entire population, male working groups acknowledged that "violence and war are men's business, in which women pay most dearly". But men also said that too much attention was paid to the concerns of women. They expressed resentment about the emphasis placed on the issue of women being raped. Such statements reflect men's perspectives on their own suffering, and are an indirect way to request assistance, as well as indicating the potential for backlash in advocacy efforts against gender-based violence.

What Men Said about Violence against Women in Tanzania[132]

- We think women exaggerate. They are not the only ones to suffer sexual violence. We have, too. For example, men have had their genitals cut off.
- Other men have survived seeing their families mutilated and/or killed in front of them, while being able to do nothing to save them. Those men live with a sense of guilt and are deeply frustrated at not having been able to discharge their primary duty as men, which is "protection of the family".
- Some men have been forced to do things against their conscience, such as killing someone they know, a close friend or even a member of their family. Now they live in hiding, broken in spirit, or rotting in overcrowded jails. They are full of remorse. They commit suicide.
- Some killers, even those who have repented, are traumatized and haunted by the deaths.
- Our country invested principally in "the men". Now, since many have been killed or are in prison or in exile, the few who remain must bear the economic weight of society; they cannot manage.
- Men are frustrated at the emergence of women who begin to solve problems like men.

Poverty and lack of education are often associated with men's physical and sexual abuse of their wives. In a study conducted in five districts of Uttar Pradesh,[133] 18 45 per cent of husbands reported physically abusing their wives. Of those who acknowledged being physically abusive, men who had little education, those who had more than one child, and those who were extremely poor were more likely than other men to have physically abused their wives. In separate analyses of these data examining relationships between wife abuse and male reproductive health, the prevalence of abuse was significantly higher among men who had had extramarital or premarital sex, those who had ever had an STD, and those whose wives had had an unplanned pregnancy.

---

[131] WHO, "Management and Care of Women Victims of Violence" (orientation workshop, Kigali, Rwanda, 11–14 February 1997), 1999, p. 21.

[132] Ibid.

[133] *Family Planning Perspectives* 26, no. 1 (March 2000); S. L. Martin, "Domestic Violence in Northern India", *American Journal of Epidemiology*, 1999; S. L. Martin et al., "Sexual Behaviours and Reproductive Health Outcomes: Associations with Wife Abuse in India", *Journal of American Medical Association* 282, no. 20 (1999): 1967–72.

Other traditional practices require men's political will in order to be eradicated. These practices include any that affect the reproductive and sexual health of women and adolescent girls. The most common practices are son preference, early marriage and FGM — ICPD asserts that the practice of female genital mutilation is a violation of basic rights and a major lifelong risk to women's health.[134] In fact, there is evidence that some men have silently endured certain cultural practices, while longing for them to change. For example, it has been reported that some men whose women have undergone FGM tend to seek sexual satisfaction with uncircumcised women whom they regard as less inhibited and unscarred.[135]

Many cultures condone or at least tolerate a certain amount of male violence against women as "natural" manifestations of their so-called prerogatives to "establish their authority and power in the home" as a confirmation of their manhood. A comprehensive study, "Beyond Victim and Violence — A Culture of Sexual Violence", involved 37,236 men, of whom 26,000 were children and youths in school.[136] It also surveyed 197 police officers, magistrates, prosecutors, district surgeons, nurses, women's organizations, social workers and government officials. According to the researchers, "the findings are highly disturbing and have enormous consequences' for the nation's struggle to stop the spread of HIV and AIDS". The study found one in four young men admitted having had forced sex, without a woman's consent, by the age of 18. Eight out of 10 young men claimed women were responsible, or partly responsible, for sexual violence inflicted on them. Three in 10 thought women who were raped "asked for it", and two in 10 said women enjoyed being raped. The cycle of violence is difficult to break, since the propensity for violent behaviour is influenced by environmental factors present during childhood and adolescence.[137]

Multiple sexual relationships inside and outside marriage is another example of detrimental practices condoned by societies in which men's superiority is considered a way of life. Another practice — levirate (the sometimes compulsory marriage of a widow to a brother of her deceased husband) — "is another way of having multiple sexual partners even though it was driven by the need to keep wealth in the family, whether that wealth is child, land or goods. After all, it is the family, not the individual man, that produces the bride wealth of a brother; so when he dies, the family wants that wealth back. In its purest form, a leviratic' union was not consummated, because the inheritor was a caretaker. Of course, this has now collapsed, and levirate now contributes to the decimation of entire families due to the HIV/AIDs pandemic".[138]

The elimination of such practices requires the co-operation of traditional leaders, who tend to be men, and convincing individual men of the health consequences of these harmful and outdated practices. As will be addressed in more detail in chapter V, realities can be changed and are changing. Practitioners report: "The injustice of violence against women seems to have struck those, both men and women, who are not locked in gender role stereotypes and unequal rela-

134 United Nations, "Report of the International Conference on Population and Development", para. 7.35.

135 M. Kisekka, "Addressing Gender Based Issues", p. 17.

136 J. Ncube, "Sex: The Shocking Truth", in *Drum* (Durban, South Africa), 13 July 2000.

137 Ibid.

138 W. Mbugua, personal communication, e-mail of 20 October 2000.

tions from childhood. They lay the groundwork for an active partnership between men and women to stop violence against girls and women".[139] Optimistic findings emerged from sponsored research in 1997 that interviewed about 160 "activists who were doing something to stop some form of violence against girls and women in South Asia". They said: "We consider our wives, sisters and mothers equal to us and as capable as us. Taking dowry is a form of violence against women. I arranged for my son to marry this woman without dowry." "I am greatly influenced by my mother. My mother taught me to share with people and to reach out to others and help. She taught me that I am a human being first and a man second. And that as a man, I should help the women publicly and privately to build their lives."[140] Such research helps destroy myths, and this combined with political will may lead to a reduction of violence, including harmful rituals. Men must involve themselves in protecting women's reproductive health as a matter of self-interest and to protect their families, as well as for its own sake.[141]

Prevention of maternal mortality and men

Men do not bear the physical burden of carrying a pregnancy, but they can be active partners in this life cycle, provided they have the information about pre- and postnatal care and risky pregnancy, and are taught the symptoms of childbirth requiring emergency care.

The ICPD+5 review has served as a reminder of the roles men can play in safe motherhood by planning for childbirth, supporting women during pregnancies, dealing with the delays women face in obtaining safe delivery and helping them through the post-partum period.[142] In addition, men can support women's efforts to balance motherhood in the context of all their other responsibilities — housework, childcare and other labour.[143]

The goal of reducing maternal morbidity and mortality provides an excellent opportunity for building partnerships with men. When they learn about pregnancy, pregnancy and childbirth risks and complications, and how they can help their partners in these circumstances, men will become more responsive to women's needs. A programme in India that involved men in maternal health care increased by 40 per cent the number of men seeking out health workers to register their wives for early prenatal care. Other results were an increase in the number of men accompanying their wives on hospital visits, and more fathers bringing infants for immunizations.[144]

Men can help women stay healthy by planning their families with their partner, limiting and spacing their children, encouraging good nutrition, assuring that a trained attendant is present at the delivery and paying for these professional services. Other responsibilities they can take to

---

139 R. F. Hayward, "Needed: A New Model of Masculinity".

140 Ibid.

141 UNFPA, "Lives Together, Worlds Apart: Men and Women in a Time of Change", in *The State of World Population*, 2000, New York.

142 E. Ransom, "Men's Roles in Women's Health and Safer Motherhood" (paper presented at the Population Association of America, 2000, session 126).

143 Ibid.

144 S. Raju and A. Leonard, eds., "Enhancing Roles and Responsibilities of Men in Women's Health", in *Men as Supportive Partners in Reproductive Health*, pp. 28–29.

assure their partner's health are to seek immediate care when their partner requires it; provide or make necessary arrangements for transportation to the clinic; accompany their partner on pre- and postnatal visits; and help with household chores, especially those requiring heavy lifting such as collecting wood and carrying water. Encouraging and making sure that their partner is well nourished and gets enough rest after a delivery, a miscarriage or an abortion are other ways men can help reduce maternal deaths and help women remain healthy. A study in Egypt on husbands' involvement in post-abortion care concluded that support by husbands is critical for patients' recovery and use of contraception. "Emotional support by the husband is particularly important for women's physical and emotional recovery."[145]

Abortion and post-abortion care offer providers opportune moments to inform men who accompany their partners about the woman's condition, postoperative care and family planning methods that might ultimately prevent further unplanned pregnancies. In Senegal, 65 per cent of the post-abortion care patients interviewed wanted their husband or partner present during family counselling. In Turkey, men who participated in post-abortion care family-planning counselling were more likely to choose vasectomy compared with those who had no counselling.[146]

Other studies reflect how men's uninvolvement — or worse, support of doctrines that repress women — contribute to maternal mortality. Where strict purdah, or seclusion of women, is observed, for instance, women require their husband's permission to seek health care, even during childbirth. Serious damage to the health of the mother or child, or even maternal mortality, may result from the husband's absence.[147] These factors play a role in the high mortality rate in northern Nigeria, where the ratio is greater than 1,000 maternal deaths per 100,000 live births. In this predominantly Islamic culture, which undervalues women and where women's reproductive needs are under strict male control, women's access to medical care is restricted. Other harmful traditional practices, including early marriage and pregnancies, occur before maternal pelvic growth is complete.[148] In Zimbabwe, a study attributed 32 per cent of rural and 28 per cent of urban maternal deaths to delay in seeking treatment, in part due to lack of transportation to the clinic. Inability to recognize the severity of the patients' conditions was another factor that contributed to the delay in treatment and referral, and ultimately to death.[149]

Political changes to achieve partnerships between men and women

Gender equity and effective partnerships with men can only exist in an environment that fosters such principles. This requires laws and policies that promote gender equality, ensure access to information and services for all women and men, and decrease the gender gap in education. A

145 N. A. Tawab et al., "Effects of Husband Involvement on Post-Abortion Patients: Recovery and Use of Contraception in Egypt", Population Council Operations Research Project and the Egyptian Fertility Care Society, 1997, p. 24.

146 Population Council, "Meeting Women's Health Care Needs after Abortion", *Frontiers in Reproductive Health Brief*, no.1, August 2000.

147 M. Kisekka, "Addressing Gender Based Issues", p. 17.

148 L. L. Wall, "Dead Mothers and Injured Wives: The Social Context of Maternal Morbidity and Mortality among the Hausa of Northern Nigeria", *Studies in Family Planning* 29, no. 4 (1998): 341.

149 S. Fawcus et al., "A Community-Based Investigation of Avoidable Factors in Maternal Mortality in Zimbabwe", *Studies in Family Planning* 27, no. 6 (1996): 319.

political environment that is friendly to the ICPD agenda encourages women's access to economic resources and increases their political participation. It protects women from violence, provides child care and promotes health reform that covers the costs of sexual and reproductive health care.

Several levels of policy may be involved. Some countries have modified or passed new laws in order to provide legal recognition to children born out of wedlock, and to obligate fathers to take responsibility for their children. Colombia, Panama and Venezuela had provisions prior to the Cairo conference; but since then, several have been strengthened. In Nicaragua, the Health Law (law no. 149) was modified to obligate men to acknowledge their paternity by using clinical tests and witnesses. The law also promotes male responsibility by requiring fathers to provide alimony for their children. In Peru, a bill was introduced to reform the civil code on paternity issues and allow for judicial hearings on extramarital paternity disputes. The new constitution in Venezuela explicitly states that the "State guarantees the right to investigate paternity and maternity", and establishes that the "father and mother have shared obligations" for educating and raising children (Article 56). In Argentina, Chile and Costa Rica, laws have been promulgated to eliminate discrimination against children born out of wedlock. Similarly, Botswana changed its rape laws in 1998, after lobbying by women's groups and human rights groups. The minimum prison sentence rose significantly, with added penalties if the rapist knew he was HIV-infected.

Another area where legislative changes are beginning to occur is in labour laws. At the national level, the absence of paternity leave makes it difficult for men to share in the care of their infants. In Sweden, the government's efforts to get more men involved in the gender-equality issue has focused primarily on persuading more fathers to take paternity leave and to work in schools and within the child-care system, and on supporting men who are involved with working against violence against women. In 1974, Swedish men gained entitlement to periods of leave upon becoming parents, and men's use of parental leave has been the subject of debate. In 1998, the parental benefit increased from 75 per cent to 80 per cent of pay. During the 1980s, fathers in Norway, Denmark and Finland were granted corresponding rights, while Iceland introduced a similar scheme at a later date. In the South, Brazil led the way, when in 1988 its constitution included parental leave, though stipulating a "maximum of five days". Chile reformed its labour code by allowing parental leave in the case of a child's illness. The rule allowing for the transfer of postnatal leave to the father in case of the mother's death is an indication of the gender bias that remains in effect, despite some well-intended reforms.

Easy access to reproductive-health commodities is another essential factor that can facilitate men's partnership in planning families and avoiding infections. The cost and availability of condoms continues to be a problem, because many countries levy high tariffs on imported condoms or limit their distribution.[150] Nevertheless, some countries still forbid providing information and services to unmarried youth, and family life education in schools.[151] Some countries keep

[150] C. P. Green and N. Danforth, "Involving Men in Reproductive Health: Policy Implications for Developing Countries" (paper presented to the American Public Health Association, New York, 1996), p. 3.

[151] E. K. Bauni and B. O. Jarabi, "Family Planning and Sexual Behavior in the Era of HIV/AIDS", p. 77.

pregnant teenagers out of school. In Botswana,some providers continue to require a husband's consent before issuing condoms to married women.[152]

Finally, cultural and traditional beliefs that hinder women's advancement and harm men and women must be abandoned. Examples of these include the belief that variety in sexual partners is essential to men's nature, and that men cannot control their sex drive and violent outbursts; the culture of silence that keeps women ignorant about sex and passive in sexual interactions; FGM; early marriage; the belief that virgins cleanse men of, or protect them from, infections (in Tanzania, the majority of adolescents who show up at hospitals for complications of abortion have been impregnated by older men who see young women as safer from the risk of HIV/AIDS),[153] and that men are invulnerable.

In conclusion, achieving gender equality in reproductive and sexual health and in population and development strategies is not possible without men achieving a sense of comfort with their identity and without changing their lives. In effect, it requires a focus on men in future programmes and real partnership that respects both men and women, recognizes their differences provides for equal opportunities, and promotes safe and respectful behaviour.

[152] S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes", report for the Royal Ministry of Foreign Affairs, Oslo, Norway, 21 February 1999, p. 9.

[153] A. Mundigo, "Determinants of Unsafe Induced Abortion in Developing Countries" (paper presented at the Meeting on Priorities and Needs in the Area of Unsafe Abortion, WHO, Geneva, 28–29 August 2000).

Chapter 2

Prevailing Male Attitudes and Practices in the Areas of Reproduction, Sexuality and Services

As a result of the AIDS epidemic, sexual behaviour is better reported. Findings on men's sexual and reproductive health knowledge and practices inform gender-sensitive programmes that focus on men. Notably, the pre-Cairo family planning framework pervades available survey questions, and most of these data embrace men as married partners. Knowledge of health and fertility decision-making remains insufficient to guide new strategies to reach men, although there is progress as couples' decisions are increasingly taken into account. The data summarized below should be read with "gender lenses" to keep the masculinity equation analysed in the previous chapter in mind. Gender and social systems provide the social context for individual actions that are described here.

The role men play in the AIDS crisis

The emphasis on STDs and HIV prevention reflects the world's ongoing concern with the AIDS pandemic, its inability to stop its spread, and its increasing threat to women due to a power imbalance that makes it impossible for them to protect themselves. Five years after Cairo, knowledge of the physical factors and the behaviours that contribute to the crisis is much broader, but efforts to reduce the spread of AIDS have failed. The failure can be attributed to many factors, which include entrenched behaviours and attitudes that are linked to traditional gender roles, conservative attitudes that deny sensitive issues such as men having sex with men and older men having sex with young girls, and the lack of political will to address gender inequalities that lead to unwanted sexual relations.

Statistics confirm that men play a critical role in spreading AIDS. The data clearly show that men's risky sexual behaviour puts women and men at risk, not only of spreading AIDS, but other STDs as well. Married women are particularly at risk in some areas, such as Kigali in Rwanda, where a study indicated that 20 per cent of HIV-positive women had had only one sexual partner, with 45 per cent contracting the virus from their husband.[154] Men are eight times more likely to transmit HIV to a female partner through unprotected sexual intercourse than women are to transmit the virus to men, but statistics are poor since male reproductive health is often

[154] "AIDS and the World II", eds. Jonathan M. Mann and Daniel J.M. Tarantola, Oxford University Press, 1996

not medically assessed and is under-studied. "A man with HIV probably has a one in 500 chance of passing the virus to his partner in a single act of unprotected vaginal intercourse. The odds of woman-to-man transmission in the same circumstances are about one in 1,000."[155] Facts such as these contribute to the crisis, but also enrich the knowledge required to develop strategies to stop the disease from spreading.

Risk perception and the variety of sexual relationships

The issue of men's multiple sexual partners has not been adequately acknowledged in HIV prevention campaigns, even though research confirms that men tend to have more sexual partners than women, including with other men (3 to 16 per cent of men report having sex with men). The likelihood that men have two or more concurrent or consecutive partners also puts them at greater risk of becoming infected and transmitting the virus. A 1995 study in 18 countries found that more men than women reported having casual or outside partners. Men also generally have more sexual partners over their lifetimes, and prior to marriage, than women. In Costa Rica, 70 per cent of women, compared with 9 per cent of men, had only one sexual partner. In the UK, 24 per cent of men, compared with only 7 per cent of women, reported 10 or more sexual partners over their lifetime. In Nigeria, 80 per cent of school-enrolled, sexually active, unmarried young women (aged 15 24) surveyed reported having a stable sexual partner, compared with just 44 per cent of unmarried young men.[156]

Recent research in various parts of the world also points to the fluid perception of risk that changes according to the partner a man is with (that is, married partner, casual or commercial). A study of STI clients in Shanghai, China, found that about 15 per cent of all clients had three or more sex partners, and between 6 per cent and 16 per cent had two or more unpaid casual partners.[157] Furthermore, over half of the clients attributed their infections to unprotected casual or paid sex, and only 2 per cent had worn a condom when they last had sex with their wives. Men's uncertainty about their vulnerability to STDs with casual partners is examined in another study in south-west Nigeria, which found that HIV transmission in some regions is characterized by a "diffused pattern of sexual behaviour or sexual networking" and different patterns of transmission of HIV among the general population".[158] A similar study of risk perception in Nepal confirms that men in casual relationships do not always use condoms, largely because they perceive themselves not to be at risk of contracting STIs/HIV. Sixteen per cent of the men who did not use condoms in their last sexual relationship did not do so because they believed that their partners did not have other partners. The rationale expressed by a 22-year-old married truck driver in Nepal captures men's perceived invulnerability to STDs and HIV/AIDS: "As I

---

[155] M. foreman, ed. *AIDS and Men: Taking Risks or Taking Responsibility?*(London: The Panos Institue and Zed Books, 1998) , p.7

[156] G. Barker, "Boys, Men and HIV/AIDS", UNAIDS briefing paper (second draft, Instituto Promundo, Rio de Janeiro, Brazil, January 2000).

[157] WHO/HRP, "Improved Services and Counselling Reduce Risk-Taking Behaviour and Increase Condom Use in Shanghai, China", *Social Science Research Policy Briefs*, series 1, no. 3, June 2000, p. 5.

[158] L. J. Messersmith et al., "Who's at Risk? Men's STD Experience and Condom Use in Southwest Nigeria", *Studies in Family Planning* 31, no. 3 (2000): 203–16.

have sex with clean…women, there is no need to use condoms. It is natural to fear (AIDS), but I take precaution by being selective about my partners".[159]

Men are also more likely than women to use alcohol and other substances — behaviours that may impair sexual decision-making and increase their risk of HIV infection. These facts have motivated advocates to say that "persuading 10 men with several partners to use condoms, sterilize needles or have fewer partners has a far greater impact on the epidemic than enabling 1,000 women to protect themselves from their only partners. The 10 men are at the beginning of a chain of infection; the 1,000 women are its last link"[160] Of course, such a statement does not imply that we should focus only on men in prevention efforts, but stresses the notion of sequential transmission.

Some sexual activities represent a higher risk of infection than others, but men may not always accept their partner s request to use a condom. "Anal intercourse, because of increased friction and the fragile tissues in the anus, represents a higher risk of HIV transmission than vaginal intercourse, particularly for the receptive partner — in this case, women. Surveys from various countries confirm the extent of anal intercourse between men and women. In various studies in Africa, Asia and North America, 15 19 per cent of women report anal intercourse. Anal intercourse among men and women may be practised to preserve virginity' or to avoid pregnancy."[161]

In addition, sex between men exists in every society, but continues to be highly stigmatized and thus remains secretive. Men's refusal to use condoms and to stop relations with multiple partners, and their denial of sexual relations with other men, are other factors that put men at risk.[162] "Most sex between men is hidden. According to surveys from across the world, up to one-sixth of all men report having had sex with another man. Many men who have sex with men also have sex with women — their wives or regular or occasional girlfriends. Hostility and misconceptions about sex between men have resulted in inadequate HIV prevention measures in many countries."[163] Younger and poorer men, and those that are physically or psychologically weaker, are also vulnerable, because they tend to take the recipient role in anal intercourse.[164]

Finally, the issue of older men having sex with young women and girls, often in exchange for money or favours, should also be considered in discussions of HIV/AIDS risks and violence. There is evidence that sex between older men and younger women is responsible for the spread of HIV in some areas. A multi-site study in Africa found high HIV rates in girls aged 15 19, but far lower rates in boys their own age. However, men over age 25 had HIV rates 10 times higher than 15 19-year-old boys, indicating that older men were the main source of HIV trans-

---

159 WHO/HRP, "Men in Nepal Ignoring Risks from Unprotected Casual Sex", *Social Science Research Policy Briefs*, series 1, no. 2, October 1999.

160 M. Foreman, *AIDS and Men*, pp. xi, xii.

161 G. Barker, "Boys, Men and HIV/AIDS".

162 M. Foreman, ed., *AIDS and Men*, p. ix.

163 World AIDS Campaign, see Web site: www.unaids.org, September 2000.

164 M. Foreman, ed., *AIDS and Men*, p. 6.

missions to the younger women. In some settings, older men deliberately seek young women and girls as sexual partners because they believe that young women are less likely to be HIV infected.[165]

Men and HIV/AIDS transmission from mother to child

Men's role in causing HIV transmission from mother to child, or in the orphaning of their children, has also seldom been considered. Both in the case of children who are orphaned because one or both parents die from AIDS, and in the case of children infected through birth or breastmilk, men as fathers are indirectly involved. In the vast majority of these cases, men became infected with HIV in their outside sexual relationships and passed HIV to women, who subsequently died from AIDS or passed HIV to their children during childbirth.[166]

The AIDS crisis is helping health providers recognize the capacities and skills they need to work with men. They are learning that AIDS prevention strategies must be as diverse as the audiences they target, and carefully designed to convince specific sub-groups of men: young, old, single, married, rich, poor, heterosexual, bisexual, homosexual, employed, unemployed, that they are at risk of becoming infected and spreading the disease. STD/HIV prevention programmes also need to address the range of sexual relationships and the meanings and behaviours associated with them. For instance, men's condom use is highest in commercial sex, inconsistent in casual relationships and lowest in marriage.[167]

Reproductive intentions, knowledge and practices of men as married partners[168]

Efforts to capture the reproductive intentions and unmet needs of men, women and couples through surveys such as the Demographic and Health Surveys (DHS) are enriching the understanding of factors involved in carrying out these intentions. The DHS on men have also increased knowledge about the role men play in reproductive decision-making, their reproductive preferences, knowledge of methods, approval and current use of family planning. More surveys are interviewing men and women, and some are interviewing couples to gather such information. In addition to a long-standing practice of interviewing women, for example, the DHS now collect comparable data about family planning attitudes and sexual practices from men. Besides measuring sentiments about whether men approve of family planning and their family-size intentions, these surveys gauge male awareness of contraceptive options, their concerns about STDs and their use of contraception.[169] As of 1996, the DHS studies had been completed with more than 45,000 male respondents, representative of all men of reproductive age in 22 coun-

---

165 Ibid.

166 G. Barker, "Boys, Men and HIV/AIDS".

167 L. J. Messersmith et al., "Who's at Risk?" p. 203.

168 Most of the analysis that follows is adapted from B. Robey and M. Drennan, "Male Participation in Reproductive Health", *Network* 18, no. 3 (Family Health International, spring 1998); and S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes", report for the Royal Ministry of Foreign Affairs, Oslo, Norway, 21 February 1999.

169 The interpretation of data that follows is derived from B. Robey and M. Drennan, "Surveys Suggest Men Have a Strong Interest in Family Planning and Other Reproductive Health Issues", *Network* 18, no. 3 (Family Health International, spring 1998); and from S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes".

170 S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes".

tries.[170] One of the first major comparative studies on results for men was published in 1996, based on v7 DHS conducted from 1987 through 1993; only four of these studies were completed before 1990.[171]

Men's awareness of family planning and STDs

Men may identify reproduction as a female responsibility. A survey of couples at family planning centres in Azerbaijan shows that 50 per cent of the men thought contraception was solely the woman's responsibility.[172] This, in part, is due to the extensive availability of female-centred contraceptive methods, along with family planning programmes that until recently were entirely directed towards women and excluded men.

In almost all 15 countries surveyed, men are more likely than women to know about contraception. Surveys, however, report only whether respondents have heard of the various contraceptive methods. They do not gauge the depth of knowledge, including whether respondents know how to use methods correctly. In all 15 countries, a majority of men know about at least one modern method and one traditional method. In all but one African country (Rwanda being the exception), a higher percentage of men than women know of a modern method. In Egypt, Morocco, Bangladesh and Pakistan, men and women report similar levels of awareness. The gap between men's and women's awareness of contraception is greater in countries where overall knowledge is low.

The spread of HIV and other sexually transmitted diseases has brought an increase in awareness and use of condoms. For example, in Kenya, Tanzania and Zimbabwe, where HIV and other STDs are widespread, DHS results show that virtually all men have heard of AIDS and most know that sexual intercourse can transmit it. While the surveys also reveal much misinformation about HIV, they show that many people know that using condoms is a means of protection. In Zimbabwe, for example, 57 per cent of men cited using condoms as a way to avoid contracting AIDS, and in Tanzania, 55 per cent. In Kenya, however, only 36 per cent of men who believe that people can protect themselves against AIDS identified using condoms during sex as a means of protection.

Men's approval of family planning

According to recent DHS, men are more likely to approve of family planning and to know about contraception than stereotypes about men suggest. Based on data collected from men in 15 countries — 11 in sub-Saharan Africa, plus Bangladesh, Egypt, Morocco and Pakistan — Alex C. Ezeh and colleagues at Macro International, Inc. (the U.S.-based organization that organizes and helps conduct the DHS studies) report that in most countries, except for West Africa, "the reproductive preferences and attitudes of men and women towards family planning are similar".[173] While the 15 countries represent only portions of Africa and Asia, there is a striking consistency

---

[171] A. C. Ezeh et al., "Men's Fertility, Contraceptive Use, and Reproductive Preferences", DHS Comparative Studies No. 18, Macro International, Calverton, Maryland, March 1996.

[172] Johns Hopkins University School of Public Health, "New Perspectives on Men's Participation", *Population Reports*, series J, no. 46, October 1998.

[173] A. C. Ezeh et al., "Men's Fertility, Contraceptive Use and Reproductive Preferences".

among them regarding male interest in reproductive health, enough to suggest a similar level of male interest elsewhere. While only a few DHS have interviewed men in Latin America and the Caribbean (Brazil, Dominican Republic, Haiti and Peru), initial results suggest a similar pattern of male interest. For example, in Brazil, men are even more likely than women to say that they do not want to have more children. In Haiti, 92 per cent of men surveyed approve of contraceptive use, and in Brazil, 86 per cent approve. Most men, like most women, approve of family planning. In nearly all countries surveyed, better-educated men express greater approval of family planning than do men with less education.

Approval is lowest in West Africa, although in this region men's approval appears to be on the rise. In Ghana, for example, the percentage of men who approve of family planning rose from 77 per cent in 1988 to 90 per cent in 1993. Within most of these countries, men are less likely than women to approve of family planning. Eroll Alexis, a specialist on men's involvement at the Margaret Sanger Center of New York, observes: "Many men are suspicious of family planning programmes because they see them as a conspiracy to undermine their power".[174] This fact may in part explain why men often are pictured as obstacles to contraceptive use.

Men's reproductive intentions and family size

In most surveyed countries, the number of men who want to have another child is only slightly higher than the number of women. This finding shatters one of the most widespread myths about men — that they generally want much larger families than do women. In most of the 15 countries, the differences in reproductive intentions between men and women are small. The fact that men are somewhat more likely to want another child, however, helps account for the finding that, even though men tend to know somewhat more about contraception than do women, they are less likely to approve of its use.

Certainly there are countries, especially in West Africa and in Pakistan, where the findings are not promising.[175] In West Africa, men are substantially more likely than women to want another child. In Niger, the extreme case, 93 per cent of men want to have another child compared with 82 per cent of women. However, in countries like Niger, Burkina Faso and Ghana, male approval ratings for family planning exceed 60 per cent. A review of research on reproductive health and AIDS in sub-Saharan Africa concluded, "Failure to target men in reproductive health interventions has weakened the impact of reproductive health programmes".[176]

Men's KAP gap in reproductive health

So widespread are STDs that reproductive and sexual health programmes need to promote and provide condoms for disease protection as well as for family planning. It has been estimated that over 1.9 million disability-adjusted life years of men aged 15 59 will be lost to STDs excluding

[174] I. Ndong and W. R. Finger, *Network* 18, no. 3 (Family Health International, spring 1998).

[175] S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes".

[176] M. Mbizvo and M. Bassett, "Reproductive Health and AIDS Prevention in Sub-Saharan Africa: The Case for Increased Male Participation", *Health Policy and Planning* 11, no. 1, 1996.

[177] C. J. L. Murray and A. D. Lopez, eds., *The Global Burden of Disease,* Global Burden of Disease Series, vol. 1 (Boston: Harvard University Press, 1996). It should be noted that the HIV/AIDS impact projections were made prior to improvements in the UNAIDS database and are likely conservative.

HIV/AIDS, and another 16.8 million to HIV/AIDS itself.[177] Infertility, frequently a consequence of untreated STDs, affects millions of men, but statistics are poor since male reproductive health is often not medically assessed and is under-studied.[178] Thus, men's practices in reproductive health cannot be measured simply on the basis of use of male-oriented family planning methods. However, this is the type of data that most demographic surveys collect.

Worldwide, men's knowledge of condoms is extremely high. National surveys with married men in 21 developing countries find that 50 per cent to 99 per cent of men know about condoms. But for a variety of reasons, condom use is not as widespread as it could be. In most developing countries, prevalence of condom use is typically below 5 per cent. Most problematic is that consistent condom use in men's heterosexual relationships is low, and generally associated with occasional partners, including sex workers. In national household survey data from nine developing countries, among currently married men, only between 3.6 per cent and 10.4 per cent of men reported currently using condoms.[179] A 1994 survey in Zimbabwe found that five times more married men reported using condoms in the previous month with an outside sexual partner (60 per cent) than with their wives (12 per cent). In another study in Zimbabwe, men interviewed had sex with sex workers an average of seven times a month, but used condoms in only about half of those encounters.[180]

Interestingly, men are more likely than their partners to report using contraception, according to the 15 available surveys. One possible explanation is that some men may be reporting condom use outside of marriage. In Zimbabwe, a study on men's attitudes toward vaginal microbicides found that men would consider using them with girlfriends and prostitutes, but not with wives.[181] Another possibility is that some women may not acknowledge use of contraception to survey takers, since they are using it without their husbands' knowledge. Whether the explanation lies primarily in men over-reporting contraceptive use or women under-reporting is unknown.

Despite this scientific basis for optimism, existing DHS studies reveal a family planning "KAP gap" among men — a contradiction between the level of "knowledge and attitudes" about family planning compared with "practices" (KAP). Men's contraceptive use is lower than might be expected, given their overall levels of approval and knowledge. Between one-quarter and two-thirds of men surveyed want no more children, yet neither these men nor their partners were using contraception.[182] An indication that men assign contraceptive responsibility to women is

---

178 U. D. Upadhyay and B. Robey, "Why Family Planning Matters", *Population Reports*, series J, no. 49, Baltimore, Maryland, Population Information Program, Johns Hopkins University School of Public Health, 1999.

179 Comparing men's rates of condom use across countries and studies is difficult, because in some studies men are asked whether they use condoms for contraception or birth control, while in other studies they are asked whether they use condoms for HIV prevention; other studies do not specify. Only a few studies have looked at men's use of condoms in different settings (e.g., with stable or casual partners) and their motives (that is, contraception or HIV prevention).

180 G. Barker, "Boys, Men and HIV/AIDS".

181 H. H. M. Janneke et al., "Men's Attitudes Toward Vaginal Microbicides and Microbicide Trials in Zimbabwe", *International Family Planning Perspectives* 25, no. 1, 1999.

182 F. Roudi and L. Ashford, "Men and Family Planning in Africa", Population Reference Bureau Chartbook of DHS Data, Washington, DC, 1996.

the significantly lower prevalence of male-dependent methods of contraceptives. Condoms, vasectomy, withdrawal and periodic abstinence amount to approximately one-third of all contraceptive use among married couples. In developing countries, 31 per cent of couples of reproductive age rely on "non-supply" methods, primarily withdrawal and periodic abstinence, even though these methods have high failure rates.[183] Moreover, the proportion of contraceptive use attributed to men (including condoms, withdrawal, periodic abstinence and vasectomy) has been falling in recent years. It has reached 26 per cent, a drop of 11 per cent since 1987 and 5 per cent since 1994.[184] Vasectomy (male sterilization) is a safer and less invasive procedure than its female counterpart (tubectomy), but it is much less widely practised.[185] Different potential users cite various reasons they find particular methods unacceptable. These include concerns about permanence or reversibility, interruption of spontaneity, adverse affects on libido or sexual performance. But these methods offer benefits: HIV prevention in the case of condoms, permanence of many vasectomies, lack of financial cost for abstinence and withdrawal.[186]

There is progress, however. Sam Clark et al.[187] observe a dramatic increase in the use of condoms world-wide. In Uganda, where condom use increased from 10 per cent to 17 per cent between 1995 and 1998, its use is particularly high among individuals reporting multiple sexual partners or extramarital relationships.[188] In many cases, the increase is among high-risk groups, such as adolescents and commercial sex workers. Global sales of condoms via social marketing in 60 nations rose by 20 per cent in 1997 to a total of 937 million condoms.[189] The Thailand "100 per cent condom" programme reported an increase in condom use at brothels from 14 per cent in 1989 to 90 per cent in 1994.[190]

In addition, few satisfactory contraceptive choices apart from withdrawal, condom and vasectomy have been designed for men. Research is under way to provide men with hormonal methods that could be delivered through implants, injections or possibly as a vaccine. Other considerations are providing men with additional contraceptive methods and revisiting whether withdrawal is a viable method for avoiding pregnancy and STDs including HIV/AIDS. These findings imply that if programmes could find better ways to meet men's unmet needs as individuals and as members of couples, contraceptive use might rise considerably.

---

183 K. Ringheim, "Male Involvement and Contraceptive Methods for Men, Present and Future" (paper presented to the American Public Health Association session "Toward Gender Partnership in Reproductive Health", November 1996), p. 2.

184 K. Ringheim, "Reversing the Downward Trend in Men's Share of Contraceptive Use", *Reproductive Health Matters,* 1999, p. 14.

185 UNFPA, *State of the World Population Report 2000*, p. 31.

186 Ibid.

187 S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes".

188 T. Lutaol et al., " Trends and Determinants of Contraceptive Use in Rakai District, Uganda, 1995–98", *Studies in Family Planning* 31, no. 3 (2000): 217–27.

189 W. R. Finger, "Social Marketing Campaigns to Prevent AIDS Have Made Condoms Readily Accessible and Affordable, *Network* 18, no. 3 (Family Health International, spring 1998).

190 K. E. Nelson et al., "Changes in Sexual Behaviour and a Decline in HIV Infection among Young Men in Thailand", *New England Journal of Medicine* 335, no. 5 (1996): 297–303.

MEN'S ROLES IN COUPLES' DECISIONS PERTAINING TO REPRODUCTION AND SEXUALITY

Treating couples as the unit of analysis adds a different perspective and enhances our understanding of reproductive preferences and decision-making. The couple-level approach involves direct comparison of the preferences of the two individuals who matter most in reproductive decision-making. Despite new studies on men and couples, little is known about the dynamics of couples' sexual and reproductive decision-making or about how gender roles affect these decisions. Such decisions can include whether to practice family planning, choosing when and how to have sexual relations, engaging in extramarital sexual relations, using condoms to prevent STDs, and seeking care for prenatal and post-abortion complications.[191]

Men and couple's decisions related to reproductive intentions

In most developing countries, husbands dominate reproductive decision-making, regarding contraceptive use, family size and birth spacing. However, the perception that men are the ultimate decision-makers in reproductive matters may be exaggerated.[192] With the exception of West African nations, there is growing evidence that men and women tend to have similar reproductive preferences and attitudes towards family planning, and that men's approval for intentions to use family planning are similar to women's.[193] At the country level, the evidence suggests that husband-wife agreement is stronger in the less gender-stratified contexts than in the more stratified ones.[194] A review of couples' attitudes and reproductive intentions found a concordance between partners on these matters ranging between 60 and 70 per cent.[195]

Some recent research is informative about the absence of communication among couples on sexual and reproductive matters, why this occurs and its implications.[196] Demographic and Health Survey data collected in 18 developing countries between 1990 and 1996 were used to directly compare husbands' and wives' attitudes towards fertility and contraception. Education is shown to be an important predictor of increased husband-wife communication.[197] In Uganda, couples in urban areas were more likely to talk about child-bearing than were rural couples.[198] Spouses may have disparate reproductive goals, and data from both partners are necessary to ascertain these differences.

---

191 M. Drennan et al., "New Perspectives on Men's Participation", *Population Reports*, series J, no. 46, (Johns Hopkins University School of Public Health, October 1998).

192 A. Banakole and S. Singh, "Couples' Fertility and Contraceptive Decision-Making in Developing Countries: Hearing the Man's Voice", *International Family Planning Perspectives* 24, no. 1 (1998): 15.

193 S. Clark et al., "Increased Participation of Men in Reproductive Health Programs", p. 9.

194 K. O. Mason et al., "The Husband's Role in Determining Whether Contraception Is Used: The Influence of Gender Context in Five Asian Countries" (paper presented at IUSSP, Buenos Aires, Argentina, 13–15 May 1998).

195 S. Becker, "Couples and Reproductive Health: A Review of Couple Studies", *Studies in Family Planning* 27, no. 6 (1996): 291–306.

196 A. Blanc et al., "Negotiating Reproductive Outcomes in Uganda", Macro International, Calverton, Maryland, December 1996, p. 214.

197 Seminar on "Male Involvement in Reproductive Health: Summary of Research Findings and Future Directions" (Alexandria, Egypt, Population Council Asia and Near East Operations Research and Technical Assistance Project, 4–5 May 1998).

198 A. Blanc et al., "Negotiating Reproductive Outcomes in Uganda", p. 214.

The new data on men also show wide regional variation in the proportions of men and women ted having any discussions of family planning in the past year. About three-quarters of respondents from West African nations reported no discussion of family planning in the past year. In West African countries, only a minority of married men surveyed reported discussing family planning with their wives in the past year — from 23 per cent in Niger and Senegal to 43 per cent in Mali (see Figure 3). In East African countries, surveyed men were more likely to have discussed family planning — from 49 per cent in Burundi to 68 per cent in Kenya.[199] Although Bankole and Singh's study[200] included only a few countries outside sub-Saharan Africa, their results show that sub-Saharan Africa and the rest of the developing world may differ in important ways. They found that husbands tend to want more children than their wives, and to want the next child sooner. Among the countries covered by DHS, there is more agreement between spouses on the ideal number of children in Asia, Latin America and North Africa than in sub-Saharan Africa. This compares with 21 per cent of Egyptian men and women reporting no discussion in the past year.[201] In some settings, age difference between a husband and wife is a determinant of "whether spouses have similar reproductive preferences".[202] Age difference is obviously an area where polygamy plays a negative role in couples' dynamics. A study that examines the reproductive decision-making in Nigeria also found that "fertility decisions are determined by who controls and allocates economic resources within the family".[203]

Alternatively, couples may agree without knowing it. DHS data consistently show that many wives think their husband opposes family planning when in fact the husband approves.[204] Data from Uganda in 1995 found that 24 per cent of wives thought their husband disapproved of family planning when he in fact approved. Another 17 per cent did not know what their husband's attitude was, but the husband approved (see Figure 4).[205] Hence, in the Uganda case, over half the wives either did not know the husband was in favour of family planning, or incorrectly assumed he was opposed to it. Studies in Egypt found that husbands and wives seldom discuss the use of family planning or the number of children each wants. Despite this finding, husband-wife agreement on those issues tends to be high. These results indicate that improved communication between spouses has a potential to increase the use of family planning. However, the discrepancy between what respondents claim they do and what actually happens suggests some degree of "social desirability bias" in response to the question "Who has the final say over use of family planning?" Since, in Egypt, the husband is expected to be the dominant figure in the family and the wife is expected to obey, both husband and wife are likely to subscribe to this image, especially in public, for example, in an interview, lest they be labelled "deviant". In private, the dynamics of husband-wife relations are more complex.[206]

199 M. Drennan et al., "New Perspectives on Men's Participation".

200 A. Bankole and S. Singh, "Couples' Fertility and Contraceptive Decision-Making in Developing Countries", pp. 15–24.

201 A. C. Ezeh et al., "Men's Fertility, Contraceptive Use, and Reproductive Preferences".

202 A. Bankole and S. Singh, "Couples' Fertility and Contraceptive Decision-Making in Developing Countries", p. 17.

203 U. C. Isiugo-Abanihe, "Reproductive Motivation and Family-Size Preferences among Nigerian Men", *Studies in Family Planning* 25, no. 3 (1994): 150.

204 M. Drennan et al., "New Perspectives on Men's Participation".

205 Ibid.

206 Seminar on "Male Involvement in Reproductive Health".

The similar fertility preferences found in these surveys obscures substantial disagreement between men and women at the couple level.[207] Surveys in Bangladesh, the Dominican Republic and Zambia found substantial differences between spouses in contraceptive and fertility intentions in all three countries. There is greater dissimilarity between husbands and wives regarding intention to practice contraception than there is regarding child-bearing intentions.[208] Surveys also find that men's beliefs concerning fertility, contraceptive use and sexuality are so diverse that the differences between their attitudes can be greater than those between men and women.[209]

Among younger generations, and in certain cultures, men's control over reproductive decision-making may be weakening. In Peru, Argentina and Brazil, young men negotiate sexual and reproductive decisions with their partners. In Sri Lanka, where women's levels of education and literacy are high, more than half of the wives and about two-thirds of the husbands reported making joint decisions about family planning.[210]

The gap between the number of children a couple wants and the number of children they have may be due in part to the fact that some couples rarely communicate about these matters. Entrenched cultural, traditional, religious and gender norms are obstacles that block communication about reproductive intentions among many couples. Many men and women still find it very difficult to talk among themselves about sexuality and anything distantly related to it, including family planning. DHS in Senegal and Niger indicate that only 25 per cent of men familiar with family planning have discussed it with their partner during the year that the survey was conducted. In Cameroon, a slightly larger percentage of men (39 per cent) have talked about this subject with their partner.[211]

Indirect or absence of communication between partners about family planning, reproduction and sexual matters contributes to the tendency of both men and women to overestimate each other's demand for additional children. Real or perceived opposition by partners contributes to increasing the unmet need reported by women, and a shift in the contraceptive mix to favouring traditional methods over modern ones.[212] A study in Nigeria confirms that "even in situations where no spoken decision is made, men's perceived wishes or objections may influence their wives' actions. For instance, a woman who favours family planning may fail to take the initiative in using contraceptives because she perceives her husband's attitudes to be negative, although he

---

[207] M. Greene and A. Biddlecom, "Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles", *Population and Development Review* 26, no. 1 (2000): 96.

[208] S. Becker, "Measuring Unmet Need: Wives, Husbands or Couples?" *International Family Planning Perspectives* 25, no. 4 (1999): 172–80.

[209] M. Greene and A. Biddlecom, "Absent and Problematic Men", pp. 81–115.

[210] Johns Hopkins University School of Public Health, "New Perspectives on Men's Participation", p. 20.

[211] Johns Hopkins University/Population and Communication Services and Académie pour le Développement de L'Education (AED/SARA), Les Hommes: Partenraires-Clés de la Santé de la Reproduction (report of the First Conference of Francophone Countries on Male Involvement in Reproductive Health, Ouagadougou, Burkina Faso, 30 March–3 April 1998), p. 12.

[212] B. Wolff et al., "The Role of Couple Negotiation in Unmet Need for Contraception and the Decision to Stop Childbearing in Uganda", *Studies in Family Planning* 31, no. 2 (2000): 124–37.

may not state his objection outright".[213] Even when communication takes place, the power imbalance reduces women's ability to negotiate on equal terms.

Many believe that including men in sexual and reproductive health programmes will ease communication about sexuality and reproduction between men and women and foster actions that promote gender equity, such as taking turns using contraceptives. This assumption is supported by the clear correlation between smaller families and communication among men and women about family planning documented in several studies. Couples who discuss family planning are more likely to use contraception effectively and to have fewer children. In contrast, men and women who don't know their partner's fertility desires, attitudes about family planning or contraceptive preferences are more prone to unintended pregnancies, unsafe abortions and STDs.[214] However, the concept of communication as indicator of joint decision-making assumes a Western nuclear family model. In cultures where many families are structured very differently, and where solidarity with the extended family may compete with the emergence of strong nuclear family relations, partners may communicate their reproductive desires or concerns through non-verbal or indirect means. In Uganda and in Nigeria, for example, most communication between men and women regarding reproductive issues took the form of suggestions, hints, and talking to friends or relatives in the hope that they would convey the information to the sex partner.[215] Other researchers question the validity of the question: "Have you discussed family planning with your spouse?" Respondents may have had an understanding of the concept of "discussing" that is different from that of researchers. For example, a casual conversation or a joke with the husband about using family planning may be considered a form of discussion by some respondents, but not by others.[216]

Couple communication is just one of many factors that influence couples and affect their reproductive decisions and well-being. Education level, family pressures, social expectations, socio-economic status, exposure to mass media, personal experience, expectations for the future and religion also shape such decisions.[217]

Safer sex negotiation in couples

The extent to which men and women perceive STD/HIV/AIDS risks and are able to discuss them with their respective partners can positively influence behaviour change.

Even though it is a life-saving matter, not much is known about safer sex negotiation within marriage or in casual relationships, because most of the research available on couple communication focuses on family planning decision-making. Unsurprisingly, spousal communication on matters relating to family planning is found to be easier than talking about HIV/AIDS.

---

213 U. C. Isiugo-Abanihe, "Reproductive Motivation and Family-Size Preferences among Nigerian Men", p. 151.

214 Johns Hopkins University School of Public Health, "New Perspectives on Men's Participation", p. 21.

215 A. Blanc et al., "Negotiating Reproductive Outcomes in Uganda", p. 214.

216 Seminar on "Male Involvement in Reproductive Health".

217 L. Beckman, "Communication, Power and the Influence of Social Networks in Couple Decisions on Fertility", in *Determinants of Fertility in Developing Countries*, vol. 2, R. A. Bulatao et al., eds. (New York: Academic Press, 1983), pp. 415–43.

Nevertheless, some men believe it is increasingly possible to talk about the issue, and this may offer a window of hope.[218] However, misperceptions of risk shared by both genders need to be addressed. Notably, some believe that menstruation and menopause reduce women's risk of infection. And condom use within marriage is viewed with suspicion by both partners.[219] We also know that lack of consistency in condom use is another impediment to safer sex, and is notable in cases where one man has several different kinds of relationships, casual and commercial.

Programmes to encourage partnership with men in reproductive and sexual health and rights (PMSRH) face a major challenge in the area of safer sex negotiations. Women often lack sufficient power to negotiate safer sex with their partners, whether they are married, engaged in a casual relationship or involved with commercial sex. A young woman's emotional involvement with her partner may prevent her from discussing sex or using condoms.[220] Because of gender roles, many women around the world have trouble talking about sex or mentioning reproductive health concerns. They may not be able to ask their partners to use condoms, or to refuse sex, even when they know they risk getting pregnant or being infected with an STD, including HIV.[221] In Uganda, research found that one person in every four believes that a woman cannot refuse sex, even if she knows her partner has AIDS. Women may submit to men because they are afraid of retaliation, such as being beaten or divorced, and because their gender roles place them in subordinate positions in society.[222] In Kenya, spousal discussion of the risk of STDs, including HIV/AIDS, is inhibited by the desire to avoid accusations or counter-accusations of marital infidelity between spouses. There is a belief that discussing STDs presents an opportunity for the wife to accuse the husband of infidelity, behaviour both the wife and the husband are reluctant to acknowledge. Men fear that such suspicions could spur the wife to retaliatory behaviour. The persistent culture of silence makes sexual matters taboo even for spousal discussion; and male sexual transgressions, for the same reason, go unpunished. Other factors include low education levels, educational gaps between spouses, lack of information about STDs, and men's prevailing desire to control or be in control.[223]

More work is needed on gender differences in reproductive preferences and behaviour and sexual relations. The investigation should be extended to unmarried men and women, particularly never-married men and their sexual partners, and to more countries, especially in regions other than sub-Saharan Africa. As noted earlier, there is little information on safer sex negotiations among casual partners.

---

218 W. Muhwava and N. Matinhure, "Awareness and Perceptions of STD/HIV/AIDs and Spousal Communication: Opportunities for Behaviour Change" (forthcoming, Project 97908F, supported by WHO/HRP, University of Zimbabwe, Centre for Population Studies, Harare).

219 Ibid.

220 Panos Institute, Panos HIV/AIDS Briefing No 6 (summary information prepared on basis of "AIDS and Men: Taking Risks or Taking Responsibility?", M. Foreman, ed., December 1998).

221 M. Drennan et al., "New Perspectives on Men's Participation".

222 A. Blanc et al., "Negotiating Reproductive Outcomes in Uganda", p. 214.

223 B. M. Fapohunda and N. Rutenberg, "Expanding Men's Participation in Reproductive Health in Kenya" (Nairobi, Kenya: African Population Policy Research Centre, 1999).

Men's reproductive health needs as clients

Effective gender-sensitive programmes seize the opportunity to empower men to improve their and their partner's health, and consider the needs of the individual and the couple, while protecting women's reproductive health and rights.

Sexual and reproductive health services for men

Although there is no consensus on the extent to which population programmes and primary health care settings can satisfy the unmet sexual and reproductive health needs of men, there is general agreement that men's reproductive health concerns are not being met. These include family planning, prevention and treatment of STDs, sexuality and sexual dysfunction, psychosexual problems, infertility, prostate and testicular cancers, and urologic conditions.[224] Other reproductive health concerns that men often express range from size of penis, impotence, early ejaculation, masturbation, AIDS and other STDs.

Though men have been left out of reproduction services, they have indeed been involved, but without the benefit of the education and information that young girls and women are privy to. Men's interest in, but lack of knowledge about, sex and reproduction, and their sexual dysfunctions, especially impotence and infertility, has been ignored in primary health care settings. In rare cases, for those able to afford it, urologists outside of the sexual and reproductive context have treated some of physical problems in men's reproductive organs. Men also want to know when during a woman's menstrual cycle she is most likely to conceive.[225] Men know little about their own or women's sexuality; they communicate very little about sexuality in their relationships, and often believe sexual myths. In India, investigators involved in studies on men's perceptions of illnesses of the genital area, and attitudes and perceptions of men and youth about sexuality and related matters, were unable to complete the research because they were uncomfortable communicating about sexual matters. This convinced the implementing agency, Social Action for Rural and Tribal Inhabitants of India (SARTHI), that staff members needed to overcome their own internal barriers and increase their sensitivity to sexual matters if their research was to succeed.[226]

Men require sexual and reproductive health services that are flexible, and respond to their sexual behaviours and changing needs throughout their lives. An adolescent male in a non-stable relationship will have different needs than a middle-aged married man with two children, as will an older man dealing with prostrate cancer. However, the services provided and their delivery may vary significantly due to local needs, cultural values and available resources. In some cases, refer-

---

[224] PATH, "Involving Men in Reproductive Health", *Outlook* 14, no. 3 (1997): 1. See also, C. Laudari, "Gender Equity in Reproductive and Sexual Health" (paper presented at UNFPA TSS thematic workshop on Male Involvement in Reproductive Health Programmes and Services, Rome, November 1998), pp. 6–7.

[225] S. Raju and A. Leonard, eds., "Perception of Male Members about Reproductive Health Matters: Preliminary Evidence from a Tribal Area of Gujarat", in *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality* (Population Council South and East Asia Regional Office, 2000).

[226] R. Saraswati and A. Leonard, "Men's Involvement in Women's Health: the SARTHI Experience", in *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality*, eds. S. Raju and A. Leonard, p. 21.

rals for services that are beyond the scope of a basic family planning or reproductive health clinic may be a more efficient way of operating. This may be the case for patients who need cancer care, STD/HIV/AIDS treatment, mental health care, sexual therapy, and employment counselling and services.[227]

Acknowledging that men need sexual and reproductive services for themselves has been a factor in building partnerships with men in sexual and reproductive health. Studies that examine the gap between men's positive attitudes about family planning and their failure to use contraceptives suggest that if men are provided with education and information about women's and men's reproductive systems, contraceptive methods and access to specific services, they may increase their participation in reproductive health.[228]

Health providers working with men are learning about the complexity and far-reaching implications of involving men in sexual and reproductive health. Men have their own health issues, sometimes independent of those of their partners. Men's health programmes face the challenge of responding to men's wide-ranging and fluid reproductive and sexual health needs. Prevention and treatment of STDs, particularly HIV/AIDS, provides a clue to the complexity of a health provider's work. A sexuality-based approach to men's services would require considering not only changes throughout a man's life-cycle, but also how needs differ according to sexual-relations patterns. In case of polygamy, men's needs vary according to the wife they are with,[229] or they may have multiple partners — a casual one with whom they tend to use condoms as a prophylactic, and a steady one, with whom they do not.

Reproductive health programmes and family planning providers play a key role in helping individuals realize their contraceptive and reproductive intentions. Use of a given method is influenced by providers.[230] Physicians may assume that vasectomy is unacceptable to their male clients, or that a certain family size should be achieved before recommending sterilization. They are also more likely to recommend procedures that they perform.[231]

Studies show, however, that service providers have little or no experience in working with men and/or issues of sexuality. Furthermore, traditional training emphasizes acquiring technical knowledge, but issues such as power relations between men and women, and between providers and clients, are not usually addressed; neither are sex or gender-based violence.

---

227 I. Ndong et al., "Men's Reproductive Health: Defining, Designing and Delivering Services", *International Family Planning Perspectives* 25, supp., 1999.

228 R. Saraswati and A. Leonard, "Men's Involvement in Women's Health".

229 P. Ngom, "Men's Unmet Need for Family Planning: Implications for African Fertility Transitions", *Studies in Family Planning* 28, no. 3 (1997): 192–202.

230 R. J. Magnani, "The Impact of the Family Planning Supply Environment on Contraceptive Intentions and Use in Morocco", *Studies in Family Planning* 30, no. 2 (1999): 120–32.

231 K. Ringheim, "Male Involvement and Contraceptive Methods for Men, Present and Future", p. 3.

Health systems that reinforce men's and women's unequal positions

Male health care workers who work with women's reproductive and sexual health must be familiar with gender issues. Some aspects of service delivery reinforce or weaken the gender inequalities in and sustained by the health system itself, and societal biases are reflected in staffing patterns within health care organizations (as in others). Men tend to be over-represented in decision-making positions. They are the physicians, directors and high-level administrators, while women make up the lower levels as nurses, aides, counsellors and community-based workers.[232] In Chile, for example, although women make up 70 per cent of health personnel, according to Health Ministry data, and hold the majority of intermediate professional and administrative positions, men predominate in the highest ranks. Unequal relations are implicitly reinforced in the training of health professionals, leading to a clear sexual division of labour with respect to medical specialties, some of which are promoted as "female" and others as "male".[233]

We also need to work with health providers in public services to develop training programmes with an emphasis on gender, quality of care and sexual and reproductive health. The goal of building partnerships between men and women extends to the men and women in the medical profession. Paternalism is endemic in health care. "The public health services generally operate within a biomedical model, which can be described as patriarchal and based on hierarchical relations. This model encourages dependency and submission and affects the inter-relationships between health professionals and other health workers in service provision and between providers at all strata and the users of services.... For instance, the learned subordination to masculine authority seemed to reinforce an over-valuing of the authority of male doctors, a common tendency among male and female patients.... Male doctors particularly tended to treat women like children by calling them "little mamas" or "girls". With this language and the non-verbal pat on the shoulders' that often accompanies it, women are patronized and devalued and can be more easily treated with indifference."[234] The Philippines is an exception. Largely due to circumstances and culture rather than design, both the government and NGOs have a large proportion of women in mid-level and managerial positions in the health system, supervising a field force dominated by midwives and female Baranguay Health Workers. MCH/FP services appear to be highly "women-oriented". For example, women admitted for septic-induced abortions are treated as patients and not as offenders; unwed mothers do not appear to be ostracized during hospital delivery. On the other hand, the female orientation of service delivery poses a problem in promoting male involvement and addressing male reproductive health needs.[235]

Doctors and nurses may make decisions for patients without involving them, under the assumption that they know best. Successful partnerships are non-hierarchical, and the partners share decision-making and responsibility.[236] In fact, physicians are increasingly required by law to

[232] J. Helzner, "Male Involvement in Reproductive Health", *Reproductive Health Challenges* (1996): 5.

[233] M. A. Matalama, "Gender-Related Indicators for the Evaluation of Quality of Care in Reproductive Health Services", *Challenges in Reproductive Health Matters* 6, no. 11 (May 1998): 10–21.

[234] Ibid.

[235] UNFPA, "Implementing the Reproductive Health Vision — Involving Men in Reproductive Health", *Evaluation Findings*, issue 24 (July 1999): 5.

[236] "Paternalism or Partnership: Patients Have Grown Up — and There's No Going Back", *British Medical Journal* 319 (1999): 719.

respect patients as equals, capable of and responsible for making life decisions. Doctors are required to provide patients with the medical information they need to make informed decisions.[237] A UNFPA evaluation recommended that reproductive-health orientation and t raining programmes should include gender equality concepts and be designed for providers as well as the general male population. In addition, gender sensitivity training should be built into reproductive health services, rather than being treated as separate topic.[238]

In conclusion, this overall assessment of men's needs in terms of attitudes, reproductive and sexual practices, and communication behaviour has provided some indication of where future programme priorities would be. In countries where men's opposition to family planning and disinterest in sexual and reproductive health seems more myth than reality, more efforts are needed in changing prevailing men's attitudes vis- -vis gender-based violence, risk taking behaviour and opportunities for safer sex negotiation. As men are generally excluded from reproductive health services, this is another niche to be filled to improve men's understanding of sexuality, their role in maternal health and mortality, and how to act on their procreation decisions. "Particularly urgent is the need to improve sexual responsibility among young men, including more condom use. Sexual activity often begins at a young age and before marriage. Because life-long attitudes and behaviour patterns often form during youth, addressing the needs of young men can have a long-term impact."[239]

[237] R. J. Cook (1995), p. 357.

[238] UNFPA, "Implementing the Reproductive Health Vision", p. 5.

[239] B. Robey and M. Drennan, "Male Participation in Reproductive Health".

Chapter 3

Future Programme Directions

This chapter spells out the philosophy, purpose and expected outputs of new programmes concerned with building effective partnership with men in sexual and reproductive health "partnering", and suggest some indicators.

What benefits could be derived from a partnership with men in sexual and reproductive health? Benefits can be grouped into six categories: social benefits, benefits to the community, benefits to couples, benefits to women, benefits to men and benefits to children.[240]

Social benefits refer to: the reduction of the HIV/AIDS pandemic by reducing male sexual partners' risks for HIV infection; the reduction of gender-based violence and harmful practices that affect women and powerless adolescents; the promotion of reproductive rights, which are respected when every individual is empowered to make informed and safe decisions on sexuality and reproduction; and the possibility of achieving equitable relationships between men and women.

Community benefits refer to: fewer adolescent pregnancies; fewer sexually transmitted infections (STIs), including HIV; fewer sex-specific abortions and incidences of female genital mutilation (FGM), and a more valued girl child; better understanding of, and community organization around, maternal health and survival, domestic violence, and adolescent needs for information, education and services; and increased understanding of how changing gender roles might benefit everyone.

Benefits to couples include: the possibility to negotiate sexual safety; joint decision-making in sexuality, procreation and parenthood; and more intimate and sexually satisfying sexual relationships.

Benefits to women include: increased sense of entitlement and empowerment in reproductive health and rights; consensual and more pleasurable sexual relations; less heavy burden for contraception, pregnancy, child rearing and domestic chores; and fewer risks of HIV/AIDS/STDs and domestic violence.

Benefits to men include: an increased sense of comfort with their own identity; an increased

[240] Adapted from M. E. Greene, "The Benefits of Involving Men in Reproductive Health" (paper presented at the Association for Women in Development and at USAID, November 1999).

understanding of their entitlements and obligations; better acknowledgement of their multiple sexual relations, including men having sex with men; increased skills to negotiate rather than impose decisions on women regarding sexuality, contraception, procreation and child-rearing; increased contraceptive use and higher rates of diagnosis and treatment of HIV/STIs, cancers, infertility, sexual dysfunctions and other psycho-sexual problems.

Finally, **benefits to children** include: offering of positive father role models, better care and nurturing from both parents; and the reduction of sexual abuse and domestic violence.

In a UNFPA-sponsored meeting in Asia, advocates for women's sexual and reproductive health described male involvement as "an active acceptance of, and support for, their female partners' needs, choices and rights in reproductive health. Male involvement, moreover, is viewed as leading to improved understanding of men's own reproductive and sexual behaviour. Because of their dominant positions (as policy-makers, media gatekeepers, religious leaders, managers and service providers, community leaders and heads of households), men could do much to ensure the success of population and reproductive health programmes. Their role is important for the promotion of gender equity, girls' education, women's empowerment, and the sharing of household chores and child-rearing within their families, communities and in the work-place, and they could significantly advance gender equity, girls' education, women's empowerment and the sharing of household chores and child-rearing. In their home, men can take a more active role by sharing reproductive decision-making with their partners, by supporting their partners' choices, and by practising contraception and/or periodic abstinence".[241]

The challenge of implementing the gender perspective of the Cairo mandate is to translate these broad principles into practical, operational strategies, and to achieve measurable changes in policies, programmes, communities and individuals.

Four programming frameworks, corresponding approaches and expected outputs

As the paradigm of population programmes evolves to reflect a stronger gender perspective, different approaches have been used to translate these broad goals into action. Specifically regarding men's participation, there are currently four frameworks that guide implementation.[242] These frameworks are located on a continuum from the absence of a gender perspective to a fully fledged one. First, the conventional *family planning model* predates Cairo but continues to inspire some strategies, including the research agenda. Second, the *men and family planning mode*" in vogue immediately after Cairo views men mostly as "contraceptors" and decision-makers in reproductive health. Third, the *male equality model* aims at men as reproductive health clients. Finally, the most recent model can be called the *gender equity in reproductive and sexual health* framework, and integrates a gender perspective in line with the ICPD spirit.

---

241 UNFPA and ECO, "The Role of Men in Population and Reproductive Health Programmes" (Baku, Azerbaijan, 21–24 September 1998), *Conference Report*, June 1999, p. 48.

242 M. E. Greene, "The Benefits of Involving Men in Reproductive Health".

Each of these models, their purpose, assumptions and limitations, and the implementation approaches of men's programmes that correspond to each of these frameworks, are reviewed. Approaches that pervade these programmes have stressed the following dimensions: solidarity, responsibility, health marketing, education and human rights.[243]

The pre-ICPD family planning framework from which men are nearly absent

Prior to Cairo, when the emphasis was to reduce fertility by increasing women's contraceptive prevalence, men were simply problematic in family planning programmes, but also absent from demographic research.[244] Because of the traditional relationship between fertility and health, the focus of these programmes was on women, because they experience pregnancy and childbirth in their bodies. Consequently, population studies took women as the unit of analysis, in spite of the fact that it is couples who reproduce.[245] Proof is found in the type of indicators that analyse women in union who use a contraceptive method without any explicit reference to men[246].

This conventional *family planning framework* is mostly concerned with the provision of contraceptive services, almost exclusively to women; it ignores explicit reference to gender in health practices and services and assumes that women's use of contraceptives will slow population growth. The main goal is demographic, the means are contraceptives and the target population is women. Examples of this model can be found in Ross and Frankenberg.[247] In this context, the reproductive behaviour and intentions of couples are not seen, as they should be, as a process of interaction and negotiation between men and women. "Males are identified as facilitators or obstacles to women in making reproductive decisions that generate a given level of fertility.... The male appears as a sort of collateral, with his participation in the reproductive process diluted".[248] Because males are seen as individuals who take part in reproduction in a secondary fashion, attempts to question their links to reproduction have also been treated in a secondary manner in data collection, contributing to our limited understanding of the male side of the equation. The result has been to distance and separate males from the experience of reproduction by not measuring it, investigating it or documenting it; and therefore, indirectly, demographic methodologies have contributed greatly to invalidating it.[249] Such beliefs may reinforce service providers' bias against male methods. Clearly, such a narrow, demographic-driven model should be abandoned.

---

243 S. I. Cohen and D. D'Cruz Grote, "Communication and Gender: Some Reflections Based on Experiences from UNFPA, UNICEF and UNAIDS" (presentation at UNAIDS Communication for Behaviour and Social Change Workshop, Geneva, August 2000).

244 M. Greene and A. Biddlecom, "Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles" (paper presented to the IUSSP/CENEP seminar on Men, Family Formation and Reproduction, Buenos Aires, May 1998).

245 J. G. Figueroa, "Some Reflections on the Presence of Males in the Reproductive Process" (forthcoming, in "Male Sexuality and Reproduction", El Colegio de Mexico, Union Internacional para el Estudio Cientifico de la Poblacion y Sociedad Mexicana de Demografia).

246 Ibid.

247 J. A. Ross and E. Frankenberg, "Findings from Two Decades of Family Planning Research", Population Council, New York, 1993.

248 J. G. Figueroa, "Some Reflections on the Presence of Males in the Reproductive Process".

249 W. Mbugua, e-mail of 20 October 2000.

The men and family planning framework

The *men and family planning framework* is a sort of transitional model placed between the pre- and post-ICPD paradigm. The motive behind involving men is still demographic in essence: it tries to encourage men to use contraception or to encourage their female partners to do so, in order to increase the overall contraceptive prevalence and to initiate and sustain fertility decline.[250] It builds on studies of "the decisive role that families and lineages play in demographic decisions. This type of analysis may be credited for inspiring programme interventions to focus on other *social groups* that influence reproductive decisions — age at marriage, use of contraception, timing of birth, rites of passage — not just individual men and women".[251] This perspective has helped us to see men and women as actors in fertility decisions. In parallel, surveys have indicated that men are more supportive of family planning than originally thought. The model adopts a more positivist view of men's potential to change,[252] and on concerns about HIV/AIDS. Contraceptive services are now targeting both men and women, but only as a practical consideration in pursuing other programme goals; which also translate into attempts to foster couple communication on fertility intentions, unwanted pregnancy and contraception. Practical flaws include the difficulty of integrating men into services that have long solely served women.[253] By viewing men as a route for women's well-being, they "instrumentalize" men and fail to address their needs.[254] Such a model still ignores sexual health in its totality, especially male motives for sexuality outside marriage and the negotiation of safe sex to prevent STDs and HIV/AIDS. Women's empowerment and gender-equity issues continue to be ignored in these programmes, and thus, do not fully reflect the gender perspective agreed to in Cairo. In fact, some believe that this framework contributes to strengthening traditional, unequal gender roles by relying on men to convince women to use contraceptives. This framework tends to be translated into two approaches that stress responsibility and/or solidarity.

The solidarity approach

This approach views men as supportive partners of women. The goal of this approach is to involve men as supportive and informed partners. Expected outputs of this approach are increased communication among couples about sexual matters and joint decision-making; men's support for pre- and postnatal care; and men participating in household responsibilities, including child-rearing.

Activities in this type of programme include educating and informing men about reproductive health and sexuality, including the importance of pre- and postnatal care; the risks, complications and symptoms of pregnancy and childbirth; and the role they can play in emergencies. Advocating male participation in safe-motherhood initiatives relies on education, information, counselling and community mobilization to enable men to become supportive partners.

---

250 M. Greene and A. Biddlecom, "Absent and Problematic Men".

251 W. Mbugua, e-mail of 20 October 2000, in which she refers to the work of John C. Caldwell, *The Theory of Fertility Decline* (Australian National University Academic Press, 1982).

252 For instance, see Z. A. Sathar and J. B. Casterline, "The Onset of Fertility Transition in Pakistan", working paper no. 112, Population Council, New York, 1998.

253 M. E. Greene, "The Benefits of Involving Men in Reproductive Health".

254 UNFPA, "Male Involvement in Reproductive Health: Incorporating Gender throughout the Life Cycle", *TSS Occasional Paper*, no. 1, June 1998.

The responsibility approach

This approach considers men as sexual partners with a set of obligations. The goal is to change men's and young men's attitudes and behaviour by providing them with information and tools to facilitate their practice of safe sex. Expected outputs include improved communication between couples and increased use of condoms, possibly for dual protection to prevent unwanted pregnancies and STDs, including HIV/AIDS. Reduction in the number of sex partners, and abstinence or delay in initiating sexual activities, may be expected outcomes of adolescent programmes. The approach tends to be grounded on a negative premise of men's irresponsibility, but also recognizes that if men do not take full responsibility for their sexual and reproductive behaviour, it may not be due to their irresponsible nature. Men are acting within a set of cultural norms that determine gender relations, roles and acceptable behaviour for each gender. Aspects of programmes using this approach include couple communication; information about infectious diseases, their symptoms and prevention, and available methods to protect oneself from becoming infected or spreading an infection; distribution of condoms, and the female condoms and how to use them. Social marketing may be is one component of service delivery.

The male equality framework

Another interpretation of the Cairo mandate, and probably the most controversial one, is the *male equality framework*. Programmes within this rubric assume that men have been neglected and that their reproductive health needs, as clients, must be met. Proponents of this view[255] interpret the Cairo mandate as a sort of remedial focus to fulfil the unmet needs of men. While the case is valid that men do have a wide range of sexual and reproductive health needs, such a proposition ignores the fact that the burden of reproductive mortality and morbidity is in great excess for women in comparison to men. When mentioning gender equity, the ICPD Programme of Action was mostly concerned with women's subordination and low status. This approach also hides the fact that family planning was not really offered as a simple good to women for their own benefit, but for the benefits of society and national interests.[256] These so-called male-equity programmes make no effort to integrate existing services for women with those provided to men, nor do they attempt to build partnerships between men and women. They tend to hire male providers for men, establish male-only clinics, and provide additional services, and in so doing, provoke concerns for diversion of scarce resources for women's health. However, such services certainly bring a more holistic view of sexual health; they bring more attention to male sexuality and help men see the gains of changing. This framework is translated into programmes that adopt the "health marketing" approach.

The health marketing, or meeting men's reproductive health needs, approach

The marketing approach views men as clients. It combines clinic-based services with community-based distribution and educational programmes in the workplace. This strategy offers men medical contraception, medical care and psycho-social support. By appealing to men's self-

255 C. Laudari, "Gender Equity in Reproductive and Sexual Health" (paper presented at UNFPA TSS thematic workshop on Male Involvement in Reproductive Health Programmes and Services, Rome, November 1998); T. H. Hull, "Men and Family Planning: How Attractive Is the Programme of Action?" (paper presented at the Psychosocial Meeting, New York, March 1999).

256 This situation was well articulated by M. E. Greene in "The Benefits of Involving Men in Reproductive Health".

interest, these activities hope to attract more men to reproductive health services. Historically, this approach has neglected the gender perspective. However, so long as it does not undermine existing programmes for women, these efforts should contribute to the reproductive health of women, men and children at the same time.[257]

The gender equity in reproductive health framework

The *gender equality framework* concerns itself with the sexual and reproductive health needs of men as equal partners of women (and/or other men). It recognizes that gender inequity influences not only fertility behaviour, but also reproductive and sexual health and rights in general, and that such inequities can only be addressed with the full participation and co-operation of men, because they hold more power and constrain women's choices. These programmes promote gender equity, and women's and men's reproductive health through substantial male participation.[258] "Men as Partners", the name AVSC International uses for its programmes that involve men, probably best captures the intent of the ICPD.

As in the men and family planning framework, this one emphasizes partnership in sexual and reproductive health in decision-making, and mutual support among couples in protecting themselves and each other from infections, unwanted pregnancy, and taking care of their and their partner's reproductive health, and their families. However, such a framework goes beyond the measurement of fertility and the provision of medical services. It connects reproduction with sexuality and views sexuality as an expression of gender and power relations between men and women; it questions gender identity, sexual practices and violence, and explores the possibilities of access to a satisfactory reproductive and sexual life from both an individual and social point of view. "It also considers men beyond the persons who participate by supporting or hampering the behaviour of the women with whom they reproduce".[259] Becoming aware of gender relations and power imbalances in sexuality opens up the possibility for considering behavioural and attitudinal alternatives for men as well as their partners. Understanding men's problems and coping mechanisms, translating these issues into male-identity models that serve better equality, and finding psycho-social advantages to changing male roles that do not perpetuate women's alienation thus appear as essential steps for transforming gender relations. Some challenges include convincing men that gender equality and women's empowerment is in their best interest.

Two approaches correspond to this latter framework, the educational approach and the human rights approach.

<u>The educational approach</u>

This approach reaches men early in their lives. It integrates a gender perspective into family life education, peer education and sex education. The goal is to sensitize male adolescents and boys about men's and women's sexual and reproductive health, gender inequalities, stereotypes and

---

[257] S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes", report for the Royal Ministry of Foreign Affairs, Oslo, Norway, 21 February 1999.

[258] M. E. Greene, "The Politics and Practice of Involving Men in Reproductive Health", Center for Health and Gender Equity, Takoma Park, Maryland, 1999, p. 8.

[259] J. G. P. Figueroa, "Some Reflections on the Presence of Males in the Reproductive Process".

the implication of traditional gender roles. Expected outcomes are graduates who are knowledgeable about gender inequalities, willing to resist peer pressure and to seek help, and who are committed and supportive of new roles and behaviours that empower women and allow them to achieve fulfilling relationships.

Frameworks and Corresponding Approaches of "Partnering"

Frameworks	Approaches	Purpose/Emphasis	Programme Implications
		PRE-CAIRO	
Family Planning	Women only	■ Increases contraceptive prevalence. ■ Reduces fertility	■ Contraceptive delivery to women only. ■ Absence of men.
		INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD) CAIRO, 1994	
Men and Family Planning	Solidarity Responsibility	■ Increases contraceptive prevalence. ■ Reduces fertility.	■ Contraceptive delivery to women and men. ■ Views men as actors in fertility decisions. ■ Downplays gender implications.
Male Equality	Health marketing or meeting men's reproductive health needs	■ Addresses men's reproductive health needs as much as women's RH needs have been addressed	■ Men as clients. ■ Appeals to men's self interest. ■ Downplays gender implications.
Gender Equity in Reproductive Health	Educational Human Rights	■ Promotes gender equity. ■ Promotes women's and men's reproductive health through substantial male involvement.	■ Men as partners. ■ Integrates a gender perspective. ■ Reaches out to young men and male adolescents ■ Protects reproductive rights, gender equality and child rights.

SOURCE: Adapted from M. Greene. "The Benefits of Involving Men in Reproductive Health." 1999.

260 W. Mbugua, e-mail of 20 October 2000.

261 UNFPA and ECO, "The Role of Men in Population and Reproductive Health Programmes" (Baku, Azerbaijan, 21–24 September 1998), *Conference Report*, June 1999, p. 48.

The human rights approach

This is a macro-social strategy that promotes zero tolerance for gender-based violence as a violation of human rights, and for harmful practices including FGM, early marriage, and polygamy and son preferences. It calls for legal systems that protect reproductive rights, gender equality and the rights of the child. The human rights approach also draws attention to the rights of women, and does not pressure men to conform to stereotypical gender norms, although some argue that such a risk or harm reduction approach tends to categorize men as the problem.[260] The right to good sexual and reproductive health means that services should be designed to meet the needs of both men and women, and that men should have access to information, knowledge and understanding about themselves and their partners.[261]

Expected outputs of "partnering" and indicators

Results-based management places a high value on efficiency, accountability and impact, and calls for organizations to measure the effects of their work. Organizations are being asked to assess results of their activities via *output indicators*, and quantify the activity provided via *process indicators*. Indicators play an important role in all stages of a programme, from design to implementation, and from monitoring to evaluation. The aims of creating indicators of "partnering" from a gender perspective are to create a set of tools for the women's health movement, the users of services and the health services themselves. This implies selecting those variables that would best bring to light any changes that should be made based on the results of research. Clearly, there are many possible indicators from a gender perspective, and they can be adapted to the particular needs of each evaluation. The process of selecting indicators also helps establish a consensus on the changes that need to be made and the indicators needed to evaluate them.[262]

The expansion of sexual and reproductive health services into a change in social norms and behaviours that govern gender relations is driving the need to develop new outputs and corresponding indicators for "partnering" programmes. Embracing a gender perspective in programming for sexual and reproductive health calls for redefining outputs. Such outputs are informed by underlying assumptions, as described above, and theories of social change.

The ICPD Programme of Action and the Beijing Platform, and the renewed commitment in their respective follow-up processes, mandate the involvement of men in population and development, sexual and reproductive health programmes to achieve the following outputs:

1) Redress current imbalances that are linked to patriarchy and men's own discomfort with their identity, and that alienate women's attainment of reproductive and sexual rights as through violence directed at women and girls;

2) Promote equality in gender and sexual relations via partnerships in actions indirectly related to reproduction (e.g., fatherhood, sexual safety);

3) Promote equality in gender and sexual relations via partnerships in actions directly related to reproduction and sexuality;

---

[262] M. I. Matalama, "Gender-Related Indicators for the Evaluation of Quality of Care in Reproductive Health Services", *Reproductive Health Matters* 6, no. 11 (May 1998): 19.

4) Improve male and female reproductive health;

5) Promote safe and healthy reproductive and sexual behaviour in men, including young men.

Interestingly, in evaluating gender approaches, we may have done a better job at identifying gender inequality problems than in translating these approaches into positive behavioural outcomes directed at solving the problems. What is in fact a gender-equitable man? The working definition of Barker, which he applied to young men, deserves some thought: "Equitable young men are respectful in their relationships with women and seek relationships based on equality with their partner. They support the notion that women have as much sexual desire and entitlement to a sexual role as do men, and they seek and form intimate relationships that go beyond physical relations and sexual conquest."[263]

Expected Behavioural Outcomes from Gender Equity-based Programmes in Reproductive and Sexual Health and Rights Programmes, with a Focus on Men[264]

- Promoting gender equality in labour policies, health and education: promoting paternity leave; opposing harmful practices such as FGM, son preferences, early marriage, "sugar daddies" and non - consensual polygyny; supporting the education and training of girls and women; promoting women's access to reproductive and sexual rights; mobilizing against gender-based violence; providing gender-sensitive reproductive health services; and demanding that life-planning skills and sexuality education be taught in schools;
- Eschewing gender violence in men themselves and opposing it in others,[265] and promoting non-aggressive conceptions of male sexuality and masculinity;
- Practising responsible fatherhood: supporting their partners in child-rearing and household tasks; protecting their children's health and investing in their future; teaching their sons respect for girls and women's needs and perspectives; developing open and supportive relationships with their daughters; providing their children with accurate and sensitive information and positive role models;
- Protecting their partner's health and supporting her choices: adopting sexually responsible behaviour; communicating about sexual and reproductive health concerns and working together to solve problems; considering adopting male methods of contraception (including vasectomy and condoms); arranging transport to reproductive health services and paying for reproductive health service costs;
- Confronting their own reproductive health risks: learning and acting on how to prevent or treat sexually transmitted infection, impotence, prostate cancer, infertility, sexual dysfunction and violent or abusive tendencies; using condoms consistently; seeking health care and psycho-social support.

263 G. Barker, "Exploratory Operational Definitions of Gender Equitable Behavior by Young Men", notes from dissertation research, July 2000.

264 Adapted from *State of the World Population Report*, 2000: Living Together, Worlds Apart, UNFPA, p. 36.

265 A recommendation in *Memorias del Simposio Sobre Participatión Masculina en La Salud Sexual y Reproductiva: Nuevos Paradigmas* (report of a meeting in Oaxaca, Mexico, October 1998), AVSC International, New York, 1999.

In the same spirit, the list above proposes a set of behavioural outcomes.

Specific output indicators are identified in the same order. The range of indicators includes both quantitative and qualitative ones, even though qualitative indicators are often undervalued by the health services.[266] The indicators need to be prioritised and ordered according to the level of intervention, whether social, institutional or individual.

1) In highly detrimental contexts, it may be necessary to adopt a remedial approach to redress current imbalances that are linked to patriarchy and men's own discomfort with their gender identity, and that alienate women's attainment of reproductive and sexual rights.

Corresponding output **indicators** include:[267]

- changes in the way police, courts and hospitals handle victims of violence, including complications of unsafe abortions;
- changes in policies and enforcement of anti-domestic violence laws; media coverage that condemns violence against women;
- changes in rates/incidence of violence;
- changes in community awareness of the existence of such violence;
- changes in men's attitudes vis-à-vis harmful practices such as FGM for their own daughters and granddaughters and future wives, son preferences, polygamy and forced marriages.

This output calls for mobilization activities against violence perpetrated against women, including domestic sexual abuse; work with the judiciary bodies, police and health settings to identify victims; work with the perpetrators; and addressing the root causes of violence such as poverty.

2) The promotion of equality in gender and sexual relations via partnerships in actions indirectly related to reproduction calls for greater donor awareness and support for "partnering" initiatives, greater availability of resources and materials at the regional level, and building a more sophisticated knowledge base on men, and safe motherhood.

Possible **indicators** include:[268]

- changes in language and implementation of donor and government policies and legislation, espe-cially those related to male norms that affect reproductive and sexual health (e.g., see Sweden's laws on paternity leave);
- changes in donors' and national policy-makers' attitudes and knowledge about male gender norms and women's reproductive and sexual rights.

---

[266] M. I. Matalama, "Gender-Related Indicators for the Evaluation of Quality of Care in Reproductive Health Services", p. 18.
[267] N. Yinger and E. Murphy, "Illustrative Indicators for Programming in Men and Reproductive Health" (draft presented at IGWG plenary meeting, 6 October 1999).
[268] Ibid.

The knowledge base on male identity and gender concerns calls for measurement of:

- changes in men's knowledge about their coping mechanisms, and their seeking psycho-social support;
- changes in men's attitudes about gender roles, and men's knowledge of women's sexual and reproductive rights as human rights;
- more equitable sharing of household and child-rearing tasks;
- and changes in male adolescents' knowledge and attitudes vis-à-vis gender roles.

At the national level, this includes legal and policy interventions that encourage fathers to play a greater role in essential aspects of safe motherhood and child-rearing. Programming categories include social and community mobilization for normative change, education on gender equity, and communication to support behaviour change (media and policy advocacy).

Indicators of Gender-equitable Behaviour in Young Men

Barker[269] offered additional indicators to operationalize his working definition of gender-equitable young men:

- Gender-equitable young men criticize or question the prevailing double-standard that men are "allowed" or expected to have outside or occasional sexual partners in addition to their girlfriend, spouse or partner, while women are expected to be faithful to their boyfriend, spouse or partner.
- They seek to be involved fathers. "Involved" means that they believe they should take financial and at least some care-giving responsibility for their children. They show this involvement by providing at least some child care, showing concern for providing financially for the children, and/or taking an active role in caring for their children's health.
- They assume some responsibility for reproductive health issues. This may include taking the initiative to discuss reproductive health concerns with their partner, using condoms, or assist ing their partner in acquiring or using a contraceptive method, or in seeking an induced abortion.
- They do not use violence against women in their intimate relationships, and they are opposed to violence against women. This may include young men who report having been violent towards a female partner in the past, but who currently believe that violence against women is not acceptable behaviour for men — is not "right" — and who do not condone this behaviour by other men.

3) In promoting equality in gender and sexual relations via partnerships in actions directly related to reproduction and sexuality, corresponding **indicators** could be:[270]

- the extent to which sexual relations are desired by both partners as opposed to being forced;
- the extent to which both partners are able to negotiate sexual safety;

269 G. Barker, "Exploratory Operational Definitions of Gender Equitable Behavior by Young Men".

270 J. G. Figueroa, "Some Reflections on the Presence of Males in the Reproductive Process".

- the extent to which pregnancy is desired by both partners as opposed to unwanted;
- whether contraception is negotiated, imposed or unilaterally used;
- the extent of negotiations for the care of the products of pregnancy, including its complications (see Figueroa for a discussion of a new research agenda).

The following additional **indicators** are adapted from Yinger and Murphy:[271]

- changes in providers' attitudes about the role of men in support of women's sexual and reproductive health;
- changes in health clinics to make it easier for men to attend delivery and its complications;
- changes in providers' and men's attitudes towards abortion and support for the women;
- changes in men's understanding of pregnancy danger signs, and their taking action during pregnacy, childbirth, and post-partum or post-abortion complications.

Additional **indicators** should also be considered:

- the extent to which policies and legislation support individuals' ability to negoti at safer sex in high
- risk contexts (e.g., compulsory condom use in brothels, access to condoms in refugee camps);
- society's acceptance of adolescents' sexuality;
- men's awareness of greater women's vulnerability to STDs, HIV/AIDS;
- men's acceptance of women's right to a satisfying and safe sexual life.

A wide range of programming initiatives is available in this area. These include training providers to offer couples sexual and reproductive health services, including post-abortion care and counselling; behaviour change communication, including community mobilization about the dangers of pregnancy and delivery and how to address them; youth peer counselling for expectant fathers and active sexual partners; and behaviour change communication on shared decision-making on sexuality and procreation.

4) Improve male and female reproductive health. Output **indicators** include (adapted from Yinger and Murphy):[272]

- changes in providers' attitudes and skills in offering quality services to men and couples;
- changes in men's knowledge, acceptance and use of reproductive health services;
- changes in men's and women's knowledge of their bodies, male sexual and reproductive dysfunction and symptoms, and where to obtain services;

[271] Ibid.
[272] Ibid.

- promotion and provision of dual protection services; prevalence in use of male FP and safer sex methods.

Programming in this area includes participatory community assessment of men's reproductive unmet needs from the perspectives of men, couples, women and adolescents; reproductive health education and services in health settings, workplace programmes and social marketing venues, including community-based distribution; reproductive health promotion via media campaigns; provider training and behaviour change; and special reproductive health services for men.

5) The promotion of safe and healthy reproductive and sexual behaviour in men, including young men, can be measured with such **indicators** as:

- changes in reproductive health services that integrate maternal and child health/family planning willprevention of reproductive tract infections and STDs/HIV/AIDS, voluntary counselling and testing, and care;
- changes in men's intentions to reduce harm and safeguard their own and their partner's bodies;
- condom use by both partners; communities' acceptance of sexuality education for adolescents;
- changes in school programmes to offer education and counselling on safer sex;
- changes in adolescents' sexual practices, including delay of sexual experience, age of marriage, first pregnancy, and practice of safer sex.

A variety of programming interventions would accompany such changes, including research on male sexual networks, and men's motives and social circumstances that underlie risk behaviour; behaviour change communication to increase men's sense of self-efficacy in staying sexually safe; couples' individual ability to negotiate safer sex; adolescence and sexuality education in various settings, including parent education and community mobilization.

Chapter 4

Programming Considerations

Addressing gender roles in reproductive and sexual health raises the issue of conflicting interests. A women's right to decide whether, when and the number of children to have is a cornerstone of the women's movement and a right that could seem threatened if men are going to be included in reproductive and sexual health. In many countries, men are the decision-makers and still control women's reproduction and sexuality. Including men in population programmes may initially appear as a step back rather than forward, particularly if inadequately focused programmes transfer the "locus of control from women to men".[273] Existing male-involvement programmes tend to share potentially problematic aspects: first, male components are usually limited to male methods of family planning, only one element of reproductive health. Second, they tend to address only men, in a similar way as the old programmes addressed only women, without taking into account their gender relations. A focus on men only is as inadequate as a focus on women only, because it fails to take into account the way in which many decisions are made and the context that influences them. Third, they tend to be grounded on a negative premise, men's irresponsibility, rather than a positive one of promotion of men's rights. Fourth, by viewing men as a route for women's well-being, they seem to "instrumentalize" men and fail to address men's needs.[274]

In order to avoid a shift in the locus of control, programmes should aim to incorporate not only *more* involvement, but *adequate* male involvement. Thus, programmes should be based on the understanding of gender dynamics, on how decisions are made and implemented, on the changing needs of both genders and their interaction. This chapter reviews a number of programming principles that could guide *appropriate* male involvement, as opposed to *more* male involvement, in the areas of ethics, resource allocation, and some strategic planning approaches to identify priorities.

Addressing ethical issues

An organization that wants to tackle gender issues has to start by assessing itself in gender terms; it must evaluate the impact it has based on its own gender relations. This undertaking is not an

[273] C. Laudari, "Gender Equity in Reproductive and Sexual Health" (paper presented at UNFPA TSS thematic workshop on Male Involvement in Reproductive Health Programmes and Services, Rome, November 1998).

[274] "Male Involvement in Reproductive Health: Incorporating Gender throughout the Life Cycle", *Technical Support Services Occasional Paper*, no.1, UNFPA, June 1998, pp. 6–11.

instrumental measure, but rather an ethical demand.[275] This is also true of health organisations. Indeed, achieving effective partnerships with men poses challenging ethical issues for providers, both internally and in their dealings with clients. Specifically, providing services for men and/or including husbands in health care for their spouses raises a number of ethical issues, as follows:[276]

- The goal of providing reproductive and sexual health services to men is intended to benefit both men and women. Hence, careful monitoring must be integrated into programmes to make sure that paying more attention to the needs of male clients does not come at the expense of the needs of female clients.[277] Given current gender power imbalances and the fact that women are the ones who die in childbirth, women's empowerment and gender equality remain critical elements of reproductive health programmes. It is essential to assure that women maintain the gains they have made towards achieving the sexual and reproductive rights that enable them to make sexual and reproductive health choices in a free and non-coercive way.
- Services for men must not take away or undermine quality of reproductive health services for women; for example, providing information to the husbands should not become a substitute for giving counselling to the women. The provision of services for men should not affect the quality of services women receive; for instance, by making providers less available to provide services for women, or by making women who go to those facilities uncomfortable due to the presence of men.

- Providers need to be sensitive to the needs of women and continue respecting their privacy. Women should be asked if they want their husband to be involved in their health care, so that women's autonomy will not be undermined. The delivery room, according to the preference of some women and providers, remains off-limits to most men. A study in Kenya found that women preferred that the labour ward and delivery room should remain women's territory. This may be due to the crowding and lack of privacy.[278] Changes in the configuration of services may need to be addressed, as men and women strengthen their reproductive partnership and needs change.
- Involving husbands could result in undermining women's autonomy and in reinforcing men's control over women. Between 7 and 20 per cent of women use contraceptives without the knowledge of their husbands in sub-Saharan African countries.[279] Involving husbands could pose a risk to some patients who terminated a pregnancy without the knowledge of their husbands. Training should help providers resolve ethical dilemmas; for example, which side should the provider take in the case of husband-wife disagreement about a specific issue. Providers also need to be trained to face such challenging ethical issues as consent, privacy and parental rights.

---

[275] B. Egero, "Considerations on Male Involvement" (presentation at UNFPA Gender Advisory Panel, New York, 23–25 March 2000), p. 7.

[276] "Seminar on Male Involvement in Reproductive Health: Summary of Findings from Operations Research", *Frontiers* (Population Council, Alexandria, Egypt, 4–5 May 1998).

[277] AVSC International, *Introduction to Men's Reproductive Health Services*, 2000, p. 1.3.

[278] Population Council, "Integrating Men into the Reproductive Health Equation: Acceptability and Feasibility in Kenya", The Robert H. Ebert Program on Critical Issues in Reproductive Health, 2000, pp. 10–11.

[279] M. E. Greene and A. Biddlecom, "Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles", *Population and Development Review* 26, no. 1 (March 2000): 95.

- Services for youth should be provided in a culturally sensitive manner to minimize negative reactions from parents or other stakeholders. Every effort should be made to protect the confidentiality and privacy of youth seeking those services.

Allocation of resources and costs of men's programmes: diversion from women's programmes?

Although there is growing acceptance of the important roles men play in achieving the ICPD objectives, five years after Cairo serious tensions appear in the implementation of the Programme of Action. There is a genuine concern among some women's health advocates that involving men will divert resources deemed insufficient to achieve women's health objectives and redirect them to men's health programmes; worse yet, that it may contribute to men regaining control of women's reproductive and sexual lives. Others argue that when services are set up based on an understanding of the underlying gender relations, they will benefit both women and men, and thus services for men are not necessarily expensive, nor do they compete with the scarce resources available for women's services.[280]

The true costs of providing health care services to women and men remain unknown. The emphasis on co-existing services that build on established structures, capacities and skills is intended to reduce the cost of providing separate services for men and women. A study conducted in 1997 for USAID concluded that major progress in male involvement requires additional funds to cover the costs of research, outreach strategies, and interventions to reach rural men and adolescent males. Men's reproductive health requires services that do not exist in current programmes. Staff need to be trained, and issues such as male dominance, gender roles, sexual mores, marriage and family relations, all profoundly affecting reproductive health, need to be addressed.

AVSC International has developed a list of activities that health facilities can initiate for men, and has broken them down into cost categories. Cost estimates vary depending on the country and context, but provide some idea of the types of services that can be provided at minimal cost.[281] For instance, allowing men to participate in family counselling sessions with their partners, with their partners' consent, and encouraging female clients to discuss family planning and reproductive health with their partners, can be integrated into existing counselling services at little or no additional cost. Providing special counselling services to men, however, requires expenditures for training counsellors, adjusting the facility, making a space available to assure men of privacy, confidentiality and promotion. The costs of integrating screening services into existing services range from medium to high, since this involves training staff training staff in male sexuality and working with men, conducting male examinations, creating a private space for examining men, and possibly hiring more men as front-line staff, to help male clients feel more comfortable when they arrive at the facility. Other costs that need to be considered are designing or adjusting the facility so that it is welcoming to men, advertising to inform men about these

[280] UNFPA, "Male Involvement in Reproductive Health: Incorporating Gender throughout the Life Cycle", pp 6–11.

[281] AVSC International, *Introduction to Men's Reproductive Health Services*, pp. 6.6, 6.7.

services, and social marketing campaigns to motivate men to use them.[282] Finally, integrating or starting clinical services for men is costly, because it requires hiring specially trained providers; training existing staff; offering testing and treatment for STIs, including HIV testing and counselling; and providing treatment for impotence, erectile dysfunction, infertility, vasectomy. Promotion and facility-adjustment costs listed under "screening" apply here as well.

The USAID study also found that NGOs have been very resourceful in finding ways to support programmes for men.[283] In a few cases (for example, Profamilia in Colombia) profits from reproductive health programmes for men have been used to subsidize services for women. Recently, family planning associations in Latin America have begun to sell their information, education and communication (IEC) programmes to the public sector. In Colombia, for instance, as a consequence of health reform, the government contracted with Profamilia to provide health services to the public. Bemfam, the family planning association in Brazil, has contracts with local municipalities and provides health services and training for the municipalities' health providers. The associations are marketing their services in creative ways that offer buyers options. Selling curricula or marketing information and education services to large employers is another means through which to finance men's health services. For instance, an employer can purchase the curriculum and have in-house trainers teach it, or can decide to buy a complete programme that includes a specially trained facilitator to run the workshops.[284] Some condom-marketing projects have become self-supporting within a few years of their inception.[285] Another scheme is cost-sharing. In Madagascar, an employer-financed health maintenance organization, the Association M dicale Inter-Entreprises de Tananarivo (AMIT-Inter-enterprise Medical Association of Tananarivo) is sharing costs with Management Sciences for Health/APROPOP. The latter provides training, contraceptives, technical assistance, IEC materials and modest funding to cover transportation for supervision, while employer and worker contributions pay personnel, infrastructure and service provision costs.[286]

[282] Ibid., p. 6.7.

[283] N. Danforth and C. P. Green, "Involving Men in Reproductive Health: A Review of USAID-Funded Activities", USAID and Population Technical Assistance Project, 1997, pp. 35–36.

[284] Personal communication with IPPF/WHR staff, September 2000.

[285] N. Danforth and C. P. Green, "Involving Men in Reproductive Health", p. 36.

[286] C. Severo et al., "Factories, Port Authorities and Vineyards: Why Do They Care? Enterprise-based Distribution of Family Planning Services in Madagascar: Results of the First 18 Months" (paper presented at APHA, 1997), p. 2.

The range of reproductive health services for men according to their cost[287]

No-Cost Services

- Allowing men to participate in family planning counselling sessions with their partner
- Encouraging female clients to discuss family planning and reproductive heath with their male partners
- Discussing male methods of contraception with men.
- Encouraging male and female clients to bring in their partners for STI testing.
- With their partner's permission, allowing men to observe their partner's reproductive health visits and procedures to generate awareness and encourage support.
- Encouraging men to be supportive of prenatal care, post-partum care and safe motherhood.
- Encouraging male community and religious leaders to promote the men's services offered at a facility.
- Promoting men's services at community education workshops.
- Forming partnerships with other male-oriented community groups.
- Displaying male-related posters on clinic walls.
- Putting male-oriented magazines in the waiting rooms.

Low-Cost Services

- Putting male-oriented magazines in the waiting rooms.
- Including "men's services" on facility signs and on leaflets that advertise services.
- Conducting community-education workshops with men.
- Conducting educational sessions with men within the clinic.
- Conducting and teaching self-testicular exams.
- Conducting prostate cancer screening.
- Providing parenting and fatherhood education at the clinic or in the community.
- Developing medical record forms that are suitable for male clients.
- Forming a satisfied-clients panel to conduct education in the community.

Moderate to High-Cost Services

- Hiring male front-line staff workers.
- Providing condoms free of charge to clients.
- Designating a rest room for men only.
- Scheduling clinic hours for times when men are likely to attend.

---

[287] AVSC International, *Introduction to Men's Reproductive Health Services*.

- Designating special hours for male-only clinics.
- Providing men with testing and treatment of STIs, including HIV testing and counselling.
- Providing treatment for impotence or erectile dysfunction.
- Providing infertility treatment for men.
- Providing vasectomy services.
- Training staff in male sexuality and working with male clients.
- Training service providers in counselling men and conducting male examinations.
- Creating a private space for counselling and examinations.
- Advertising men's services in newspapers, on the radio, and via flyers.
- Conducting a social-marketing campaign in the community to motivate men to use services.
- Changing the name of the facility so that it is appropriate for men.
- Designing the décor of the facility so that it is welcoming to men

High-Cost Services

- Hiring male service providers.
- Designating a special section of the facility for men only.
- Offering a male-only clinic.

THE NEED FOR A HOLISTIC AND MULTI-PRONGED APPROACH BEYOND FERTILITY AND HEALTH: REPRODUCTIVE AND SEXUAL HEALTH AND RIGHTS WITH A GENDER PERSPECTIVE

Partnership with men from a gender perspective is a multi-dimensional concept, which requires a holistic programme approach. Such an approach is based upon an examination of larger social, structural and cultural, political, economic and environmental contexts. It aims at a deeper understanding of multi-causality that is reflected in social and gender processes. The ICPD Programme of Action integrates sexual and reproductive health into a wider social context by recognizing that cultural, economic and social circumstances affect people's sexual and reproductive behaviours. To achieve the ICPD goals in the area of male responsibility, a holistic approach that goes beyond fertility and contraceptive use is required.[288] For instance, assumptions based on traditional gender roles, such as the belief that girls need education less than boys, contribute to the gender gap. Boys and girls should learn that they are equal to the family and to society, and that "denial of another's humanity diminishes their own".[289] Furthermore, the impetus to concentrate on promoting health rather than just treating disease and dysfunction necessitates a consideration of the social, economic and environmental determinants of health;

[288] B. Egero, "Considerations on Male Involvement", p. 7.

[289] N. Sadik, "Human Rights and Global Needs: Ethical Considerations in Population Policies" (statement made at the CORDAID Symposium, Netherlands, January 1998).

for instance, gender-based discrimination that denies women opportunities for achieving physical and mental health.[290]

Strategies need to make a difference between our expectations and the realities; but we first need to consider the context in which people live, since it conditions their ability to change. Then, we can build on people's own individual power to conform to/oppose standards of gender conduct. Strategies regarding a gender perspective in reproductive and sexual health that focuses on men therefore need to address the mix of social and individual factors to achieve our goals. Macro-social and micro-social and long-term and short-term approaches can be combined and readjusted as needed.[291] To ensure successful outcomes, programmes need to be guided by assessments of men's and women's needs in a given community, a general knowledge of the extent to which the community is receptive to gender equality and social change, and existing structures, capacities and skills. The notion of practical needs versus strategic needs is helpful to assess such needs.[292] All organizations in the community, in the market and in the state follow rules, activities and resources that are characterized by power relations shaped by gender roles. To involve men as partners we need to understand:

- the norms, activities, resources and power in the reproductive sphere;
- how these play out in a given institution in different geographical and cultural contexts;
- how different organizations relate to each other in complex webs of influence, such as state laws that oppose sex education for adolescents or policies that require a husband's authorization in order for a wife to receive health care, and how these factors affect behaviour, including reproductive behaviour.[293]

"In approaching gender issues, programs often face a difficult decision — how much to accept a society's gender roles and work within their confines to make health gains in the short term, and how much to devote attention to the long-term task of changing gender roles to promote gender equity. For example, increasing condom use for HIV prevention through social marketing is a practical short-term need. Changing social norms so that women no longer fear violence in negotiating condom use and consensual sexual relations is a strategic interest.... Long-term social change can seem threatening to men who see power distribution as a zero sum game, in which women can gain only if men lose. Practical needs and strategic interests need not conflict, however. In fact, addressing the practical needs of women can be an "entry point" to working for longer-term gender equity or fairer power relations.[294] Therefore programs need to address strategic interests with an eye to minimizing opposition and gaining support from male leaders".[295]

---

290 R. J. Cook, "Gender, Health and Human Rights", *Health and Human Rights* 1, no. 4 (Cambridge: Harvard School of Public Health, 1995), p. 358.

291 A. Wouters, trip report from Zambia, UNFPA CST Harare, 15 January 1999.

292 CEDPA, "Gender Equity: Concepts and Tools for Development", Washington, DC, 1996.

293 UNFPA and ECO, "The Role of Men in Population and Reproductive Health Programmes" (Baku, Azerbaijan, 21–24 September 1998), *Conference Report*, June 1999, p. 52.

294 CEDPA, 1996, "Gender Equity: Concepts and Tools for Development".

295 M. Drennan et al., "New Perspectives on Men's Participation", Population Reports, series J, no. 46, (Johns Hopkins University School of Public Health, October 1998).

While no programme can effectively incorporate all possible aspects of a holistic approach to male roles, it is essential to identify a few key dimensions for intervention from micro to macro levels. This wide angle allows us to work on both ends of the continuum, from promoting less damaging practices (practical needs) to promoting social change (strategic needs). This implies that population policies and programmes must be co-ordinated with other sectors within communities, including education, employment and religions to address gender biases that leave women dependent on men and undermine women's rights. For instance, desired family size can be influenced by investing in education and health, particularly for women, while population growth can be stabilized by delaying marriage and improving the social and economic opportunities of young people.[296] Policies that increase women's political participation and protect women from violence are also key to empowering women.[297]

Adopting a life-cycle approach to assess men's profiles and needs

A life-cycle approach is also suggested by some to examine gender systems and their implications for gender relations, sexuality and reproductive health.[298] The life cycle is a common feature of all human populations and provides a useful format for incorporating interdisciplinary perspectives, including the socio-cultural context. Moreover, its framework can be effectively utilized to generate participatory discussions (with colleagues or informants) in settings where little is known about male perspectives.

This approach considers health from a holistic perspective, including the fact that people's needs change as they evolve. A life-cycle approach considers the implications of reproductive health programmes for children (education for parents and children); adolescents, adults and older adults; and some discriminatory health and education practices because of age.

The life-cycle approach has been very useful in the understanding of the prevalence and incidence of age-specific discriminatory health and education practices affecting women. Comparing male-specific aspects of the life cycle with those of the female can highlight key issues, characteristics and roles of each gender. This assessment would lead to a pertinent analysis of the actual, ascribed and prescribed roles of each gender, and help identify areas of intervention.

The two following examples illustrate how a life-cycle approach may inform programmes. The first is from Brazil and indicates generational changes as follows: "One observes among the men in the younger generation (ages 25 to 39) a greater and more spontaneous concern regarding the overwork their partners are subjected to, and they recognize the importance of the women's careers. The men in this group also show a more authentic interest in their children and express greater pleasure in affectionate contact. This is a generation that seeks solutions on a more personal level in both their professional life and their family relations, by practising more intensely what had been announced in the generation before it."[299]

---

[296] M. E. Greene, "The Politics and Practice of Involving Men in Reproductive Health" (paper presented at AWID and USAID, Center for Health and Gender Equity, November 1999), pp. 6–7.

[297] G. R. Gupta, "Gender , Sexuality, and HIV/AIDS: The What , the Why, and the How", plenary address, XIIth International AIDS Conference, Durban, South Africa, July 2000, p. 11.

[298] UNFPA, "Male Involvement in Reproductive Health: Incorporating Gender Throughout the Life Cycle", pp. 6–11.

The other example of using a life-cycle approach concerns mid-life concerns for men. A UNFPA workshop found that there are lots of unanswered questions regarding the social lives and needs of older men:[300] "As men grow older, they become insecure and feel that the wife and children are ganging against them. Some resort to violence, hostility, alcoholism or take on younger girl friends or more wives in a bid to assert their ego and sexuality. In turn, younger women exploit these old men in order to get at their money. Therefore, helping everyone to understand the dynamics of ageing and how to support those going through the change' is a very important but neglected aspect of public health."

However, some researchers[301] point out that there are situations not reflected by life-cycle patterns, in which women's and men's interests may or may not coincide. For instance, in the case of non-married partners, common interests to avoid unwanted pregnancy or STDs may be less easily acknowledged and negotiated among partners than in married couples. Other situations such as poverty, in which households are struggling together on the economic front, may bring more agreement on livelihood strategies and common interests, including reproductive intentions and outcomes.

The need for more research, monitoring and evaluation to learn about men's perspectives on sexuality, violence, family matters and what works

Identifying men's needs is a critical step in establishing services for men. Existing tools have to be adjusted and new ones are needed that inform and address changing priorities. The inclusion of men in sexual and reproductive health is rendering conventional tools inadequate, because they were developed to inform about women's fertility and reproductive behaviour. For example, previous DHS were inaccurate in reflecting men's needs, because men have more than one sexual partner, and their unmet needs may differ from one partner to another. Furthermore, current DHS do not take into consideration polygamy, prevalent in several African societies.[302] In fact, strategies that analyse fertility and most of the current indicators are constructed and calculated as a function of women.[303] In addition, current knowledge about men's perspectives on family matters and violence is sketchy and provides few clues about successful strategies and viable methods to reduce men's use of violence.

299 M. Muszkat et al., "When Three Is Better Than Two", WHO/HRP, 2000, p. 2.

300 UNFPA/CST, *Report of a Sub-Regional Workshop on Access and Quality of Reproductive Health Services*, vol. 1, Addis Ababa, Ethiopia, 2–10 October 1997, p. 42.

301 J. Casterline, personal communication, Geneva, 2000.

302 P. Ngom, "Men's Unmet Need for Family Planning: Implications for African Fertility Transitions" *Studies in Family Planning* 28, no. 3 (1997): 193, 195.

303 J. G. Figueroa, "Some Reflections on the Presence of Males in the Reproductive Processes" (forthcoming, in "Male Sexuality and Reproduction", El Colegio de Mexico, Union Internacional para el Estudio Cientifico de la Poblacion y Sociedad Mexicana de Demografia).

Other key areas for research identified at the UNFPA Expert Consultations held in Africa,[304] the Arab States,[305] Asia and the Pacific, [306] Latin American and the Caribbean,[307] are:

- Research frameworks within social contexts that respond to use needs and take into account life-cycle considerations and a gender perspective.
- Interdisciplinary research that considers how real life situational factors influence decision-making processes.
- Contraceptive research on new methods that "resolve rather than exacerbate the complexities in people's lives".
- Men's understanding of, and their stand on, traditional practices that are harmful to women.
- Men's understanding of high-risk sexual behaviour, sexual deviance and violence.
- Men's responses to programmes that seek to "re-socialize" men and women to adopt shared decision-making in family planning and seek health for STD and HIV/AIDS prevention.
- Men's perceptions and health-seeking behaviours "with respect to their reproductive and sexual diseases and conditions".[308]
- A national research and policy-needs assessment in reproductive health. This is a vital step in designing an effective country-wide reproductive health programme that will identify gaps and types of approaches that may be most successful in a country. This type of needs assessment can also serve as a baseline study for later evaluations to determine what works and what doesn't work.
- The needs of marginalized, vulnerable and underserved populations, including adolescents; the impact of substance abuse on sexual and reproductive behaviour; violence and its implications for women and men; and the importance of focusing on met and unmet needs.

Other areas for research include gaining information about men's understanding of their roles as sexual partners and as fathers; their choices with regard to fertility and contraceptive use, and how these choices are supported by or undermined by governmental, religious and provider attitudes and practices; and how partners affect each other's use of reproductive health and family planning information and services.

---

304 UNFPA, "Expert Consultation on Operationalizing Reproductive Health Programmes: Africa", *Workshop Proceedings*, Addis Ababa, Ethiopia, 25–30 January 1997.

305 UNFPA, "Expert Consultation on Operationalizing Reproductive Health Programmes: Arab States", *Workshop Proceedings*, Rabat, Morocco, 24–28 November 1997.

306 UNFPA, "Expert Consultation on Operationalizing Reproductive Health: Asia and the Pacific", *Workshop Proceedings*. New Delhi, India, 22–26 November, 1997.

307 UNFPA, "Expert Consultation on Operationalizng Reproductive Health Programmes: Latin America and the Caribbean. Lima", *Workshop Proceedings*, Lima, Peru, 3–7 November 1997.

308 UNFPA, "Expert Consultation on Operationalizng Reproductive Health Programmes: Africa", p. 15.

We have other methodological problems as well. For instance, field workers (or other behavioural scientists) rarely observe the sexual act or couples' interactions. Underreporting of such practices as heterosexual anal intercourse, or denial of extramarital partnerships in societies that provide for the illicit maintenance of a "common law" household, are illustrative of problems of this sort encountered today.[309] To deal with such sensitive issues, gender and values of researchers also need to be considered. In addition, measuring men's and couples' unmet needs remains problematic for the following reasons:

- Men have different reproductive intentions than women; their decision to have children is not time bound, unlike women's. Men's "latent" desire to father conflicts with women's "urgent" one.[310]
- Men's power influences women's reproductive decisions.
- Men's reproductive intentions are different with partners inside and outside of marriage; and in polygamous marriages, they differ from one wife to another.
- Respondents to surveys tend to over-report their use of contraceptives.
- The same man may be using a contraceptive with one partner, but not with another.

An underlying tension is noticeable between theoretical and operational research. The former enriches our understanding about gender constructs, their variable dimensions and links to reproduction and sexuality.[311] It tends to focus on what we do not know and advocate for more research. The latter builds on existing knowledge, documents programme experiences, and responds to programmers' urgent need to test what has been learned and apply it on a larger scale. Given the urgency of achieving change, rapid assessment procedures and situation analysis that involve stakeholders are becoming the tools favoured by policy-makers, donors and providers.

309 G. Herdt, "Sexual Cultures and Population Movement, Implications for AIDS/STDS" in *Sexual Cultures and Migration in the Era of AIDS: Anthropological and Demographic Perspectives* (Oxford: Clarendon Press, 1997).

310 E. D. Bilac et al., "The 'Family Man': Conjugality and Fatherhood among Middle-class Brazilian Men in the 1990s", WHO/Human Reproduction Programme, January 2000, p. 16.

311 J. G. Figueroa, "Some Reflections on the Presence of Males in the Reproductive Processes".

Chapter 5

Changing Culture, Policies And Behaviour Through Communication

To incorporate a men-inclusive gender perspective in reproductive and sexual health and rights means, in effect, that gender relations are not only carefully considered as a time-invariable environment, but also as targets of change. Changing alienating gender relations is possible. Hierarchical relations between men and women are not biological givens, but are largely products of social and cultural processes. As such, they are not universal and ahistorical. They are dynamic and changeable.[312] Sociologists say it may take three generations for gender equity to be achieved. Indeed, in Sweden, it took close to 40 years for "ideals" to become "norms" and influence the behaviour of the majority of Swedish men towards a gender-equality process. Other case studies found that men had made decisions in family planning based solely on economic motives, without changing gender relations and without their spouse's involvement. This ultimately resulted in greater women's empowerment, but took five generations.[313]

One key question is *how to hasten this process of change* in settings where gender equality is less advanced. While it may take several generations to change gender patterns, population programmes in light of the ICPD mandate are committed to provoking faster political and socio-cultural change. Two programme vehicles are at their disposal: advocacy communication to change policies and social norms, and behaviour change communications (information, education and communication, or IEC) to change individual knowledge, attitudes, beliefs and behaviour. Both advocacy and IEC are required to empower women and men, build equal partnerships with men and women, and provide appropriate services to men, especially young men. The purpose of advocacy is to promote or reinforce change in social culture, policy, programme or legislation. Rather than providing support directly to clients or users of services, advocacy aims at winning support from others, that is, creating a supportive environment. IEC is more concerned about individual attitudinal and behavioural changes. There is a need to define the right mix of strategies for addressing both social and individual change factors.

---

312 H. Moore, *Feminism and Anthropology* (Cambridge: Polity Press, 1988).

313 M. Karra et al., "Male Involvement in Family Planning: A Case Study Spanning Five Generations of a South India Family", *Studies in Family Planning*, vol. 28, no. 1 (March 1997).

ADVOCACY: THE NEWEST EMPHASIS IN COMMUNICATION PROGRAMMES THAT FOCUS ON MEN

When it comes to HIV/AIDS risk, studies have shown consistently that simple knowledge of AIDS is not enough to instil safe sex or self-protection from the risk of HIV infection; the so-called health belief model to predict behaviour change has shown its limit.[314] We must make a distinction between knowledge and behaviours, since knowing the correct rule or practice to protect oneself from risk is insufficient. Other factors, such as resources, personal commitment, empowerment and self-confidence, are required to resist pressure from peers and influentials within one's "risk milieu" and stop activities that are detrimental to personal well-being. In short, what is at stake is access to power in a general sense, and the empowerment of the agent to make informed choices in a cultural risk milieu.[315]

Advocacy and empowerment at the community level concern themselves with the creation of a new, positive cultural milieu for a safe sexual and gender-identity formation that promotes equity and empowerment, that is, the creation of a "risk-reduction milieu":

> *[A milieu] in which the cultural setting or institutions and supporting groups teach safe practices, and protection against risk, thereby supporting the ability of individuals to make reasoned and empowering decisions, as well as to take actions that ensure self-protection. For instance, forming a support network with others is helpful in the negotiation of violence on the streets, homophobia in everyday life and in the classroom, and risk-taking in the context of sexual encounters.*[316]

Changing behaviours through a "social" approach, one that depends on deep-rooted and lasting social change, is the most difficult to achieve, but is being increasingly embraced to fight the AIDS epidemic. This is a time-consuming and uncertain process, which relates to HIV/AIDS and to the broader issues surrounding gender relations.[317]

The notion of individual's accountability

The failure of conventional-behaviour change models that focus solely on knowledge change of individuals does not mean that individuals have no power to change entrenched gender roles. The emphasis on male identity being *socially constructed* as a set of characteristics and behaviours that are *expected* from all men in a given culture may be misinterpreted. Men may argue that they cannot be held "responsible" for their lack of "involvement" or "participation", which reflect prevailing gender norms, when in fact they are accountable for their actions. Identifying contextual factors does not mean that individuals are shaped only by social pressures. As has been demonstrated by the gay and feminist movements in the West, a minority is always able to ques-

---

314 The health belief model asserts that health behaviour is affected by an individual's perceptions about the severity of the health problem, whether one is susceptible to the health problem, whether one is aware of the benefits of taking preventive action, and whether one feels capable of doing something about the problem (known as "self efficacy").

315 G. Herdt, "Sexual Cultures and Population Movement, Implications for AIDS/STDS" in *Sexual Cultures and Migration in the Era of AIDS: Anthropological and Demographic Perspectives* (Oxford: Clarendon Press, 1997), pp. 10–17.

316 Ibid., p. 17.

317 M. Foreman, ed., *AIDS and Men: Taking Risks or Taking Responsibility?* (London: Panos Institute and Zed Books, 1999), p. 43.

tion gender expectations. People have the *individual* power to conform to or oppose standards of gender conduct and to fashion their own identity.[318]

Advocacy is also about addressing controversy

When attempting to change gender roles, we can anticipate backlashes from a system in which one-half are in a position of domination. It is reasonable to realize that the dominating part is interested in its continuation, and the subaltern is interested in its change. In the gender system, men are interested in its continuation and women are interested in change.[319] For instance, the term "empowerment of women" has created staunch resistance, especially in the developing world, where fears that women will become masculine are voiced. Given that power is a founding trait of masculinity, women's empowerment may be associated with men's loss of competency. Some men's groups believe they have been marginalized and lack reproductive and custodial rights. Careful advocacy is needed in this regard.[320]

Opposition to women's emerging rights is not always organized. It may take the form of an increase in domestic violence.[321] In the Navrongo experiment in northern Ghana, changes in contraceptive practices, in a setting where this had been considered unattainable, were achieved. However, an unintended outcome of this project was the physical abuse and reprisals women were subjected to by their partners and extended families. The programme exemplified the strains in gender relations that can result from contraceptive use.[322] In Mexico, a study that examined the importance of sexual fidelity found that some men, particularly migrants who spend large parts of every year apart from their wives, believe "rights to sexual freedom are the final frontier of male privilege".[323]

New research and change models are required for advocacy strategies that take into account contextual factors

The starting point of any communication strategy targeting men rests on an improved understanding and assessment of men's socialisation context. Research that informs about men's circumstances, knowledge, attitudes, practices and behaviours is critical to formulating advocacy and IEC programmes that involve men. Formative research helps develop convincing arguments on a specific issue, as well as identify key beneficiaries, partners/allies, adversaries, decision-makers and their characteristics.

---

318 A. Wouters, trip report from Zambia, UNFPA CST Harare, 15 January 1999.

319 R. W. Connell, "La organización social de la masculinidad", in *Masculinidad/es, Poder y Crisis", T. Valdés* and J. Olavarría, eds., Isis Internacional, Ediciones de las Mujeres no. 24, Santiago, 1997.

320 M. Villarreal, "Construction of Masculinity(ies): Implications for Sexual and Reproductive Health (paper presented at the TSS thematic workshop on Male Involvement in Reproductive and Sexual Health Programmes and Services, UNFPA, Rome, 9–13 November 1998).

321 M. E. Greene, "Benefits of Involving Men in Reproductive Health" (draft paper presented at the meeting of the Association for Women in Development, November 1999), p. 17.

322 A. A. Bawah et al., "Women's Fears and Men's Anxieties: The Impact of Family Planning on Gender Relations in Northern Ghana", *Studies in Family Planning* 31, no. 1 (1999): 54–66.

323 J. S. Hirsch and C. A. Nathanson, "Amor and Infidelidad: The STD/HIV Prevention Implications of Changing Ideas about Marriage and the Importance of Sexual Fidelity in Western Mexico" (paper presented at American Public Health Association [APHA], November 1999), p. 5.

Researchers suggest that existing research tools need adjustments in order to collect information about male circumstances, identity, and men's and couples' unmet needs. Changing sexual and reproductive behaviours requires additional research that "contributes to the process of redefinition and reconstruction of the area of reproduction".[324] In 1999, UNAIDS produced a key document on communication for dissemination and implementation in countries fighting the spread of HIV/AIDS and STD: "Communication Framework for HIV/AIDS: A New Direction".[325] Within this framework, communication programmes for HIV/AIDS prevention should aim not only at individual behaviour change, but also at bringing about changes in contextual factors that facilitate individual actions. Five contextual factors are proposed: government policy, socio-economic status, culture, gender relations and spirituality. While experiences may be limited in the execution of programmes that combine these five contextual factors, this model provides a research agenda for creating an enabling environment for the role of men in reproductive health and rights.

Examining communication programmes that target men with a "gender lens"

Communication programmes and services that take gender roles into account encourage more equality between the sexes. To plan effective, gender-sensitive communication, programme planners should be aware of their own assumptions about gender and also their clients' assumptions. Reinforcing stereotypes of men and women that lead to behaviour harmful to their physical and mental health should be avoided. Communication programmes should promote images of men and women that will help protect their health and that of their community.[326]

Important lessons about gender awareness have also been learned from unintended consequences of programmes designed to increase men's participation. For example, during the 1970s and early 1980s, Profamilia in Colombia used the Latino macho image to promote vasectomies.[327] Another classic example is found in Zimbabwe, where a multimedia campaign in 1993-94 promoted men's use of family planning. The campaign, which relied on prominent sports players to tell men about the importance of practising family planning, succeeded in reaching men and encouraging their participation. Many of the messages used the sports motif to emphasize teamwork, for instance: "*To win the family planning game by reaching the goal of a small family with the help of their teammates* (spouses/partners) *and coaches* (service providers)". Other messages, however, may have reinforced men's willingness to take control alone, such as "*Play the game right; once you're in control, it's easy to be a winner*", and *It's your choice*". As an unintended consequence, some men exposed to the campaign were more likely to believe that they alone should make family planning decisions.[328]

---

[324] J. G. Figueroa, "Some Reflections on the Presence of Males in the Reproductive Processes" (forthcoming, in "Male Sexuality and Reproduction", El Colegio de Mexico, Union Internacional para el Estudio Cientifico de la Poblacion y Sociedad Mexicana de Demografia).

[325] "Communication Framework for HIV/AIDS: A New Direction", United Nations Programme on HIV/AIDS (UNAIDS) and Pennsylvania State University, 1999.

[326] F. T. Chikara, "The Role of IEC in Reinforcing or Changing Gender Stereotypes and Promoting Gender Equality", in "Sexual and Reproductive Health and Rights of Women", *Discussion Paper*, issue 1, IPPF London, 1995.

[327] M. Drennan et al., "New Perspectives on Men's Participation", *Population Reports*, series J, no. 46, (Johns Hopkins University School of Public Health, October 1998).

[328] Johns Hopkins University Center for Communication Programmes, *Reaching Men Worldwide: Lessons Learned from Family Planning and Communication Projects*, 1986–1996, Working Paper Series no. 3, Baltimore, January 1997.

The use of stereotypical images as part of one's communication strategy is a delicate balancing act, requiring even greater diligence in the selection of messages, particularly when directed towards men, who will quickly grasp any perceived opportunity to take control.[329] Consequently, several guides have been developed to help incorporate gender sensitivity into programme design, implementation and evaluation.[330] The Johns Hopkins University Center for Communication Programmes and the Centre for Development and Population Activities (CEDPA) has developed a "CAP Tool",[331] a practical approach for incorporating gender in reproductive health communication programmes that enables organizations to proactively review communication campaigns from a gender perspective and make necessary adjustments. Tools that can be used to assure the integration of a gender perspective into programmes include *checklists* of questions to be raised from the planning stage of a men's programme; *desegregated* data, to provide more accurate data that take into account social roles of men and women; *activity profiles* to examine who does what in productive and reproductive activities, which helps planners see the work of women and men in their social context and identify what assistance men and women may need; and *gender analysis matrix*, which provides a community-based technique for identifying and analysing gender differences in order to assess the different impacts on men and women of a given intervention.[332]

Selected advocacy strategies to change culture and policies, with a focus on men and gender roles

Expected outputs from male-focused gender-equity advocacy programmes include: (1) nurturing a supportive socio-cultural climate for women's and men's empowerment and gender equity; (2) adopting constructive male roles on a large scale; (3) fostering a favourable policy environment for gender equity and reduction of gender-based violence; and (4) reorienting services to meet the needs of men, particularly young men. Experiences in advocacy strategies are reviewed here in the same order.

Advocacy for gender equity: aiming at cultural changes

A rights-based perspective implies that people have the means to exercise choices. Creating an enabling environment for faster changes in attitudes, beliefs and behaviours is the means through which the IPCD Programme of Action envisions achieving its objectives in gender equity and increased male responsibility. We cannot promote gender equity without questioning patriarchal and other power hierarchies that accept men's power and women's subordination and curtail women's access to human rights, including reproductive and sexual rights.[333] Advocacy regarding men and reproductive health and rights is about fostering change in cultural values and promoting power balances and mutual respect in sexual relationships. Also, advocacy is expected to

---

329 Johns Hopkins University Center for Communication Programmes, "Better Together: A Report on the African Regional Conference on Men's Participation in Reproductive Health", Baltimore, April 1997, p. 6.

330 I. Tweedie, "Walking the Stereotype Tightrope: Lessons Learned from Communication Approaches to Men's Participation in Zimbabwe", report from the meeting on "Changing Communication Strategies for Reproductive health and Rights" (The Health and Development Policy Project, Population Council, Washington, DC, 10–11 December 1997), pp. 44–47.

331 CEDPA, "Gender Equity: Concepts and Tools for Development", Washington, DC, 1996, p. 43; S. Pfannenschmidt et al., "Through a Gender Lens", US Agency for International Development, Washington, DC, October 1997, p. 44.

332 M. Ladjali, "Gender Quality of Care: Common Approaches for Common Goals", WHO, Geneva, 1998, p. 6.

333 M. E. Greene, "Benefits of Involving Men in Reproductive Health".

play a major role in sensitizing and mobilizing the community to take responsibility for their own health, and at getting men as a collective group to resist social pressures that foster violence.

Grass-roots advocacy to change gender attitudes and address concerns and misconceptions about male involvement

Advocacy/social mobilization strategies targeting traditional opinion leaders at the community level are central to generating change in social norms; traditional leaders are the guardians of customary law, and as such, have the power to modify them. Strategies are aimed at men in their policy-maker and community leader roles; their purpose is to enlist influential males, so that they collectively take the lead to transform traditional cultural ideas and social norms about masculinity and implement the necessary policy and programme changes. In this process, policy-makers and programme managers are invited to question whose interests are best served by an uncritical acceptance of cultural values.[334]

Building bridges with and involving other members of the community including traditional and religious leaders, as well as political and popular ones, can be a deciding factor that determines a programme's success or failure, especially in settings where women's independent actions to regulate fertility upset the social contract that defines gender relations, and where the control over women is complete and their status as property deeply rooted. In Navrongo in the Kassena-Nankana District of northern Ghana, community leaders and local groups used durbars — pub-

Pathbreaking Grassroots Advocacy in Uganda

In Uganda, UNFPA spearheaded in 1995–96 an innovative, culturally sensitive programme aimed at supporting the efforts of the community to discard the FGM practice. The project, called Reproductive, Educative and Community Health (REACH), was based on the premise that cultural values may be perceived as immutable and a core reflection of the group identity. Values, however, are often expressed through practices, which depend on community exposure to knowledge, technology and traditions; practices may be subject to easier change. Following this rationale, the REACH programme attempted to detach the practice of cutting the genitals of girls and women from the cultural value of initiation from girlhood to womanhood. It did so through a consultative and persuasive process with key change agents in the community (such as political, clan and religious leaders, elders, women's and youths' representatives) to recognise and appreciate the serious health risks associated with FGM. Coalition-building with conservative groups such as elders and clan leaders such as the Sabiny Elders' Association, and networking with education institutions, religious groups, politicians, health institutions and community leaders enabled the programme to sensitise the community. Young people were also mobilized as peer educators and equipped with information and facts about the harmful aspects of FGM. A cultural day in the district offered an opportunity to mark the passage from girlhood to womanhood with alternative rituals.

SOURCE: F. Farah, "A Promising Success in Discarding Female Genital Mutilation: The REACH Project in Uganda", in Innovations, *Innovative Approaches to Population Programme Management*, vol. 6 (ICOMP, Kuala Lumpur, Malaysia, 1998).

334 Ibid.

lic meetings through which leaders communicate with local people, mainly men — to inform people about the programme and establish open discussion of health-related topics with the community. This helped legitimize the programme.[335]

Advocacy with religious leaders for cultural change

Tremendous progress has been achieved because cultural and religious leaders have joined in partnership with each other and with population professionals in advocating safe sex and facilitating adolescent sexual and reproductive health programmes.

Religious leaders working with UNFPA, local NGOs and community leaders are engaged in correcting the false perception that Islam is opposed to family planning. Since religion is a sensitive issue, the government of Bangladesh encouraged the Family Planning Association of Bangladesh (FPAB) to overcome religious opposition and to gain support of the religious leaders in promoting family planning. In 1984, the FPAB established an Islamic Research Cell and launched advocacy and orientation programmes with the religious leaders. Strong support of religious scholars and interpersonal communications led to overcoming wrong conceptions about family planning programmes and learning that nothing in Islam opposes the adoption of a small family norm. Marriage registrars and Imams were also oriented. Today, religious opposition has been reduced considerably in Bangladesh, and Imams have been preaching in favour of family planning. However, many men are still uninformed and spread misconceptions.[336]

Similarly, in West Africa, the International Colloquium on Islam and Population, co-sponsored by UNFPA and the Groupement des Association Islamiques Nigeriennes pour la Planification Familiale et la Promotion de la Femme en Islam (GAIPFI) (Association of Nigerian Islamic Groups for Family Planning and the Promotion for Women in Islam), is an example of advocacy efforts that involve religious leaders. One of its outcomes, the "Declaration of Niamey",[337] clearly spells out Islam's support of family planning. The declaration also invites mullahs to study demographic conditions, and considers their role in sensitizing and mobilizing their communities around these critical issues. In Senegal, UNFPA helped create a network of religious leaders who interpreted the Koran and its precepts regarding sexuality, family planning and reproductive health. The work included visits to Iran, Indonesia and Egypt. As a result, Imams address family planning and sexuality in their Friday sermons, particularly with men, who have previously been left out of the discussion, though they are the decision-makers in the family. Debates that include adolescent reproductive health are aired on a regular basis on radio and television. Religious leaders have also developed audiocassettes on reproductive health based on Islamic beliefs. Contraceptive use, though still low, doubled between 1993 and 1997 (from 4 per cent in 1993 to 8 per cent in 1997).[338] Also in Senegal, Tostan, an international educational NGO based there worked with women, their husbands, the village chiefs and religious leaders to end

---

335 B. A. Agula et al., "Women's Fears and Men's Anxieties: The Impact of Family Planning on Gender Relations in Northern Ghana" *Studies in Family Planning* 30, no. 1 (1999): 62.

336 A. Neaz, "Converting Banglasdesh's Influential Religious Leaders", *Planned Parenthood Challenges* 2 (1996): 38–39.

337 GAIPFI, "Islam, Population et Développement, Place de la Femme dans l'Islam, Islam et Santé de la Reproduction", Niamey, Niger, 1998, pp. 5, 19–27.

338 UNFPA, e-mail message from Fatou Sarr Diop discussing ethics, religion and reproductive health, January 2000.

the traditional practice of female genital cutting in 31 villages.[339] In Ghana, one product of such a collaboration is the *Parent's Handbook on Sexuality & Communication Skills*, produced by UNFPA, the Religious Bodies Welfare Project and the Family Planning Association of Ghana.

Promoting new male gender roles

Involvement of men in child care is usually beneficial for the mothers, the children and, not least, the men themselves, as they develop closer ties to their children and wives. Spending time with children and catering to their physical and emotional needs may also contribute to the development of men's empathic qualities, which are often lacking, according to recent research. In only a few countries do fathers have the opportunity for, and take advantage of, paternity leave.[340]

Communication strategies can help men envision new male images and gender roles. Bringing men into the domestic sphere is seen as key to establishing a more equitable distribution of roles and responsibilities between men and women. Experiences in men taking a fair share of household chores are better known in developed countries than in developing ones. However, father

Sharing the Household Workload in Burkina Faso

The sexual division of work and responsibilities in most societies imposes on women a multitude of "feminine" tasks, which tend to be more numerous than men's. Thus, time-budget studies inevitably find that women have a longer working day than do men. Many West African women, for example, put in a 12hour day. Concerned by the health consequences of this workload, the Regional Antenna of Women and Health (with financial support from the Canadian International Development Agency) undertook a pilot project in selected villages in Burkina Faso to encourage men to help with domestic tasks. The results seem to indicate that the sexual division of labour is more flexible than pessimists might have thought.

One of the men involved in the project tells of the difficulties faced by the men who decided to help their wives as a result of the training and discussion groups held by the project. "When we started carrying the water and fetching the wood, even the little children made fun of us, because this had never been seen." Nevertheless, the elders recognized that there was no taboo against men doing domestic tasks. After the initial difficulties, helping the women has become a habit, and the men are reaping the benefits: "Our wives are cleaner, smarter, they have some time to look after themselves and us, they are more relaxed." Both wives and husbands claim they discuss problems more often. It is interesting that the men would now like to acquire bicycles or wheelbarrows, so that carrying wood and fetching water can become less tiring.

Source: "Femmes et Santé", no. 5, November 1993, Ouagadougou, Burkina Faso.

339 Population Council, "The Tostan Story: Breakthrough in Senegal Ending Female Genital Cutting", *Reproductive Health and Family Planning*, July 2000, www.popcouncil.org/rhfp/tostan/tostan.html.

340 S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes", report for the Royal Ministry of Foreign Affairs, Oslo, Norway, 21 February 1999, p. 12.

hood roles can be expanded to encompass tasks that are traditionally reserved for women. African seminar participants found it a promising entry point for changing roles and responsibilities in the household as it would give men opportunities for new kinds of pleasure, which are strong rewarding factors for behaviour change.[341]

Enlisting men's support in safe motherhood

Men develop an interest in women's reproductive health when they learn more about how they can help ensure safe pregnancy and delivery. There is evidence that greater MPSRH&R can reduce peri-natal mortality. In India, prenatal education to prospective fathers led to higher frequency of prenatal clinic visits.[342] There is clearly a potential for a much greater role for men in safe motherhood initiatives.[343] New initiatives in Zimbabwe to involve men in prenatal care focused on counselling pregnant women and their partners and organising outreach activities to men. Men expressed high interest, stating that pregnancy is shrouded in mystery, but at the same time, expressed concern about losing respect from peers because of being involved in "women's issues". As pregnancy progresses, the research study also found that sexual activity was reduced, leading to less intimacy and rendering communication more difficult.[344] In Senegal, women were also interested in greater male involvement; however, prenatal visits were used as opportunities to move freely; they also provide women with easier access to money to cater to their health needs. It is important, therefore, to be aware of the tension between women's autonomy and men's involvement, and carry out more intervention research.[345]

Policy advocacy for changes in the areas of sexuality, child care and violence

Advocacy is needed to ensure that policies and laws are reviewed, reformed and repackaged for the effective operationalization of reproductive health services and rights with a gender perspective. Advocacy is required to raise the awareness of politicians, and traditional, religious and other community leaders, including medical professionals and clinic directors, of the policies that need adjustment in order to execute the plan agreed to in Cairo. In many countries, laws and policies tend to impede effective partnerships between men and women. For instance, outputs are needed to provide access to information and services in reproductive and sexual health to young men, and to get law enforcement systems to consider sexual coercion a crime.

Several advocacy initiatives are under way in South Asia that work with men to end violence against women and girls. UNICEF, UNIFEM and UNDP sponsored a regional meeting in Kathmandu on "Ending Violence against Women and Girl in South Asia" in 1997. The conference produced the "Kathmandu Commitment on Ending Violence Against Women and Girls

---

341 A. Wouters, trip report from Zambia.

342 V. Bhalerao et al., "Contribution of the Education of Prospective Fathers to the Success of Maternal Health Care Programmes", *Journal of Postgraduate Medicine* 30, no. 1, 1984.

343 S. Becker and J. C. Robinson, "Reproductive Health Care: Services Oriented to Couples", *International Journal of Gynecology and Obstetrics* 61, no. 3 (1998): 275–81; J. Foumbi and R. Lovich, "The Role of Men in the Lives of Children", working paper, Interdivisional Working Group on the Role of Men, UNICEF, December 1997.

344 J. Pulerwitz, "Involving Men in HIV/AIDS and Reproductive Health Programmes" (presentation of Horizons Project findings at the MotherCare Meeting on Key Behaviour in Maternal Health and Survival, Washington, DC, May 2000).

345 Ibid.

in South Asia", which asserts: "We men, realizing that no sustainable change can take place unless we give up the entrenched ideas of male superiority, commit ourselves to devising new role models of masculinity. We shall endeavour to take off the armour and move towards becoming a more developed and complete being. We urge international bodies to focus on and explore the destructive consequences of patriarchy".[346] The commitment also calls upon the South Asia Association for Regional Co-operation (SAARC) and its member countries to fulfill and build upon the commitments of the male summit to adopt a regional convention.

Changing social norms that condone men's use of violence against women

The issue of gender-based violence is receiving increased attention from advocates. Men can be mobilized to oppose violence against women, and in the realization of women's human rights Efforts to change the culture of violence require attitudinal and social change, not simply legal enforcement.

Men, who tend to dominate the legal system, are involved in advocating ratification of CEDAW in their countries, studying the convention so that they can monitor violations and enforce compliance. Similarly, many countries' legislatures, also primarily made up of men, are reforming laws for the promotion and protection of reproductive rights.

To date, most of the intervention programmes that address violence focus on treating women survivors. Questions on how to successfully address issues of violence with men perpetrators in a constructive manner within a reproductive health setting remain unanswered. Research is

Partnership with Civil Society in the Area of Sexual and Domestic Violence

Difficult issues such as violence require partnerships for innovative approaches. Some examples of work follow:

The Jamaica Family Planning Association (FPA) is one of the few sexual and reproductive health organizations working with perpetrators to decrease the harmful effects of domestic violence. It worked in partnership with the court system and probation officers in the St. Ann's "Brothers for Change" initiative. A baseline survey with 200 participants provided useful feedback. Following training by FPA, staff at a correctional facility in St. Ann's conducted sessions with inmates on sexual and reproductive health and domestic violence. Despite increases in numbers and attendance, perpetrators' participation in counselling fell below expectations and was irregular; contrary to early feedback, the men accepted female facilitators, but experienced the programme as an imposition that they resented. Despite their reluctance, most of the participants reported that the programme was tremendously beneficial, particularly by providing behaviour options; and that what they learned in the sessions will make them think twice when about to engage in violent behaviour. In the future, the project intends to sensitize judges and probation officers nationally, and to produce a radio call-in programme.[347]

[346] R. F. Hayward, "Needed: A New Model of Masculinity to Stop Violence against Girls and Women" (paper presented to the WHO Global Symposium on Violence and Health, 12–15 October 1999, Kobe, Japan), p. 12.

[347] IPPF/WHR, *BASTA!*, spring 2000, p. 7.

The Family Planning Association of Trinidad and Tobago used "Short Change" as a tool to introduce the discussion on gender-based violence with adolescent and adult men. The interactive play presents a man who justifies violence against women, encourages his son to look for a woman like those found in porn magazines, and throws his daughter out of the house when she becomes pregnant. As part of the production, the lead character asks audience members how they think men relate to women, how they think men should relate to women, and what men must do to change.[348]

In the Dominican Republic, the Asociatión Dominicana Pro-Bienestar de la Familia (Profamila/DR) worked on passing a law against domestic violence. Profamilia then worked with UNFPA to disseminate information about the legislation to men and women by producing and distributing a simplified and illustrated version of the law.[349]

Concerned about the number of sexual offenders, the Prison Service of Dominica sought technical assistance from the Dominican National Council of Women (DNCW) to incorporate a new approach to domestic violence in the context of the new Sexual Offences Act. The project's goal is to educate prisoners on the reality of sexual abuse as it affects women and children. With the agreement of prison authorities, male prisoners participated in the design of the project. The prison project runs concurrently with the DNCW's community-based Crisis Intervention project, which assists communities in dealing with growing misogyny, particularly among men and boys who are already abusive to women and girls.[350]

In Brazil, Estudos e Comunicaçao em Sexualidad e Reproduçao Humana established and is training members of the Delegacias de Mulher, a special unit within the police responsible for responding to reports of violence, including sexual violence against women. The training activities and workshops sensitize male police officers to the special needs of women who seek their help.[351]

contributing to the development of curricula that deconstruct violence as part of masculine identity, and inform men and women about the erroneous perception that violence is a natural or biological condition of men. Recent grass-roots advocacy activities have begun to address male perpetrators of violence. Overall, such initiatives require long-term investment for any behaviour changes to occur.

Changing service regulations through strategic alliances with male opinion leaders

Men are often called "gatekeepers" because of the many powerful roles they play in society — as husbands, fathers, uncles, religious leaders, doctors, policy-makers, and local and national leaders. In their different roles, men can control key decisions and access to health information and services, finances, transportation and other resources. Policy-makers, programme managers, health care workers and other types of providers can block male involvement.

---

348 IPPF/WHR. "What Is a Man?" *Forum* 14, no.1 (January 1999): 15–16.

349 IPF/WHR, "Confronting Domestic Violence", *Forum* 14, no.1 (January 1999): 7–8.

350 D. Noel-De Bique, "The Caribbean: NGO Partnerships for Advancing Male Responsibility in Implementing the Goals of the ICPD", in *HERA: Health, Empowerment, Rights & Accountability, Confounding the Critics: Cairo, Five Years On* (conference report, Cocoyoc, Morelos, Mexico, 15–18 November 1998).

351 AVSC International and IPPF/WHR, "Male Participation in Sexual and Reproductive Health: New Paradigms" (Literature Reviw, Oaxaca, Mexico, October 1998), p. 15.

At the programme level, clinics may discourage men and adolescents from seeking services. For men and women to enjoy unfettered access to quality reproductive health care and services, such legal and policy impediments must be removed. Health care providers at all levels may deny individuals services or supplies due to biases, arbitrary policies or inadequate attention to clients' needs; clinic personnel are often unaware of their own prejudices. In particular, many health care providers lack adequate information and training to provide care to men.[352] This may occur because of conservative cultural and political values, the conventional wisdom that men are not interested in reproductive health matters, or simply the assumption that family planning is a woman's responsibility. This requires advocacy, also a useful tool for introducing or expanding delivery approaches proven to be effective in reaching and attracting men. Participants in an AVSC seminar suggested that messages developed to reach these groups should be tailored to address cultural and political issues, and as such may not be the same as those designed to reach clients and potential clients.[353]

In Mali, the Association de Soutien au D veloppement des Activit s de Population worked with the Centre for Development and Population Activities/ACCESS project to expand community-based family planning services and encourage men's participation. With the backing of traditional leaders, male volunteers were trained to distribute contraceptives and provide information about reproductive health, including STD/AIDS prevention, high-risk behaviours and condom use. The project increased men's interest in the health of mothers and children, and led to greater interest in modern methods of child spacing.[354]

Creative adaptations by existing institutions can create new opportunities to effect change. In India, Family Welfare Education and Services organizes men's and mothers'-in-law clubs to support reproductive health. The men discuss issues including alcoholism, smoking, malnutrition, family planning and women's literacy. Mothers-in-law in India exercise great influence in the household; the project encourages them to promote proper nutrition and child care, and to motivate their sons to treat their wives better, because "only a healthy and happy mother produces a healthy child".[355]

---

[352] M. Drennan et al., "New Perspectives on Men's Participation".

[353] M. Wegner et al., "Men as Partners in Reproductive Health: From Issues to Action", *International Family Planning Perspectives* 24, no. 1 (March 1998): 38–42.

[354] K. L. Mojidi, "Increasing Male Participation: Lessons from Mali, Kenya and Nigeria" (paper presented at the ACCESS Lessons Learned Conference, CEDPA, Washington DC, 18–19 June 1998).

[355] S. Raju and A. Leonard, eds., *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality* (Population Council South and East Regional Office, 2000).

UNFPA'S Work with the Judiciary System

As part of the efforts to change the persistent cultural resistance to the notion of gender equality, in Togo, more than 300 para-jurists and assistant jurists and more than 300 traditional chiefs were sensitized and informed about the concept of gender and women's rights. UNFPA in Mali sensitized decision-makers and religious leaders through study tours and workshops. In addition, a study on men's perception of FGM was undertaken. In Morocco, in collaboration with the Ministry of Justice, UNFPA initiated a pilot project of collecting and analysing data on violence against women as penal affairs in the city of Casablanca. Information is collected on such cases and their conditions are analysed. Results will be used to sensitize decision-makers, magistrates, judges, the police, health professionals and researchers, in order to enable concerted and integrated action against violence.

SOURCE: UNFPA, "Review of the Implementation of the Beijing Platform for Action in the Africa Region" (progress report for the Sixth Africa Regional Conference on Women, Addis Ababa, 22–26 November 1999).

Coalition building with men and for men: the male networks

An advocacy intervention includes coalition building and networking. Examples of groups that have similar concerns regarding men and gender equity in the context of reproductive health and rights, and with whom to build coalitions, are male networks in Sweden or the Daddies Clubs in Ghana. The purpose of the Swedish networks is to stop male violence against and abuse of children, women and other men. Other examples are Padare, a forum for men in Zimbabwe co-operating with Zimbabwe Women's Resource Centre and Network to promote women's autonomy and equality in all areas of society, and to encourage male involvement in preventing violence against women and girls; the Men's Group against Violence, Nicaragua; and CORIAC, Mexican Collective of Men for Equal Relations, Mexico.

At international levels, gender-friendly men are creating a movement and actively campaigning to raise male awareness of the problem of acts of violence committed by a great number of men, primarily against women but also against children and other men.[356] For instance, the White Ribbon Campaign began in Canada as an all-male discussion group to promote men's awareness of domestic violence. Now, chapters in Australia, Finland, Norway, the United States and Latin America urge men to display a white ribbon as a public pledge never to commit, condone or remain silent about violence against women.

The aim of the White Ribbon Campaign is to get men to take part publicly in the struggle against violence against women, to break the silence of complicity among men, and to contribute to the changing of male role models. It represents the first international campaign seeking to involve men in preventing violence towards women. In Canada, where the campaign has generated the most attention, the group has been able in involve men leaders — in business, media, entertainment, sports — to associate their name with the campaign. The group has also been

[356] See Web site: www.chebucto.ns.ca/CommunitySupport/Men4Change/index.htm.

The White Ribbon Campaign

- "We urge men around the world to wear a white ribbon, or hang a white ribbon from their house, their vehicle, or at their workplace each year for a week…. Wearing a white ribbon is a public pledge never to commit, condone or remain silent about violence against women. The white ribbon symbolizes a call for any man who is violent to lay down his arms in the war against our sisters.
- "We ask unions, professional associations, student groups, corporations, religious institutions, the media, non-governmental organizations to make this an issue of priority..
- "We urge governments to pass comprehensive laws against all forms of violence against women and to fund programmes for survivors of this violence, such as shelters for battered women and rape crisis centres, and for services to treat violent men.
- "We call for large-scale education programmes in schools and work places, for police officers and judges on the issue of men's violence.
- "We believe that respect for girls and women and equality between men and women are preconditions to ending the violence.
- "We urge men to organize local and national White Ribbon Campaigns, open to all men and boys, right across the political, social and economic spectrum."
- The group also urges men to "start with listening….Learn about violence by asking a woman who trusts you how violence has affected her life".

SOURCE: www.whiterbboncampaign.ca

successful in engaging men from a wide variety of political backgrounds, and has forged important links with women's groups by following a simple strategy of listening to and respecting women.

A Mexican affiliate of this campaign, CORIAC, has used the following messages: "Rechazar todas formas de violencia hacia las mujeres"; "Romper el silencio y la complicidad con hombres violentos"; "Construir relaciones equitativas entre hombres y mujeres"; and "Being violent against women does not make us more men".[357]

Creating a debate on the role and responsibilities of men

To change the society's culture regarding gender roles, there must a national debate on issues of concern and desired alternatives. It is important that the goal of education and communication activities be seen as stimulating reflection and discussion, rather than persuading and convincing people to adopt ready-made solutions. Change can come only from within the group, which usually knows best what is feasible and likely to work. Thus, a key goal is to help the group come up with its own ideas for solutions.[358] The Panos Institute has done extensive research on men

[357] CORIAC posters; more information at coriac@laneta.apc.org.

[358] J. du Guerny et al., "Male Involvement in Reproductive Health: Incorporating Gender throughout the Life Cycle", UNFPA TSS Discussion Paper, December 1998, p. 17.

and AIDS and concluded that behavioural change can only succeed through a full and informed debate on masculine values. The institute proposes three principles for successful outcomes:

1) Change in values cannot be imposed from outside. International AIDS programmes, political or religious leaders, institutions and organizations from outside a society that work on development, HIV, gay issues or religion, can only provide the resources that allow the debate to take place; they cannot "impose resolutions or prejudge outcomes".

2) The debate has to include individuals who may be marginalized by society; for example, drug users, gays, and men and women who are infected.

3) The discussion on masculinity or what it means to be a man must take place in all sectors of society: between husbands and wives; between individual men; within institutions, commerce, the media, churches, mosques and temples; as well as in national, state and local political assemblies.[359]

Changing media stereotypes

The mass media are powerful means through which individuals receive messages about gender identity and societal norms. A study in Uganda found that more than half the men participating in the study identified the radio as their main source of information on reproductive health matters. Twenty percent get their information from daily newspapers, and almost one-quarter from television.[360] Work with the media involves encouraging portrayals of non-stereotypical gender roles such as caring men, competent women, and men and women supporting each other, in radio dramas, videos, films or testimonials in order to promote gender equality and partnership between men and women.[361] However, promotion of sexual and reproductive health through the mass media can also be problematic. A vasectomy-promotion project in Kenya had to find creative ways of airing radio and television spots promoting clinics that offer family planning information and services for men when the Kenya Broadcasting Corporation refused to air these advertisements. The Kenyan media gatekeepers feared that airing information on vasectomy would produce a public backlash. Nevertheless, the project succeeded in getting its message across through advertisements placed in newspapers and a magazine that provided information about vasectomies. The results exceeded all expectations, with over 800 written requests for additional information sent in from all parts of the country.[362]

Activities need to be organised that sensitise media specialists as well as help orchestrate mass media collaboration in the promotion of reproductive health and the role of men. Research findings can be packaged to promote convincing arguments in favour of male involvement in reproductive health throughout the life cycle. Partnerships can be developed or strengthened with key stakeholders, national and community leaders and role models, and national and local inter-

---

359 M. Foreman, ed., "AIDS and Men", p. 44.

360 M. Thuo, "Male Involvement and Participation in Reproductive Health in Uganda: Summary of the Research Findings", UNFPA Country Support Team, Addis Ababa, 1999, p. 18.

361 F. Chikara, "The Role of IEC in Reinforcing or Changing Gender Stereotypes".

362 D. J. Wilkinson et al., "Using the Newspaper to Disseminate Vasectomy Information in Kenya", *Knowledge into Action: A Guide to Research Utilization* 14, no. 2 (1993–94): 165.

est groups. Programmes can also support the selection of key spokespersons from all walks of life to promote a focus on male involvement in reproductive health in many different settings and through different interest groups.[363]

Individuals' behaviour changes through information, education, communication (IEC) strategies

The expected outcome of an IEC programme is a change in individual or community attitudes, values, behaviours or norms. IEC strategic planning requires translating gender-equality objectives into *precise behavioural outcomes directed to overcoming obstacles and solving problems*.

The need to understand individual male behaviour via research

Programme experience of the past decade demonstrates that communication can change men's health behaviour for the better.[364] There is now a scientific basis for optimism about men's attitudes about reproductive health in many countries, except for their risk-taking behaviour. A demographic trend in male adolescent and young adult sexual risk-taking is evident. The enhanced infection rate for HIV seems to be the product of greater sexual risk-taking and continued ignorance, or deliberate ignoring of protective measures that the individual could take against the disease. This result is puzzling due to the high visibility of AIDS campaigns, and the continued efforts of society and medicine in general in countries such as the United States and Holland.[365]

To identify opportunities to induce change, communicators also need to collect or have access to information that will help them understand (1) male identity formation in specific contexts, in particular regarding sexual fears and insecurities, exercise of power in gender and sexual relations, initiation rites, and risk-taking behaviour; (2) men's perceptions of their own sexuality, their health-seeking behaviour, and male perspectives throughout the different stages of their life cycle; (3) the dynamics of couples' negotiation and decision-making, including strategies for resolving disagreement, how men relate to women's reproductive health issues, and what determines how men make decisions in this domain.

In Latin America, IPPF investigated how some men view family planning, sexual and reproductive health in a study carried out in Ecuador, El Salvador and Venezuela. Results show that men do not have a clear understanding of sexual and reproductive health and believe they essentially mean the same thing. Men related both terms to physical well-being, hygiene, "normal" sexual practice and being able to produce healthy children. They understood family planning as choosing the number of children to have and when, and mentioned communication between partners as being an important factor in planning one's family. Religious and economic factors were also mentioned as considerations in family planning. Notably, a few men brought up such issues as communication, respect, lack of violence, maturity and the need to educate young people. But gender relations, sexuality and sexual pleasure were not mentioned. Other information gained from the study are the attributes of men's stable and casual partners, how men communicate about sex, their knowledge

363 J. du Guerny et al., "Male Involvement in Reproductive Health", p. 17.

364 Johns Hopkins University Center for Communication Programmes, *Reaching Men Worldwide*, p. 50.

365 G. Herdt, "Sexual Cultures and Population Movement", p. 15.

about family planning methods and STIs, and their preferences for service delivery.[366] This study provides an example of the type of research that is relatively easy and quick to undertake and involves stakeholders. Once such information and research conditions are obtained, programmes can develop appropriate communication strategies that target men and couples.

Improving couple communication and negotiation on reproductive and sexual health matters

Improving communication between spouses/partners on household matters and issues considered as private, or for women only, or for men only, is a core process for enhancing shared decision-making and responsibilities.[367] Increasing couple communication remains an important objective for PMRSH&R programmes. Communication enables husbands and wives to know each other's attitudes towards family planning and contraceptive use. It allows them to voice their concerns about reproductive health issues, such as worries about undesired pregnancies or STDs. Communication can also encourage shared decision-making and more equitable gender roles.[368] The dynamics between sexual partners play a crucial role, such as whether the couple talks freely to each other about protection against disease and unwanted pregnancy, and whether sex is voluntary for both parties.[369]

Successful reproductive health interventions often focus on couples as a unit, rather than on just one sex at a time. Couple-based strategies tend to have better outcomes, whether for maternal and child health, family planning, or STD prevention and treatment.[370] Couple-oriented counselling stresses an equal responsibility for sexual decision-making and destroys the myth that pregnancy and STDs are only the woman's problem.[371] However, programmes that use a couple approach must be carefully designed so as not to jeopardize women's autonomy and self-determination when they do not agree with their male partner.[372]

Interventions to increase couples' shared decision-making and communication

Recently, several projects have facilitated communication between husbands and wives, using either community meetings, extension agents or mass media entertainment-education approaches. In Bangladesh, for example, the Jiggasha project uses existing rural communication networks to make discussion about reproductive health more culturally acceptable and to foster more communication among men and women.[373] Jiggashas are village discussion groups composed either of men or women; they meet separately. The jiggashas create a comfortable place for men and women to ask questions about family planning, contraceptive methods and repro-

366 IPPF/WHR, "Men in Latin America: How They View Family Planning, Sexual Health, and Reproductive Health", report of focus groups, 1997.

367 SIDA, "Men's Voices, Men's Choices: Sexuality, Fatherhood and Male Identity in a Changing Society" (report from a regional seminar in Lusaka, Zambia, 11–13 January 1999).

368 M. Drennan et al., "New Perspectives on Men's Participation".

369 W. R. Finger, "Condom and Behaviour Change", *Network* 18, no. 3 (Family Health International, spring 1998).

370 S. Becker, "Couples and Reproductive Health: A Review of Couple *Studies", Studies in Family Planning* 27, no. 6 (November/December 1996): 291–306.

371 R. Danielson, "Couple-Friendly Care: Paradigm for Reproductive Health Promotion" (presented at the annual meeting of the American Public Health Association, San Diego, California, November 1995), p. 7.

372 S. Becker and J. C. Robinson, "Reproductive Health Care", pp. 275–81.

373 Johns Hopkins University Center for Communication Programs, *Reaching Men Worldwide*.

ductive health. Specially trained field workers collaborate with male and female opinion leaders in the village to teach about contraceptive methods, answer questions, distribute contraceptives and make referrals. They also encourage both men and women to talk with their spouses about family planning. Follow-up survey results suggest that the jiggasha approach complemented existing family planning efforts by field workers. In villages with family planning field workers as well as jiggashas, the contraceptive prevalence rate (CPR) increased from 38 per cent to 56 per cent. In villages with field workers but without jiggashas, the CPR rose from 26 per cent to 32 per cent.[374]

In rural Honduras, an agricultural extension programme offers an example of a low-cost way to involve men in reproductive health and to increase couple communication about family planning. While meeting with farmers, paid extension workers used an interactive manual to talk about reproductive health. In some areas, couples also were given a booklet designed to help husbands and wives plan their long-term family goals. In both areas, communication between spouses improved. The percentage of women who reported discussing family planning with their husbands increased from 36 per cent to 50 per cent. The percentage of couples discussing STDs and HIV rose from 42 per cent to 54 per cent.[375]

In Tanzania, a UNFPA-funded radio soap opera on reproductive health, including family planning, sexual health and HIV/AIDS prevention, called "Twende na Wakati" (TNW, "Let's Go with the Times"), was among the first entertainment-education projects to focus on both family planning and HIV/AIDS prevention. The TNW project had significant effects on listeners' fertility behaviour and communication, including spousal communication. Some 61 per cent of the listeners in the treatment area said they told someone else, usually a friend or their spouse, about TNW. Most reported talking about the family planning and HIV/AIDS content of TNW. Thus, the entertainment-education soap opera stimulated considerable peer communication about HIV/AIDS prevention and family planning, mostly among individuals who listened to the radio programme. This media-stimulated interpersonal communication was very important in changing radio listeners' family planning and HIV/AIDS prevention behaviour.

A FEW STRATEGIC COMMUNICATION TIPS: LESSONS LEARNED FROM EXPERIENCE

Diversity and audience segmentation

"Men, like women, are an extremely diverse group. Some men are involved in mutually faithful, long-term relationships with women; some have occasional sexual relationships with both men and women; some men have long-term committed relationships with other men. Many men are fathers. Many men work in settings that offer status and adequate pay, while others migrate for work or work in dangerous settings. Some men have important policy-making positions. Others come from disadvantaged social groups. Many men represent positive role models for their families and communities. We must recognize this complexity when we seek to engage men." [376]

---

[374] Ibid., p. 50.

[375] CARE, "Strategies to Involve Men in Reproductive Health Care: From Farm Management to Family Management" (from *Frontiers in Reproductive Health*, Electronic Library, 1990–1999), May 1998.

[376] G. Barker, "Boys, Men and HIV/AIDS".

Men also hold diverse beliefs and the differences in attitudes related to reproductive health can be greater between men than between men and women.[377] Similar to advocacy, identifying categories of audiences, messages and specific approaches is a critical step in IEC programmes for men. Recognizing men's diversity in all its dimensions — age, education levels, socio-economic status, family situation, work environment, religious beliefs and traditional customs — and deciding how to reach and serve the needs of these different categories of men are key steps in

Segmentation of Men's Characteristics by Age[379]

Age 20–35 years	Age 36–45 years	Age 46+ years
Potential child-spacers unmet need for FP, especially temporary methods	Potential limiters — unmet need for FP, especially long-term or permanent methods	Unmet need for permanent contraception information and services
High desire for children	Married, usually with desired number of children	Married, usually with desired number of children
May have little communication with partner	May have little communication with partner	May have little communication with partner
Concerns about unsafe abortion, need for abortion counselling with partner	Potential polygamist, frequently with prostitutes (high risk of HIV/AIDS and STDs)	
Needs work, income, and housing	Economically established	Economically established
Highly mobile, may do migrant labour	More conservative than younger age groups	Traditional values
Has ambitions, looks to the future		
Can be reached through peer group, workplace education, clinics, mass media, and role models	Can be reached through peer groups, workplaces, clinics (accompanying wife and children), media, and men's club	Can be reached through peer groups, workplaces, clinics, media, and men's club
Media conscious		

developing IEC programmes. Such programmes must use diverse channels of communication to reach men at home, at work, at religious and social events, in schools and community centres and wherever they receive educational or commercial messages.[378]

Target responsible and caring men

Changing behaviours related to gender roles and responsibilities may be a lengthy process. Resistance to change is firmly entrenched, and a single exposure to an idea is not sufficient to result in such change. Accordingly, when promoting changes in gender roles, it will be important to seek out individuals who might be more receptive to change or to trying something new. It may be more strategic for programmes to focus on men who are acting "responsibly" according to their traditional role, and not just on the "irresponsible men who do not support their spouses' reproductive health".[380] They are more likely to take the risk of going against the tide of what the others do. Also, it is important to enlist support from those that are known and admired by the target audience.[381]

Beyond simplistic ands standard messages in HIV prevention: including a sexuality-based approach

A sexuality-based approach takes into account the variety of sexual relationships a person or couple may be involved in, including past partners, current ones and travel. HIV/AIDS prevention campaigns have sometimes simplistically promoted mutual monogamy and condom use as the only two options for HIV prevention among heterosexual individuals. However, mutual monogamy is not a safer sex strategy in and of itself. Men's multiple sexual partners have not been adequately acknowledged in HIV prevention campaigns.

Only sustained mutual monogamy between two sero-negative individuals who are confident of their non-HIV status provides protection against HIV. Some national AIDS campaigns — most notably Uganda's "Love Carefully" campaign — have promoted monogamy or fidelity as a way of reducing the risk of HIV. These campaigns and general awareness of HIV may be leading to increased monogamy by men in some places. A study in Tanzania found that the percentage of men over age 25 reporting occasional sexual partners declined by half in two years.[382]

Barker proposes the interesting concept of *negotiated safety*, where stable heterosexual couples may agree to use condoms in any outside relationship, but may not use condoms in their sexual activity together except perhaps as a form of birth control. Other heterosexual couples may be mostly monogamous but have some occasional partners, but decide not to have penetrative sex with these outside partners as a way of reducing the risk of HIV. All these examples suggest that preventing HIV among men in their heterosexual relationships is not as simple as merely

---

377 M. E. Greene and A. Biddlecom, "Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles" (paper presented to the IUSSP/CENEP seminar on "Men, Family Formation and Reproduction", Buenos Aires, May 1998).

378 Johns Hopkins University Center for Communication Programmes, "Better Together", p. 3.

379 Ibid.

380 B. Shepard, "Masculinity and the Male Role in Sexual Health", *Planned Parenthood Challenges* 2 (1996): 11–12.

381 M. Villarreal et al., "Male Involvement in Reproductive Health: Incorporating Gender throughout the Life Cycle", UNFPA TSS Discussion Paper, December 1998, p. 17.

382 G. Barker, "Boys, Men and HIV/AIDS"

promoting monogamy and condom use. Instead, safer sexual activity should consider the realities and desires of both partners.[383]

Of course, a sexuality-based approach must include men having sex with men. While governments are often reluctant to take these efforts on, a number of NGOs are taking the lead and need support. "In the last 15 or more years a number of programmes have started to work in HIV prevention with MSM. These include community-based or street-based outreach programmes for male sex workers and their clients; outreach programmes for networks of MSM, including in nightclubs, saunas or bathhouses where some MSM may frequent; telephone hotlines with information and counselling for MSM; safer sex workshops and condom distribution for MSM; and support groups for HIV-positive homosexual men. A number of organizations and initiatives working on HIV prevention with MSM have also worked on promoting the human rights of MSM, including legal recognition for same-sex cohabitation, and seeking to reduce discrimination against MSM in the health sector and the workplace, including the Naz Foundation India Trust."[384]

What's in it for men? Show them the gains

Both individuals and groups of people with common interests will be more inclined to try out behaviours that are not the ones traditionally linked with their gender if they are convinced that such behaviour will be of benefit to them and their families socially, economically and educationally. Similarly, before men use existing or new services, they must perceive a need for those services and relate their own circumstances to that need. This is the role of IEC. It can promote behaviour change by using carefully designed and pre-tested approaches based on thorough research and intended for specific audiences; for instance, young men or married men who want children, or married men who do not want children. IEC programmes for men must understand not only the obstacles to men's participation — physical, mental, financial and political — but also the important factors that predispose men to be advocates for family planning, and the reasons this potential remains largely untapped.

Studies and programmes have not paid sufficient attention to what represents a major challenge to IEC programmes: helping men find *advantages* in a less hierarchical relationship with women. We need to identify benefits that a redefinition of male identity towards better gender equality would generate *for men*. Such gains can derive from the experience of stepping out of their usual roles, responsibilities and behaviours. For instance, the release from pressure to be a "man" was identified by seminar participants as a key motivating factor for changing male identity.[385] Masculinity studies show that men are constrained by very limited, confined notions of masculinity. There are, however, good aspects of masculinity on which programmes can be built, and which need to be identified as well.

---

383 Ibid.

384 Ibid.

385 A. Wouters, trip report from Zambia.

Men Can Gain from Improved Gender Equality

This is the conclusion reached at a Swedish-African seminar[386] on gender equality. Gains listed include:

- More resources are available from sharing financial burdens.
- There is increased income
- Sharing responsibilities makes life easier for both men and women
- Men live longer when they have a loving relationship with their spouse
- Men are happier and feel more secure, and are less prone to depression, mental disorders and violence
- Men get more job satisfaction and feel less stress
- Men gain more time with the family and closer bonding with children
- Men become less aggressive as parents
- Men get the opportunity to be individuals rather than a means for reproduction
- Men can become more intimate, have peace of mind, and have sexual intimacy
- Boys and men will gain from expressing their feelings

Addressing men's concerns and what they perceive as their problems does not mean that women's are neglected. It is a strategy that is more likely to attract men's interest and participation for solving problems that affect both of them.

Identify and promote convincing arguments

One error commonly made when devising strategies to enlist men's support is to conceive of a process in which women would gain but men would be the losers. The emphasis on responsibility tends to lead to punitive or moralistic strategies, which may provoke a backlash and negative reactions in men. Men can be very sensitive to anything perceived as an attack on them. For example, seminar participants said that the term "male responsibility" should be banished from the gender equality agenda, as it may be seen as an unfair criticism of men.[387]

In fact, what is phrased as a responsibility or a duty can in many cases also be proposed as a right.[388] Male rights here would refer to men's freedom to behave in non-conformist, non-macho ways, to deviate from learned cultural expectations and roles, and to balance domestic and work responsibilities. For instance, stating that men have a right to care for their newborn children entails that conditions in which men are allowed to assume more responsibility are created. This positioning may lead to strategies related to parental leave, and day care centres. In

386 SIDA, "Men's Voices, Men's Choices".

387 Ibid.

388 B. Shepard, "Masculinity and the Male Role in Sexual Health".

another instance, seminar participants (in Luzaka) agreed that giving *men the right to express their feelings and emotions, and relieving men from bearing the main responsibility for supporting the family*, would be key rewarding components of a gender-friendly male identity.

In developing appropriate messages, it is important to focus on the positive aspects of what can be achieved by strengthening the role of men in reproductive health. It can be helpful to package and disseminate research findings that highlight the importance of male reproductive health needs, as well as the importance that their participation in reproductive decisions has for women's health.

Good humour is an essential ingredient in IEC efforts directed towards men. Entertaining stories, which can be presented in many ways, are a good avenue for broaching sensitive topics and stimulating group discussions. At the same time, it is important to combat some of the negative myths related to how people perceive men's attitudes and behaviours. Addressing common misperceptions of men about vasectomy, which may be wrongly associated with castration, can allay men's fears of side effects such as loss of sex drive, obesity and impotence. In Brazil, a multimedia campaign promoted vasectomy as "an act of love". The central image of the campaign was a cartoon of two hearts, one male and one female, who playfully depicted the advantages of vasectomy. The animated cartoon aired on television, and the hearts were featured in pamphlets, magazine advertisements and on billboards. During and after the campaign, requests to clinics for information about vasectomies increased substantially. Years after the campaign, family planning clients still referred to the two hearts. [389]

Use peer educators when men are not likely to admit their lack of information about sexuality, pregnancy and parenting skills

Men need information about contraceptive methods, including male methods, sexuality, basic anatomy, pregnancy and its risks. For instance, "Man Talk" in Swaziland trained men to talk to other men one-to-one in bars, pool bars, clubs and factories. Other activities include distributing educational leaflets, motivational materials and condoms, and working with local business owners. Results in this effort were demonstrated when a nightclub owner agreed to install a condom vending machine in the men's restroom.[390]

In Zimbabwe, UNFPA in collaboration with CARE supported a peer education programme using volunteers as advocates for community AIDS and reproductive health initiatives.[391] The project moves from a focus on commercial sex workers to their clients' workplaces, in which the nature of work is conducive to STD/HIV transmission, including railway and trucking companies, mines, and companies with a high proportion of migrant and seasonal personnel. Participatory approaches include problem solving, the use of group discussion in peer education, role-plays, drama, music, picture codes and lectures, networking, participatory methods and one-to-one

---

389 Johns Hopkins University Center for Communication Programmes, "Reaching Men Worldwide", p. 50.

390 L. Touré, "Male Involvement in Family Planning: A Review of the Literature and Selected Programme Initiatives in Africa", USAID/HHRA, November 1996, www.usaid.gov/regions/afr/hhraa/male/male.htm.

391 UNFPA, "The Community Peer Education Programme for HIV/AIDS Prevention" (draft evaluation report, UNFPA CST, Harare, Zimbabwe, 1998).

counselling. Peer-education sessions take place in beer halls, beer gardens and pubs; educators also distribute large quantities of condoms, and make referrals to clinics for free STD counselling and treatment. The programme has assisted in the setting up of 14 similar community-based programmes, in five neighbouring countries: Zambia, Botswana, Swaziland, Lesotho and Mozambique.

However, difficulties may include low turnout for male sexuality training, at least initially. Some men, especially young men, do not want to reveal their ignorance about sex and reproduction. Thus, they may not ask questions, may be quiet in groups, and may act differently if their wife or girlfriend is present. Nevertheless, by being sensitive to men's concerns, educators and counsellors can determine what information they need and convey it without causing embarrassment. In Denmark, plans for a carefully prepared large-scale training of male teachers and counsellors to learn teaching skills on male sexuality and male involvement in contraceptive use had unexpected difficulty recruiting trainees. Over 2,000 invitations were sent to some 1,100 schools and 800 youth clubs, but only 11 men responded and participated.[392]

Challenge self-defeating behaviour through innovative interpersonal and group communication methods

Men may be adopting self-defeating behaviours because of lack of self-esteem. In Haiti, the Groupe de Lutte Anti-SIDA (GLAS, Group in Struggle against AIDS), an HIV prevention programme conducted at Port-au-Prince workplaces, moved from educational sessions on HIV/STDs prevention to more open-ended discussions on rumours and beliefs about HIV/AIDS, and personal issues. Still, after the sessions, some men and women continued to put themselves at risk for HIV infection. Puzzled by this behaviour, the director explored how lack of self-esteem and poor communication skills impeded behaviour change. An educational and psychological tool for personal growth and change, called transactional analysis, was used in small support groups. This psychological approach focuses on teaching adults how to abandon often painful and self-defeating strategies, typically learned during childhood, and how to develop different attitudes for dealing with life's problems. It also promotes clear, direct communication.[393]

Other tools involve playing risky games with men at risk to help heighten their sense of vulnerability. In Gettysburg, Penn., groups of young men in college are learning to respect risks with the help of mentors. Activities are designed to develop skills in team-building, resisting peer pressure and accepting personal responsibility. Some games involve pairing off, then one verbally guides his blindfolded partner around the items that are labelled as harmless, or posing risks for STDs. In this game, points are given whenever a blindfolded man touches a "risky" item; accumulating a certain number of points results in an "infection". Other games involve climbing and other risky sports. At the heart of the small programme is the idea that youth drawn to impulsive and risky behaviours can learn to respect risks and prepare for them through challenging physical activities and mentors whose professions are naturally dangerous.[394]

---

392 D. Rix, "Male Sexual Education in a Danish Perspective", *Reproductive Health Challenges*, vol. 2 (1996).

393 K. Best, "Abandoning Self-Defeating Behaviours", *Network* 18, no. 3 (Family Health International, spring 1998).

394 Ibid.

Build conflict resolution skills

"Conflict resolution" is an umbrella term for different approaches that recognize that conflict is normal and need not be destructive. It takes a positive approach to addressing conflict. At its best, conflict resolution is a way of turning situations of conflict into learning opportunities. It is a way of building self-awareness, teaching practical skills, creating trust and building a safe environment, and, of course, solving specific problems.[395]

Bring information to where men gather

Programmes can reach more men when they go where men naturally congregate, such as the workplace, social clubs or sporting events. Men are comfortable in these places, form a ready audience and may be more receptive to new information.

In Namibia, UNFPA helped establish a partnership among the Northwest Health Directorate of the Ministry of Health and Social Services, the Namibia Police Force, the National Defence Force, local soccer clubs and the Evangelical Lutheran Church. The idea was to institutionalize men's positive participation in reproductive health in five male-specific groups in the Northwest Health Directorate. The project also relied heavily on the participation of non-ministry groups with large male populations, including the police force, defence force and sports clubs. In addition, the project focused on local male clergy and lay leaders, to elicit their participation and leadership in working with church youth groups and men's fora, and in preaching to congregations and providing pre-marital and family counselling, which included discussions about sexuality and couple communication. Finally, the project piloted the use of local drinking establishments — Cuca shops — to initiate and promote condom distribution in non-medical settings. Creating inter-sectoral links between the Ministry of Health, civil society and other government bodies was a right step towards achieving social mobilization and the community-empowerment objective. The project succeeded in effectively mobilizing the five participating groups to increase male involvement in sexual and reproductive health.[396]

Sports, a communication venue

All over the world, sports events attract many men. In Africa, as elsewhere, soccer is a passion among men and boys. Tapping this natural audience, Johns Hopkins Population Communication Services launched the Challenge CUP Initiative in 1997 in Ghana, Kenya, Uganda and Zambia. CUP stands for "Caring, Understanding Partners". The Challenge CUP Initiative encourages men who attend the football matches to become more sexually responsible, to prevent STDs, to learn more about reproductive health, and to discuss it with their wives or other sex partners. To reach the large crowds attending the games, a variety of materials featuring key reproductive health messages are given away, including trading cards of football stars, T-shirts, sun visors, bumper stickers and informative pamphlets.[397] At the same time, coaches

---

395 M. Kaufman, "Conflict Resolution: Finding Better Ways to Help Boys and Girls Solve Problems" (paper prepared for Gender, Partnership and Participation Section, Programme Division, UNICEF, 31 March 2000), p. 2.

396 "Strengthening Male Involvement in Reproductive Health", Northwest Health Directorate of the Ministry of Health and Social Services, Namibia, NAM/96/P01, project funded by UNFPA, 1997–2000.

397 B. Robey and M. Drennan, "Male Participation in Reproductive Health", *Network* 18, no. 3 (Family Health International, spring 1998): 11–15.

and football players are counselled about positive reproductive health behaviour. Several star players serve as spokespersons and role models, speaking about spousal communication and STD prevention at half-time during matches, and also on radio and television.

Using sports as a communication venue needs careful handling. Sport is an environment in which demands for an aggressive, competitive masculinity are usually promoted. "Sport can offer wonderful activities to develop fitness and co-ordination, and to encourage sharing and co-operation. Unfortunately, most of the sports and games developed in this century stress competition, domination, and an ethos of wining at all costs".[398]

Men on the move

UNFPA has also successfully established partnerships with the army and employers to reach men in several countries of Latin America, and more recently in Africa (see **chapter VI** on services). Men in the military constitute a priority group; as an itinerant population, they are prone to a high-risk sexual culture that predisposes behaviour leading to STD/HIV and unwanted pregnancy. High-risk sexual behaviour is encouraged by the military sexual sub-culture, which accentuates masculine stereotypes,[399] as well as more troubling issues of sexual violence in overcrowded populations such as prisons.[400] Sailors and truck drivers constitute other priority groups that have received communicators' attention in Africa and South Asia. These programmes also provide services for families of military personnel, and for civilians who use military health services.[401] Halting AIDS on the highway is the goal of a project for truck drivers in India.[402] Four drop-in centres run by the Bhoruka Public Welfare Trust at strategic halt points between state and country borders make it easy for drivers to visit the centres, where comfortable seating, fans and televisions enhance the welcoming atmosphere. Each centre has a medical officer, male and female social workers, counsellors and outreach workers who facilitate the prevention and management of STDs including HIV/AIDS.

Explore new communication channels: entertainment and Internet venues

The term Enter-Educate is a contraction of the words entertainment and education, and describes any communication presentation that delivers a pro-social educational message in an entertainment format. Men's attention can be attracted by using an entertainment format — the "enter-educate" approach — which has proved effective in many countries. In Africa, music is a

---

398 M. Kaufman, "Positive Strategies with Boys to end Violence" (paper prepared for Gender, Partnerships and Participation Section Programme Division, UNICEF, New York, 31 March 2000). On sport and masculinity, see the path-breaking book by V. Burstyn, *The Rites of Men: Manhood, Politics, and the Culture of Sport* (Toronto: University of Toronto Press, 1999).

399 UNFPA Technical Support Services thematic workshop on Male Involvement in Reproductive Health (November 1998); see Web site: www.fao.org/sd/wpdirect/wpre0123.htm.

400 H. Reyes, "Relevance of Condoms in Prisons" (paper presented at Corrections Health Services Conference, Australia, November 1997); see ICRC Web site: .

401 UNFPA, "Legislative Commitments to Sexual and Reproductive Health and Rights: A Five-Year Review of the Cairo and Beijing Conferences in Latin America and the Caribbean", 2000.

402 "Case Studies from India Examine the Status of Men as Supportive Partners in Reproductive Health" (news release, Population Council); A. Majumdar, "Halting AIDS on the Highway" (Bhoruka Public Welfare Trust, Calcultta, India, 8 August 2000); rsrls.html.

powerful mode of communication, transcending national borders, cultures and languages. In French-speaking African countries, the FHA/REDSO project is using the enter-educate approach to address the problem of HIV/AIDS and to make people aware of how to prevent the disease. Through a musical programme — *Wake Up Africa* — about 30 African musicians are helping to publicize the HIV/AIDS issue by creating and performing works on the theme of HIV/AIDS prevention. Participants in Ouagadougou watched a new music video, *Wake Up Africa*, produced by the FHA project featuring the musicians' works. In addition, the musical message is being promoted with a compact disk, an audiocassette, a live concert, radio and television spots, entertainment magazines and T-shirts.[403]

New information and communication technologies offer promising potential. In Peru, an interactive, computerized, multimedia system provided information to clients on sexuality, contraception and other reproductive health issues in clinic waiting rooms. Topics most consulted included benefits of family planning, first sexual relation, sexual education and machismo. Fifty-seven per cent of surveyed users said it was easier than consulting a traditional provider or counsellor. System users were generally young adults aged 20 30, with only 7 per cent over 40, and 84 per cent had more than a high school education. The placement of the computer in a private room, as opposed to a waiting room, was suggested for privacy.[404] Similarly, in Turkey, the ministry of Health has published Web pages that provide information to specific groups of people, including men.

[403] Johns Hopkins University Center for Communication Programmes, "Men: Key Partners in Reproductive Health" (a report on the First Conference of French-Speaking African Countries on Men's Participation in Reproductive Health, Ouagadougou, Burkina Faso, 30 March–3 April 1998), p. 11.

[404] Population Council/Inopal III, "Introduction of Multimedia as an Information Tool for Sexual and Reproductive Health Education" (in *Frontiers in Reproductive Health*, Electronic Library 1990–1999), Lima, Peru, 29 October 1998.

Lessons Learned in Communication in Reaching Men

An extensive review of its family planning communication projects throughout the developing world by the Johns Hopkins University Population Communications Services[405] found that communication strategies that work and appeal to men should:

- Publicize and promote service sites for men. Research shows men need better access to information and service providers with whom they feel comfortable.
- Improve men's image of contraceptive methods. Communication campaigns must focus on factual information and perceptions to overcome myths or rumours that sometimes generate men's opposition to certain forms of family planning.
- Use multiple communication channels to create a synergistic effect. Effective family planning programmes use several channels to deliver their messages. Research shows that individuals that are exposed to a message from multiple sources — mass and community-based media, and interpersonal communication — are more likely to take action than those exposed to a message from a single source.
- Pay attention to young men. Young men just beginning sexual activity are especially vulnerable to STDs, including HIV/AIDS. Addressing their needs can have a potentially large impact on their lives and those of many others.
- Present men as caring partners, not as irresponsible adversaries. Although men are sometimes seen as obstacles to family planning efforts, research shows the macho stereotype is often a false one. Playing to stereotypes can do a disservice to the audience and damage a family planning campaign's effectiveness.

[405] Johns Hopkins University Center for Communication Programmes, "Reaching Men Worldwide", p. 50.

Chapter 6

Reproductive Health Service Delivery Interventions That Focus On Men

In the ongoing debate about what constitutes appropriate level of male involvement in reproductive and sexual health, issues discussed include defining men's health needs and shaping services for them. Including men in population programmes seems to some a step back rather than forward, particularly if inadequately focused programmes transfer control from women to men. There is tremendous fear, especially among women's health advocates, that scarce resources already insufficient to address women's health issues will be shared with or redirected to men's health programmes, although women continue to bear a larger "burden of reproductive morbidity and mortality".[406] The feminists worry that women's rights will be threatened if men are going to be more involved in reproductive and sexual health, as in many countries, men are already sole decision-makers and control women's reproduction and sexuality.[407] The pragmatists argue that when services are set up based on an understanding of the underlying gender relations, both women and men will benefit; they also try to show that services for men are not necessarily expensive, nor do they compete with the scarce resources available for women's services.[408] In the end, all depends on whether we consider men in their decision-making role or as clients with their own needs.[409] In spite of these concerns, the population and health fields are cautiously identifying and responding to men's needs. This chapter reviews experiences and lessons learned in meeting men's needs as service clients, the range of services, their organization and quality, and reaching men in the workplace or where they meet. Finally, distribution schemes of family planning and HIV prevention are discussed.

Men's reproductive health and sexual needs

Existing DHS studies do not adequately reflect men's reproductive and sexual health needs, since only married men are interviewed. In addition, current standard questionnaires do not leave

406 J. du Guerny et al., "The Male Side of Gender throughout the Life Cycle" (paper presented at UNFPA TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, Rome, 9–13 November 1998).
407 M. Berer, "Men", *Reproductive Health Matters* 7 (May 1997): 10.
408 J. du Guerny et al., "The Male Side of Gender".
409 C. Laudari, "Gender Equity in Reproductive and Sexual Health" (paper presented at UNFPA TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, Rome, 9–13 November 1998).

room to understand "context-specific determinants" of men's sexual and reproductive health.[410] However, male clients have concerns of their own, such as fears of sexual inadequacy, ignorance about sexual and reproductive functioning, risks of STDs, risks of unwanted pregnancies with their partners, or misunderstandings about how male- and female-controlled contraceptive methods work.[411] A few studies now investigate what men report as their clinical needs. In **chapter II**, a brief list of clinical services was introduced, which included family planning, prevention and treatment of STDs, sexuality, infertility, urologic conditions and sexual dysfunction or psychosexual problems.

The AIDS epidemic is contributing to increased attention to STDs and HIV/AIDS prevention. For instance, there is recent research on the connection between circumcision and the risk of HIV. While studies in developing countries suggest that men who have been circumcised are at lower risk of HIV infection than men who have not, similar studies in the United States found no correlation between male circumcision and risk of HIV infection.[412] Participants at a recent meeting hosted by the Horizons programme of the Population Council agreed that there is "considerable evidence supporting a protective effect of male circumcision on HIV infection in men in sub-Saharan Africa". But they also concluded that "there are many unknowns" and that circumcision has "profound cultural implications, carries the risk of complications, including possible other infections related to the procedure, and its benefits are realized only many years later".[413] Further research, suggested this group of experts, should focus on exploring mechanisms of male infection; controlled trials for a male circumcision intervention that examines its efficacy to prevent HIV infection; the relationship of hygiene to HIV infection; the effect of other variables, including religion, on HIV transmission; longitudinal studies of circumcised men who are not infected to see if and why some of them become infected with HIV over time.[414]

Furthermore, there is now greater recognition that infertility, widespread in developing countries, affects men as well as women. STDs, which can lead to cancer, are the leading preventable cause of infertility. Parasitic and infectious diseases, poor health care practices and vascular injuries due to poorly performed hernia repairs can also cause infertility.

---

410 M. E. Greene and A. Mayouya, "Conceptual Frameworks and Data" (paper presented to UNFPA TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, Rome, November 1998), pp. 2–13.

411 S. Dixon-Mueller, "The Sexuality Connection in Reproductive Health", *Studies in Family Planning* 24, no. 5 (September/October 1993): 277.

412 K. Best, "Men's Reproductive Health Risks", *Network* 18, no. 3 (1998).

413 J. van Dam and M. C. Anastasi, "Male Circumcision and HIV/AIDS: Directions for Future Research", Report of a meeting, Washington, DC, Populations Council, June 2000. www.popocouncil.org/horizons/reports/circumcision.

414 Ibid.

Current Symptoms Reported by Men in a Population-Based Survey

Reported symptoms	Per cent of Men reporting symptoms:
No problem	74.2
Psycho-sexual problem •	16.7
Pain passing urine	7.9
Urethral discharge	3.1
Painful coitus	1.7
Urethral discharge plus dysuria	1.0
Genital ulcer	0.6

•Men could report more than one symptom

••Psycho-sexual problems include premature ejaculation, impotence, dissatisfaction with sexual intercourse, difficulty in maintaining an erection and "night pollution".

SOURCE: S. Hawkes, "Why Include Men/Establishing Sexual Health Clinics in Rural Bangladesh", *Health Policy and Planning* 13, no. 2, pp. 121–30, cited by C. Laudari, "Gender Equity in Reproductive Health" (paper presented at UNFPA TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, Rome, 9–13 November 1998), p. 7.

AVAILABLE MALE METHODS FOR FAMILY PLANNING AND HIV/AIDS PREVENTION

Although family planning is not the only reason men come to clinics, provision of male contraceptive methods is a key component of most reproductive health services for men. Condoms and no-scalpel vasectomy are the only highly effective available male methods, though new ones are being developed.

Condoms

Condoms are currently the best way to prevent AIDS, and the epidemic has triggered a sharp increase in their use. Chapters II and V discussed behavioural aspects of condom use. Latex condoms are reliable and effective in preventing pregnancy and STDs if they are used regularly and correctly. Unfortunately, some health providers and users continue to have negative perceptions about them. Recent advances in condom development to make them more user-friendly and improve their quality offer good reasons to trust their effectiveness, as follows:

Reasons to Have Confidence in Condoms[415]

- **Condoms are an effective means of preventing pregnancy, when used correctly and consistently.** Pregnancy rates from condoms range from 3 per cent to almost 14 per cent.
- **Condoms are an effective means of preventing STDs/HIV when used correctly and consistently.** A woman's fertile period is intermittent, but men and women can be at risk of contracting an STI, including HIV, at every intercourse.
- **Latex condoms provide an impermeable mechanical barrier**. They are impermeable to bacteria, viruses and sperm. Therefore, unless a condom breaks or slips during or after ejaculation, or has manufacturing defects such as pinholes, which are extremely rare, users are not exposed to semen or viral particles.
- **Most users do not break condoms, and a proportion of breakage is preventable**. Condom failure, breakage or slippage is concentrated among a small percentage of users. Inexperience in using them, young age, not living with one's sexual partner, having multiple sexual partners, low income, low level of education and large penis size are associated with breakage or slippage.
- **Today's condom is manufactured with greater precision**. Latex condoms are better formulated, processed, finished and packaged. Condom manufactures are responding to concerns about latex allergy, shelf life and condom performance, and are using advances in technology to produce superior condoms. Foil packaging extends the life of a condom at least five years.
- **Quality control and post-production quality assurance help ensure a reliable product**. In the era of AIDS, the condom is considered "a potentially life-saving medical device" that must meet strict standards. Minimum acceptable quality levels are enforced through worldwide and regional bodies responsible for ensuring that condoms meet the standards.

No-scalpel vasectomy

No-scalpel vasectomy, though effective, safe, quick to perform and with few side effects, continues to be underused. Approximately 54 million couples worldwide use it, while about 150 million undergo the more complicated tubal ligation. In Pakistan, for instance, vasectomy remains the least publicized contraceptive option.[416] Research on men's reasons for using vasectomy is consistent across countries (that is, Bangladesh, Brazil, Colombia, Kenya, Mexico, Rwanda, Sri Lanka and the United States). Men have vasectomies to relieve their partner from using contraception, and they are sterilized when their families are complete and consider it the best form of contraception; some cite economic reasons or concern for women's health.[417]

---

[415] Family Health International, "Reasons to Have Confidence in Condoms", adapted from "The Latex Condom: Recent Advances, Future Directions", *Network* 18, no. 3 (1998), revised 8 October 1999, www.fhi.org/en/fp/fppubs/network/.

[416] M. Douthwaite, "Male Involvement in Family Planning and Reproductive Health in Pakistan: A Review of the Literature", *Research Report*, no.7, Population Council, Islamabad (March 1998), p. 54.

[417] W. R. Finger, "Attracting Men to Vasectomy", *Network* 18, no. 3 (Family Health International, spring 1998), www.fhi.org/en/fp/fppubs/network.html.

Despite misperceptions, interest and use of vasectomy is growing. This is a result of a multi-level process. In Africa, the acceptance of vasectomy is growing thanks to the integration of good counselling, quality services, reliable information and sensitization campaigns. In some places, providers identify receptive users and recruit satisfied clients to attract other clients; satisfied clients are sometimes organized in informal support groups such as the Vihiga Club in Kenya. The Vihiga Vasectomy Club helped promote vasectomy through a media campaign that included appearances on radio and television and in the newspaper. Some of the members were trained in family planning to work as outreach workers, while others volunteered in clinics to provide information to men who were considering vasectomy. As a result, men in Vihiga are more like to consider vasectomy and use condoms, and are less likely to believe rumours associated with these and other methods, than other men in Kenya.[418] In 1989, the Mexican Social Security Institute launched a programme to increase the availability of outpatient vasectomy services and promoted them to men. The programme is associated with an increase in the annual number of vasectomies performed (from 6,283 in 1989 to 16,882 in 1993) and a decrease in the ratio of female-to-male sterilization procedures (from 21:1 in 1989 to 10:1 in 1993).[419] Other client-oriented service-delivery elements designed to increase acceptance of vasectomy include confidentiality and integration of male sterilization with other male reproductive health services.[420] In Bangladesh, where poorly performed procedures contributed to the decrease in male voluntary sterilization, providing more information, education and communication to wives, and initiating couple counselling on vasectomies were strategies proposed to stop its decline.[421]

Kiribati: The Use of Satisfied Men as Family Planning Promoters

The vasectomy project is one of the several projects that UNFPA supported in the 1980s. The project goals were to improve the health of mothers, fathers, children and family as a whole, and to increase male involvement and practice of family planning, including vasectomy.

The project enlisted satisfied vasectomized men from the community, including health personnel, as family planning promoters. Satisfied users became community advocates, who promoted vasectomy by testifying about its simplicity, safety and efficacy. Visiting family planning teams offered family planning services, including vasectomy, to all outer islands and rural areas.

In addition to IEC materials (pamphlets, posters, videos and calendars), which provided an excellent support to the reproductive health programme, the government's primary health clinic programme successfully mobilized vasectomized men to share their experiences with peers in meetings, seminars, radio and video programmes, and through one-to-one communication. Now, the number of vasectomized men exceeds the number of sterilized women, and the use of condoms has also increased — indicators of the success of this 10-year programme.

SOURCE: UNFPA CST Fiji

[418] AVSC International, "Men as Partners in Reproductive Health" (workshop report, Mombassa, Kenya, May 1997), p. 14.
[419] PATH, "Involving Men in Reproductive Health", *Outlook* (1997): 2.
[420] L. Touré, "Male Involvement in Family Planning: A Review of the Literature and Selected Programme Initiatives in Africa", USAID/HHRA, November 1996, www.usaid.gov/regions/afr/hhraa/male/male.htm., p. 12.

Dual Protection

Dual protection is the simultaneous prevention of STI/HIV and unwanted pregnancy that can be achieved in several ways: (1) correct and consistent use of condoms; (2) correct and consistent use of condoms and concurrent use of another contraceptive method. In the field of HIV prevention, dual protection means using a condom to prevent infection and pregnancy. The "single method-dual purpose" approach relies on emergency contraception in cases of contraceptive failure.[422]

Dual protection is particularly important for:

- sexually active young people between the ages of 15 and 24;
- men who put themselves and their partners at risk because of their own high-risk sexual behaviour;
- sexually people in settings where the prevalence of STDs or HIV or both is high;
- sex workers and clients;
- women or men who are at risk because of the high-risk sexual behaviour of their partners;
- those who have an STD and/or HIV, and their partners.

There is, however, considerable confusion surrounding this concept because of the different interpretations that are influenced by the public health perspective of managers and physicians.[423] For family planning providers, mostly gynaecologists and general physicians, dual protection connotes the simultaneous use of two methods, a highly effective contraceptive for pregnancy prevention and the condom for disease prevention. This "dual-method-dual purpose" approach is born out of interest in promoting the pill and in undermining the condom as an effective contraceptive method, though studies show the condom is just as effective as the pill among couples who have completed their families.[424] This dual-method-dual purpose proposal is receiving mixed reviews because of some disadvantages associated with it. These include: (1) it is unlikely that people will use two methods simultaneously when they are resistant to using one; (2) the addition of a second method may impair consistent use of the first; (3) the promotion of condoms for disease prevention stigmatizes this method and may reduce its use; and (4) two methods may not be logistically or financially feasible.[425]

Operationalizing dual protection requires:

- the integration of family planning and STD/HIV prevention services;

---

[421] Population Council, "Male Involvement in Family Planning: A Challenge for the National Programme Workshop", *Frontiers* (June 1996): 13, 14.

[422] C. Marcham et al., "Dual Protection: Reappraising the Condom as Contraception", WHO, Department of Reproductive Health and Research (background document for a meeting held in October 1999).

[423] Ibid.

[424] N. Banjos et al,. "La promotion du préservatif comme contraceptif", ANRS Information, no. 19 (July/August 1996): 47.

[425] W. Cates et al., "Dual vs. Duel(ing) Protection against Unintended Pregnancy and Sexually Transmitted Infections: What Is the Best Contraceptive Approach?" (manuscript prepared for submission to British Medical Journal, mid-2000).

- training and retraining service providers and counsellors on dual protection so that clients can make free and informed decisions;
- ensuring availability of condoms at service-delivery points and other outlets;
- a focus on young people, boys and girls;
- a focus on men as the users of condoms;
- the appropriate introduction of female condoms into reproductive health programmes;
- incorporating dual protection into programmes for prevention of other-to-child transmission of HIV;
- continuing support of research to bring a female-controlled microbicide to market.[426]

Dual protection should be promoted through person-to-person communication, rather than through promotional campaigns, in order to explain its correct meaning and respond to individual needs.[427] Hence, informed choice on contraception "must also include the acknowledgement that the condom, when used correctly and consistently, not only prevents HIV and STIs, but can also be a highly effective contraceptive." Furthermore, informed choice must also "include the understanding that many methods that are highly effective against pregnancy (hormonal methods, IUDs and sterilization) offer no protection against STIs of HIV."[428]

Other contraceptive methods

Periodic abstinence and withdrawal are other commonly used male methods of contraception. Withdrawal is one of the most widely used temporary methods worldwide. An estimated 38 million couples — representing 13 per cent of all users of temporary methods — rely on withdrawal to prevent pregnancy.[429] Further studies are under way to assess its risk in spreading STDs and HIV.

New male-oriented contraceptive technologies in progress

Meanwhile, research continues to search for alternative methods that are acceptable to men. A study in the United Kingdom assessed men's views on male hormonal contraception, currently under development. Men between the ages of 26 and 35 participated. Results show that 45 per cent of respondents preferred a daily tablet; 36 per cent preferred biannual injections as the method of delivery, and men were prepared to pay for such a method; only one-third would go to a family planning clinic to obtain the objections; and 71 per cent were not prepared to tolerate any side effects.[430] Hormonal and non-hormonal methods of male contraception under consideration are in the following table.

---

426 "Dual Protection against Unwanted Pregnancy and Sexually Transmitted Infections, including HIV", joint WHO/UNAIDS/UNFPA statement, 1999.

427 N. Banjos et al,. "La promotion du préservatif comme contraceptif", p. 48.

428 "Dual Protection against Unwanted Pregnancy", joint WHO/UNAIDS/UNFPA statement.

429 D. Rogow and S. Horowitz, "Withdrawal: A Review of the Literature and an Agenda for Research", Studies in Family Planning 26, no. 3 (1995): 140.

430 M. Brooks, "Men's Views on Male Hormonal Contraception", British Journal of Family Planning 24, no. 1 (April 1998): 7–17.

Experimental Male Contraceptives

Contraceptive prototypes for men use one of two mechanisms of action: some suppress sperm production, either through hormonal or non-hormonal means; others inhibit the ability of sperm to fertilize the ovum, usually by disrupting a key step necessary for conception.

Agent	How it Works	Research Status
HORMONAL SUPPRESSION OF SPERM PRODUCTION		
Gonadotropin hormone-releasing hormone (GnRH) coupled with protein	■ to inactivate the body's natural GnRH, suppressing sperm production ■ Annual injection	Two-year safety trial of gonadotropin hormone-releasing hormone (GnRH) combined with tetanus toxoid protein recently begun in 20 men
7-alpha methyl-19-nortestoterone (MENT)	■ Suppresses sperm production ■ Annual implant	Efficacy trials of MENT implant underway; long-term toxicology testing not yet conducted.
Testosterone buciclate (TB)	■ Suppresses GnRH secretion and thus sperm production ■ Three-month injection	TB injectable tested in a WHO-supported study indicates stronger dosage necessary for reliable contraception. Trials of TB injectable and progestogen may begin in 1998.
Testosterone undecanoate (TU)	■ Suppresses GnRH secretion and thus sperm production ■ One or two-month injection	Studies among men underway in China of TU injectable; studies of two-month TU injection with a progestogen planned.
Testosterone enanthate (TE)	■ Suppresses GnRH secretion and thus sperm production ■ Weekly injection	Provided effective contraception in 98 per cent of 399 men in a two-year WHO trial, but not considered desirable for general use because weekly injections are required.
TE/progestogen combination	■ Suppresses sperm production and thus sperm production ■ Weekly injection of TE, daily progestogen pill	Combination of TE and progestogen achieved initial contraception sooner than TE alone, but not considered desirable for general use because weekly injections are required.
NON-HORMONAL SUPPRESSION OF SPERM PRODUCTION		
Gossypol	■ Suppresses sperm production ■ Daily Pill ■ Irreversible in some men	Recent pilot study of low-dose gossypol pill indicates effective contraception without dangerous potassium depletion; larger efficacy study of 320 men planned.
INHIBITION OF FERTILIZING ABILITY OF SPERM		
Nifedipine	■ May prevent sperm enzyme action needed for fertilization ■ Daily Pill	Research planned to find variations of this drug that may specifically target sperm without producing systematic side effects.
Mifepristone (RU 486)	■ Makes sperm temporarily immotile ■ Daily Pill	Research is seeking chemically-similar compounds that may target sperm without producing mifepristone's undesirable side effects.
Sperm surface protein	■ Antibodies attached to sperm block fertilization ■ Vaccine	Immunization of male guinea pigs with sperm surface protein has demonstrated reversible contraception; other animal studies planned.

SOURCE: Family Health International, *Network* 18, no. 3 (spring 1998).

THE RANGE OF REPRODUCTIVE AND SEXUAL HEALTH SERVICES FOR MEN

Men's reproductive health services typically offer three categories of services: screening, clinical diagnosis and treatment, and information, education, and counselling.[431] The list of services included in the following table provides a comprehensive picture of the services that could be included within the rubric of male services. However, some services are clearly beyond the scope of a basic family planning or reproductive health clinic at the public health clinic level.[432] The range of services provided and their delivery may vary significantly according to local needs, cultural values and resources available. In some cases, referrals may be a more efficient way of oper-

Services included in men's reproductive health care, by whether they can be provided within a family planning clinic or through referral to other facilities

SCREENING, BASIC HEALTH SERVICES	INFORMATION, EDUCATION, COUNSELLING	CLINICAL DIAGNOSIS AND TREATMENT
On-site	**On-site**	**On-site**
■ Comprehensive sexuality and reproductive health history-taking ■ Sexual abuse and domestic violence screening ■ Contraceptive use assessment ■ Complete routine physical exam ■ Nutrition assessment ■ Cancer screening ■ Screening for substance abuse and mental health needs	■ Basic sexuality and fertility education ■ Sexual orientation counselling ■ Sexual abuse and domestic violence information and education ■ Statutory rape awareness ■ Male role definition ■ Comprehensive contraceptive counselling ■ STD and HIV prevention ■ Genital health and hygiene ■ Interpersonal communication skills ■ Post-partum and prenatal counselling	■ Treatment for impotence, premature ejaculation, disorders of the reproductive system, lesions of the genital tract, hernias and varicoceles ■ STD diagnosis and treatment ■ HIV diagnosis ■ Premarital blood tests ■ Fertility evaluation ■ Vasectomy
Referral	**Referral**	**Referral**
■ Treatment for survivors and perpetrators of sexual abuse and domestic violence ■ Parenting education ■ Vaccinations ■ Education and employment counselling and services ■ Cancer treatment ■ Substance abuse treatment and mental health care ■ Stress management and violence prevention ■ Runaway/homeless services	■ Genetic counselling ■ Mastectomy partner counselling ■ Sexuality and disabilities	■ HIV/AIDS treatment ■ Infertility services ■ Treatment of urologic disease ■ Vasectomy reversal

SOURCE: I. Ndong et al., "Men's Reproductive Health: Defining, Designing and Delivering Services", *International Family Planning Perspectives*, vol. 25, supplement (1999)

[431] AVSC International, "Introduction to Men's Reproductive Health Services", 2000, pp. 14–17.

[432] I. Ndong et al., "Men's Reproductive Health: Defining, Designing and Delivering Services", *International Family Planning Perspectives* 25, supp. (1999): 53.

ating; such instances include patients who need cancer care, HIV/AIDS treatment, mental health care, and employment counselling and services.

Screening

During screening, the service provider obtains a medical history of every client (including past surgeries, illnesses and inherited traits) and performs a routine physical examination. Screening includes inquiring about a client's sexual and reproductive history, evaluating his risk of STD and HIV/AIDS, cancers, substance abuse and mental health needs.

Voluntary HIV Testing and Counselling (VTC)

Testing for HIV is one of the more important services offered to men. When men (and women) know their HIV-status, they can disclose it to their partners and choose only confirmed HIV-negative partners, thus reducing the risk of HIV transmission.[433] VTC provides men with diagnostic services, blood tests and specialized counselling in cases where the results are positive, and referrals. VTC should be mentioned as an option to clients during the screening process.

Diagnosis and treatment

During clinical diagnosis and treatment, the provider delivers services or refers the client for diagnosis and treatment of problems detected in the screening exercise. Clients may be treated for impotence, premature ejaculation, disorders of the reproductive system, lesions of the genital tract and hernias. Treatment may also include syndromic management of STDs, HIV care, premarital blood tests, semen analysis, infertility services, vasectomy, post-vasectomy semen analysis and vasectomy reversal.

Syndromic management of STDs

Drawing blood to be tested for STDs, waiting for the results, and then treating or referring clients is one way of treating STDs. However, where resources are limited and there are no laboratory facilities, programme managers should consider the "syndromic management approach" as the first line of treatment, and only refer special cases to existing clinics with laboratory facilities. The syndromic approach uses flow charts with step-by-step instructions on how to recognize and manage reproductive tract infections and STDs, and suggest standard antibiotics.[434] It requires providers to be trained in recognizing the symptoms of common STDs (clamydia, human papilloma virus [HPV], gonorrhoea, herpes, syphilis, pubic lice and scabies). It allows more men to receive effective treatment, including appropriate antibiotics. The treatment framework also invites female partners. Health workers need to use it as an opportunity to disseminate messages on STDs and HIV/AIDS prevention and other reproductive and sexual health issues.[435]

---

[433] G. Barker, "Boys, Men and HIV/AIDS", UNAIDS briefing paper (second draft, Instituto Promundo, Rio de Janeiro Brazil, January 2000), p. 13.

[434] IPPF, "Statement on Sexually Transmitted Disease and Reproductive Health", 1997.

[435] C. Laudari, "Gender Equity in Reproductive and Sexual Health".

Counselling

Through counselling, a client learns about his options and receives education and information on contraception, STD and HIV/AIDS prevention. Counselling is the communication component of service delivery, the third category of services providers offer. The information relayed by counsellors is wide-ranging, covering such topics as sexuality and physiological development; education and counselling on contraception, including the correct use of condoms; education and counselling on STDs, including HIV infection; and education on genital health and hygiene. Counsellors should also provide information on the dual protection of male condoms, the importance of pre- and postnatal care, the risks and symptoms of pregnancy and childbirth, and the role men can play in preventing maternal mortality and morbidity.

Providing counselling is critical for men to become educated consumers of health services for themselves and their partners. Allowing men to participate in family planning counselling sessions, with their partner's consent, and encouraging female clients to discuss family planning and reproductive heath with their partners, can be integrated into existing counselling services at little or no additional costs. Providing counselling services to men, however, requires training counsellors, adjusting the facility, making a space available to assure men of privacy and confidentiality, and promotion.

INTEGRATING STDS AND FAMILY PLANNING IN SERVICES

Meeting men's needs as clients also requires adopting a sexuality-based approach, and integrating HIV/AIDS/STDs prevention. The integration of STD and HIV/AIDS prevention services has been a challenge for services that were originally created to deal with maternal health, family planning and eventually with women's reproductive health. Most national family planning programmes and international agencies place more emphasis on the risks of unplanned pregnancy than on the risks of STD and HIV/AIDS, which leads to the condom playing a minor role in these programmes.[436] Family planning providers continue to encourage women to use highly effective methods of contraceptives (pills, IUDs, hormonal contraceptives), which offer little or no protection from STDs and HIV/AIDS.[437] Biases against victims of HIV/AIDS also contribute to the reluctance of providers to offer testing for HIV/AIDS. Providers are hesitant to offer these services because they fear attracting drug addicts, gays and commercial sex workers, and that this will discourage existing clients and those they are trying to recruit from coming to their clinics.[438] This concern comes at a time when family planning associations are trying to sustain themselves by marketing themselves as qualified providers to working- and middle-class people.

Nevertheless, family planning providers are recognizing their role in STD and HIV/AIDS prevention. In 1997, the International Planned Parenthood Federation issued a "Statement on Sexually Transmitted Diseases and Reproductive Health", acknowledging that family planning programmes are well placed to help in the prevention of STDs and HIV infection by

---

436 W. Cates and K. Stone, "Family Planning, Sexually Transmitted Diseases and Contraceptive Choice: A Literature Update, Part 1", Family Planning Perspectives 24, no. 2 (March/April 1992).

437 "Dual Protection: Reappraising the Condom as Contraception"

438 Personal communications with representatives from family planning associations in Central America, February 2000.

"providing accurate and understandable information, advocating low-risk sexual behaviour and promoting the use of condoms".[439]

The schism between family planning and STD and HIV/AIDS prevention services is reflected in perceptions of the condom as either a contraceptive method or a means of protection from STDs and HIV/AIDS. Efforts are under way to promote the condom as a dual-purpose method to prevent pregnancy and infection when used correctly and consistently. UNFPA, UNAIDS and WHO have recently joined together in advocating for dual protection (see Annex).

Providing special services for men or using existing services?

Should services for men be integrated into existing services, or should men be served in separate male-only clinics? Both strategies have been successful. In some countries, custom and tradition dictate the need for separate services for men; others have succeeded in expanding services within existing facilities. Decisions on which models work best should be informed by consultation with the community to determine its preferences, men's needs and the setting they are most likely to use, and, of course, available resources. Men in Kenya, for instance, are uncomfortable visiting family planning facilities that are historically associated with women. They worry about having to queue up with women to get condoms and what the women will think of them.[440] In Bangladesh, before establishing clinics for men in pre-existing, female-focused MCH/family planning facilities, managers assessed the acceptability and need of such clinics by the community. Male-only clinics have been viable only in urban areas, where the client volume is high enough to sustain them.[441] In some cases, male clinics have generated enough income to subsidize services for women who cannot afford to pay the full fee.[442] Mobile services are another way of reaching men, since they are less likely than women to seek care. Such services are usually provided to men and women in rural areas, where there are no facilities, and in underserved urban neighbourhoods. In many cases, the mobile service is "attached" to an existing clinic that warehouses commodities and rotates staff.[443]

Other relevant considerations include understanding current health-care-seeking practices within the community and client reasons for provider choice; ensuring the availability of health workers to run the clinical services; training health workers in all aspects of male sexual health, not only clinical management, but also counselling and dealing with psycho-sexual issues; marketing the clinics through formal and informal mechanisms; ensuring that female attendance is not adversely affected; and occasional evaluations.[444] In the final analysis, sound knowledge, a

439 IPPF, "Statement on Sexually Transmitted Diseases and Reproductive Health".

440 C. Nzioka, "Male Participation in Decision-Making on Family Planning and Modern Contraceptive Use in Kenya" (report submitted to the Strategic Component on Social Science Research on Reproductive Health, Special Programme of Research, Development and Research Training in Human Reproduction, WHO, June 2000), p. 51.

441 AVSC International, "Men as Partners Initiative: Summary Report of Literature Review and Case Studies" (New York, 1997), p. 41.

442 AVSC International, "Men as Partners: Ideas from Four Continents", *AVSC News*, spring 1997.

443 M. N. Wegner et al., "Men as Partners in Reproductive Health: From Issues to Action", *Family Planning Perspectives* 24, no. 1 (March 1998): 41.

444 S. Hawkes, "Providing Sexual Health Services for Men in Bangladesh", *Sexual Health Exchange* 3 (1998): 14.

Male Call: A Gender-Responsive, Quality Reproductive Health Care Service in Selected Philippine NGOs

Taytay, the target area of the project is confronted with increasing population. The town has no public hospital; the local government's health services are provided through rural health units, which are co-ordinated by the Municipal Health Officer; and the reproductive health services provide only contraceptives.

Although Filipino males believe that children are central to the family and are investments for the future, they often confine their wives to taking care of the children and managing the household. In the course of implementing its earlier projects, PSPI, a local NGO, with support from UNFPA and the Turner Foundation, saw clearly that men were a major stumbling block in women's access to health care and services.

To address these concerns, the collaborating agencies designed a project with the overall objective of improving the reproductive health status of the target group by promoting sensitivity to gender issues and use of available services. To achieve its objective, the project provided men with information on reproductive health and thus hoped to motivate them to assume more family responsibilities.

Male Call successfully combined educational strategies (disseminating information through print media, cultural performances, participation in community events and seminars/workshops) with the provision of reproductive health services. The project maintained a close rapport with its participants, and used their feedback to prepare educational materials, and to improve and expand its work.

Service provision was an integral part of the Male Call project strategy. Klinika Medico (KM) introduced a referral system, which offered discounted rates at other hospitals, and established itself as a clinic that consciously ties family health to male reproductive health and sexual concerns. PSPI consolidated service delivery in the KM by offering outreach services. As a result, an increased number of family planning acceptors and clients sought services, such as management of reproductive tract infections, prenatal check-ups and pap smears.

The project's greatest contribution was linking gender concerns to male involvement within the broader context of reproductive and sexual health. The seminars and workshops gave men the opportunity to discuss sexual behaviours and talk more openly about reproductive and sexual issues with their partners. They asked to include their wives and male adolescents in the awareness-raising workshops. Evaluations show that the project improved men's relationships with their wives. Men became aware of gender, women's rights and men's responsibilities in the family.

SOURCE: UNFPA Manila: J. Frances et al., "Assessing the UNFPA Ted Turner Projects in the Philippines", University of the Philippines, Center for Integrative and Development Studies, 1999; E. C. Abaya et al., "Male Call: An Evaluation Study", Population Services Pilipinas, Inc., 2000; and Population Services Pilipinas, Inc., *Male Call: Enlightened Men, Empowered Citizens*, 2000.

strong commitment and providing the services that men need merit more consideration than the setting in which the services are offered. And regardless of the model chosen, outreach activities with male community groups and informal social networks should be considered, but not serve as substitutes for carefully targeted interventions.

Lessons Learned:

- Access to both information and services is key to increasing men's involvement. Providing them with suffcient information makes them more knowledgeable and supportive of reproductive health and their families.
- If properly educated and sensitized, men can serve as agents to bring more women to accept and practice family planning.
- Early socialization of young boys is a necessary input to greater male involvement in reproductive health.

Is there a special notion of quality of care for men?

The quality of care framework,[445] which includes choice of services, information, technical competence, interpersonal relations, follow-up and appropriate constellation of services, is applicable to men's programmes as well as women's. Nevertheless, additional research is required to inform providers about the range of services that men want and need, and the type of interpersonal communication that works best. New indicators are also needed to monitor the satisfaction of male clients. Some clinic-based programmes for men have helped identify key elements of "male-friendly" services (see Textbox below). Services also need to address providers' bias against men's use of family planning methods.

Ways to Help Men Feel Comfortable at a Facility [446]

- Using a name for the programme/facility that welcomes men and women. Avoid names that are women-specific or imply that men might not be welcome without a female partner.
- Using decorative materials and colours that appeal to men and women. When decorating the waiting areas and service areas, avoid colours and decorative items that are considered specific to women and babies. Changing wall colours, furniture or decor may not be feasible if resources are limited. But even in these settings, the choice of wall posters or low-cost items can send subtle messages that men are welcome.
- Designating a male rest room, if possible, and clearly marking it "Men's Room". If men and women will be sharing one rest room, use a neutral term, such as "rest room" or "toilet." In such cases, it should be possible to lock the door when the rest room is in use.
- Including reading materials men favour in waiting areas. Such materials include magazines, newspapers or other publications that are popular with men in the area and are compatible with the facility's philosophy.

445 J. Bruce, "Fundamental Elements of the Quality of Care: A Simple Framework", *Studies in Family Planning* 21, no. 2 (1990): 61–69.

446 AVSC International, "Introduction to Men's Reproductive Services", pp. 6.8–6.9.

- Making men's information, education and communication materials readily available. Display client-education materials that address men's issues and posters about male anatomy and male genital self-examination in examination rooms.
- Making condoms readily available. Display signs saying "Condoms Available" (for sale or free) at the reception desk or another area where men are likely to view them. Stocking more than one brand of condom, if possible, helps reinforce the idea that the staff takes men's contraceptive and disease-protection needs seriously.
- Creating a medical record for each male client as an individual, rather than keeping his medical information in his female partner's file.
- Providing facility space or time for seeing couples to enable men and women to receive counselling together if desired.
- Creating awareness of men's reproductive health services in the community. The availability of men's reproductive health services should be clearly announced in all the facility's communications, including literature, signs/posters about services and telephone answering messages. If possible, facility staff should arrange for outreach workers to spend part of their time at the facility.

Creating awareness of men's reproductive health services in the community. The availability of men's reproductive health services should be clearly announced in all the facility's communications, including literature, signs/posters about services and telephone answering messages. If possible, facility staff should arrange for outreach workers to spend part of their time at the facility.

Addressing providers' bias towards men, their needs and male contraceptive methods

Health provider bias can be a major impediment to men's use of reproductive health services. Furthermore, the stigma associated with AIDS, combined with prejudice and denial about men who have sex with men, hinder HIV/AIDS prevention efforts.[447] Common signs of provider bias against male involvement are making men feel uncomfortable and unwelcome; not offering male counselling or male methods; providing inadequate information about them or presenting them in a negative light; and confronting men by asking questions in a public space, rather than in a separate room where they are offered privacy, and confidentiality is assured. For instance, a needs assessment undertaken by the Family Planning Association of Kenya found that providers had a negative attitude towards male clients; considered men as unwelcome visitors in the clinics; did not believe that vasectomy was a method that should be given to men; and had difficulties counselling men.[448] When male partners accompanying women for post-abortion services at hospi-

[447] G. Barker, "Boys, Men and HIV/AIDS", p. 19.

[448] UNFPA/CST, "Male Involvement in Reproductive Health and Mainstreaming Gender in Population and Development Programmes", workshop proceedings, part I (Addis Ababa, 2–6 February 1998), p. 31.

tals in Kenya expressed their interest in receiving information about family planning, only a small proportion received any information or counselling.[449]

Another classic provider bias is the belief that men are opposed to family planning and disinterested in sexual and reproductive health. The assumption that men are not interested in taking responsibility for family planning constrains the availability of services for men. Such beliefs are more myths than reality. The fact is that when men are welcome they come. In Pakistan, a simple change in a clinic sign from "Men Not Admitted" to "Men Welcome" resulted in the creation of a clinic for male reproductive health.[450]

Many providers are also poorly informed regarding male contraceptive methods and HIV/AIDS prevention and may share the same misconceptions as their clients. Personal biases interfere with health care workers' delivery of services. For example, community health workers in Kenya, many of them women, did not promote vasectomy because they believed that men would never accept it and that promoting it would undermine family planning campaigns.[451] Misconceptions such as these, myths and personal preconceptions can be addressed in training that focuses on shifting attitudes rather than just imparting information.[452]

What's the best approach to interpersonal communication and counselling in a health setting: Men only, women only or couples?

Reproductive and sexual health programmes offer a variety of counselling services. Some counsel men on an individual basis, others counsel men and women, and some providers offer workshops for couples. Counselling men only, women only or couples are all viable alternatives. Approaches that work vary according to social and traditional customs in a given community and individual preferences. Providers who counsel couples should do so with the woman's consent, so as to protect her choices in case of disagreement with a male partner or hidden use of contraception.

Individual counselling

For men as well as for women, a good counsellor provides confidential and optimistic guidance, and respects the client's individuality.[453] However, it cannot be assumed that a counsellor that has been successful in working with women will achieve similar results with men. Counselling men requires specialized skills because of men's reluctance to speak about their concerns and to seek services.[454] If they have a health problem, they are more likely to go to a pharmacy than to a clinic. In addition, men's counselling needs are different from those of women. Men tend to

---

449 Population Council, "Male Involvement in Reproductive Health Issues: What Do We Know about Male Involvement in Reproductive Health Decisions and Family Planning?" *Programme Briefs*, 1998 (updated April 2000), www.Popcouncil.org/frontiers/orta/pbriefs/male_2.html.

450 UNFPA and ECO (Economic Co-operation Organisation), *The Role of Men in Population and Reproductive Health Programmes*, 1999, p. 12.

451 C. Nzioka, "Male Participation in Decision-Making on Family Planning and Modern Contraceptive Use in Kenya", p. 56.

452 *Reproductive Health Outlook*, September 2000, www.rho.org/html/menrh_progexamples.htm.

453 AVSC International, "Men as Partners Initiative", p. 21.

454 Ibid.

be more interactive, request more technical information and ask difficult questions.[455] They are also less likely to admit their ignorance about reproductive and sexual matters, and tend to minimize their problems.[456] A recent Johns Hopkins University/Population Communication Services study in Kenya found that Kenyan men are more interactive than women, asking more questions during counselling. Providers address a wider range of issues with men. When couples are counselled, men talk more than women. Counsellor training needs to be designed with these gender differences in mind.[457] Men tend to arrive for health reasons and end up requesting counselling for personal issues.[458]

Questionnaires and/or computer programmes available to clients in the waiting room can also be used to assess a client's HIV risk.[459] Dock workers in the Philippines who are interested in learning more about reproductive health have the opportunity to learn on their own with the help of an on-site counsellor and a laptop computer. A software programme developed by PATH enables them to assess their risk of contracting STDs and find answers to personal questions they may feel uncomfortable asking the counsellor, as well as providing information on STD prevention and family planning.[460]

Group counselling in discussion groups

Men cope less well than women when infected with HIV. They may deny their status because they believe that "real men don't get sick", or that seeking help means admitting weakness or failure. [461] Discussion groups in which men interact with other men about HIV/AIDS or other common health issues have been found effective.[462]

Couple Counselling

Reproductive and sexual health discussions and behaviour occur in a "couple context".[463] Providers are increasingly recognizing this fact, along with the lack of communication among couples about sexual relations, birth spacing, family planning and STDs; they are addressing these factors by offering counselling to couples. There are many benefits to counselling couples, especially in settings where men are the undisputed decisions-makers.[464] Such initiatives trigger better outcomes for maternal and child health and family planning, and for STD prevention and

---

455 UNFPA, "Male Involvement in Reproductive Health: Incorporating Gender throughout the Life Cycle", TSS *Occasional Paper Series*, no. 1, June 1998.

456 Family Health International, "A Clinic for Her, and One for Him", *Network* 18, no. 3 (spring 1988).

457 Y. M. Kim and D. Awasum, "What Are the Particular Aspects of Counseling Male Family Planning Clients? A Case from Kenya" (paper presented at the APHA Men and Reproductive Health Task Force Workshop, November 1996).

458 AVSC International, "Men as Partners Initiative", p. 21.

459 UNFPA and PATH, "Sexual Health", *Outlook* 16, no. 4 (February 1999): 7; and adapted from "Gender-Sensitive Reproductive Health Services", *Reproductive Health Outlook*, September 2000, www.rho.org/html/gsh_overview.htm.

460 AVSC International, "Men as Partners in Reproductive Health", p. 16.

461 M. Foreman, ed., *Men and AIDS: Taking Risks or Taking Responsibility?* (London: Panos Institute and Zed Books, 1999), pp. 21–22.

462 G. Barker, "Boys, Men and HIV/AIDS", p. 24.

463 R. Rosenzweig et al., " Male Involvement, Couple-Friendly Care, Relationship Awareness, and Gender Partnership in Reproductive Health" (paper presented at APHA meeting, November 1996).

464 K. Tolbert et al., " Improving Reproductive Health of Couples: Men, the Ignored Partners", in *Frontiers in Reproductive Health*, Electronic Library 1990–1999 (Population Council, October 1998), p. 9.

treatment.[465] Counselling for men and women in a monogamous relationship increases condom use when information on its proper use is provided.[466] Improving communication between partners on sexual and fertility-related matters appears to improve contraception use.[467] Couple-oriented counselling raises awareness about equal responsibility for sexual decision-making and addresses the myths that pregnancy, STDs and HIV/AIDS are women's problems. A study in Egypt found that husbands who received information about their wives' medical condition after termination of pregnancy, about their recovery and about benefits of contraception, provided more instrumental, emotional and family planning support to their wives. Their involvement also improved patient recovery and substantially increased the likelihood of contraceptive use.[468] However, such programmes should be designed carefully in order not to jeopardize women's autonomy and self-determination when they do not agree with their male partners.[469]

Relaying information on sexual and reproductive health through workshops for couples is another strategy some providers are using. In Zimbabwe, the Confederation of Trade Unions found that its HIV prevention activities targeting men and women as individuals were less effective than couples' workshops. These have produced mixed results. More successful outcomes have occurred when couples join single sex groups that meet separately, and occasionally meet together. One of the problems in running these workshops is finding enough men willing to participate. Similar initiatives in the Central African Republic suggest that such meetings can promote a process of communication, even if indirect. Wives can raise issues that may be for the benefit of their husbands without breaking the taboo of addressing them directly. In Cameroon, the Organisation Syndicale des Travailleurs had difficulties in mixed groups that discussed sexual matters, because women seemed embarrassed and were unwilling to talk.[470] Others report that mixed groups do not work because men tend to dominate them. Casa de la Mujer in Bolivia succeeded in increasing men's participation by having nurses visit couples at home to explain the workshops.[471]

Use of male promoters and providers

Are men willing to be treated by a female doctor? Will they listen to a female promoter or talk with a female counsellor? Will they buy condoms from female health workers? Is a female promoter more acceptable to men than a female provider? Answers to these questions and a clearer understanding of the criteria that men use to decide whether to accept services from women require further research. Current knowledge is that such decisions are influenced by the gender norms in the local setting. In more traditional cultures, men's preference for male health

---

[465] *Reproductive Health Outlook*, September 2000, www.rho.org/html/menrh_keyissues.htm#couples-counseling.

[466] W. R. Finger, "Behavior Affects Condom Use", Network 18, no. 3 (Family Health International, spring 1998), www.fhi.org/en/fp/fppubs/network.html.

[467] *Reproductive Health Outlook*, September 2000, www.rho.org/html/menrh_keyissues.htm#couples-counseling.

[468] N. A. Tawab et al., "Effects of Husband Involvement on Post-abortion Patients' Recovery and Use of Contraception in Egypt", Population Council Operations Research/Technical Assistance Project and the Egyptian Fertility Care Society, 1997.

[469] S. Clark et al., "Increased Participation of Men in Reproductive Health Programmes", report for the Royal Ministry of Foreign Affairs, Oslo, Norway, 21 February 1999, p. 11.

[470] ILO, "Lessons Learned from UNFPA/ILO Programmes about Reaching Men" (undated), p. 5.

[471] Family Health International, "Men Influence Contraceptive Use", *Network* 18, no. 3 (spring 1998).

care workers is higher. A programme in India that involved men in preparing for safe childbirth singled out male promoters as playing an important role in motivating male members of the community and "vital" in adolescent groups.[472] Another programme in India, which offered gender training for youth, found that male facilitators are important in making the training environment non-threatening and empathetic to men.[473]

In Kenya, the use of male peer-educators as conduits of family planning information to married men were acceptable and reliable sources of information to most men interviewed. The study found that the current use of female community-based distributors "raises tensions and discourages men from participating in family planning activities". Men feel "uneasy" with female community-based workers, because "local cultures are not very supportive of women as credible sources of information on family planning methods".[474] Results of another study in Kenya support the premise that male agents are more successful than female agents in reaching men. The distribution site that was serviced only by male agents distributed almost three times the number of condoms compared with the other two sites.[475]

The sex of the provider does not seem to matter to men in Colombia, Uganda or the United States. Male clients interviewed in these countries did not feel strongly about receiving care from a male provider.[476] In societies where men are amenable to working with female promoters, the abilities of a promoter to put men at ease and address their concerns is of primary importance. During their weekly discussion groups, men in Brazil talk openly in the presence of a female facilitator.[477]

Once again, the social environment and individual preferences have tremendous influence on the level of men's comfort with a female health care worker. Having a balanced mix of men and women at all staff levels not only promotes gender equality and women's empowerment, but may play a role in raising men's awareness about gender and gender roles, and possibly lead to men's increased confidence in women providers and the consideration of alternative gender roles for themselves.

Training providers to work with men

Given growing institutional commitments to men as partners, to prevent HIV and treat AIDS and to offer gender-sensitive services, training of providers is needed. Male reproductive health can be inserted in pre-service, in-service and on-the-job training. Such information may cover male reproductive physiology; male sexuality; male contraceptive methods; STD prevention and treatment; HIV prevention; causes and diagnosis of male infertility; the importance of joint

---

472 *Reproductive Health Outlook*, September 2000, www.rho.org/html/menrh_progexamples.htm.

473 Ibid.

474 C. Nzioka, "Male Participation in Decision-Making on Family Planning and Modern Contraceptive Use in Kenya", p. 59.

475 Population Council, "Male Community-Based Distribution Agents Effective at Reaching Men with Family Planning Message", *African Alternatives* 2, no. 1 (August 1995): 6.

476 AVSC International, "Men as Partners: Ideas from Four Continents".

477 IPPF/WHR, "The Flip Side: Involving Men in Sexual and Reproductive Health", Forum 14, no. 2 (December 1999): 4–5.

decision-making regarding reproduction; values clarification regarding gender roles, sexuality, adolescent sexual activity, and male contraceptive methods; and techniques for counselling, outreach and communication with men.

Appropriately trained staff, from managers and administrators to receptionists and guards, is crucial to men's health programmes. "Front line" staff, doormen, guards and receptionists are usually the first people a client sees. The behaviour of these staff members is a key element in the success or failure of a men's reproductive health programme. They should be trained to help male clients feel comfortable speaking about health-related matters; be sensitive to the health care needs of all clients; maintain client confidentiality; be objective, especially when working with couples; learn to recognize and handle potential emergencies; ask counsellors or service providers for help in a situation beyond their control; learn to distinguish between dangerous and non-threatening situations; and learn to handle angry clients.

Training should also encourage administrators to assess how their policies and procedures affect service delivery to men and how they can create a welcoming, male-friendly atmosphere within the clinic, keeping in mind that men's and women's reproductive needs should be considered in relation to each other.[478]

Training is especially helpful when the decision to integrate male services and counselling into female-oriented settings has been made. Most health workers have little or no experience working with men, nor are they familiar or comfortable with addressing sexuality, since traditional training stresses acquiring technical knowledge but marginalizes attitudes of health care providers. Conventional gender-neutral clinical training ignores such issues as power relations between men and women and between providers and clients, and does not address sexuality. New clinical protocols and educational tools, combined with training, give health care workers the knowledge and skills they need to offer more extensive services and to address clients' sexuality in a non-judgemental way.[479] Skills required to provide male services include treating clients with respect; collecting information about clients' current and previous sexual partners, practices, STD risks, sexual satisfaction and problems, to help determine their health and family planning needs; determining and suggesting contraceptive methods that meet their needs; looking for signs of STDs; being knowledgeable about men's sexual and reproductive health concerns; being supportive and non-judgemental; providing a private and confidential environment in which clients are comfortable discussing these issues; and offering other alternatives to collect sensitive information. Ideally, providers should also be trained to recognize symptoms of alcohol and drug abuse that can contribute to gender-based violence, and risky sexual behaviours.[480]

Training providers in gender perspectives

Existing programmes, whether they serve men or women, focus on each gender separately and exclusively, without considering the interaction among men and women and their respective needs. This approach is inadequate, because it fails to take into account the way in which deci-

---

478 I. Ndong et al., "Men's Reproductive Health", p. 54.

479 *Reproductive Health Outlook*, September 2000, www.rho.org/html/gsh_overview.htm.

480 UNFPA/CST, "Male Involvement in Reproductive Health", p. 60.

sions are made and the context that influences them. Other drawbacks to the abridged interpretation of "gender perspective" are its biases towards women; it assumes that men are irresponsible and views them as an instrument in women's well-being, thus failing to address men's needs.[481] It is critical to keep a gender perspective at the forefront of all health services, including those for men. This requires examining the different interests of women and men and their inputs at different stages of a programme, identifying the roles of women and men (as staff members, volunteers and clients), and being aware of the positive and negative consequences of women's needs.[482]

Gender training empowers health workers to recognize gender issues and to relate to both women and men.[483] The Social Action for Rural and Tribal Inhabitants of India (SARTHI) has been working with men and women for several years, and has concluded that training should be "experiential and participant-centred rather than clinical and trainer- or topic-centred". This evolved from its realization that "women's empowerment and men's sensitization need to be done simultaneously, as parallel processes", because men need to be liberated from the constructs of masculinity, and women from its stronghold.[484] Similarly, Salud y G nero in Mexico proposes that discussing gender and masculinity is not possible at an institutional level until the individuals involved have first reflected about their own values and realities related to gender.[485] A study in Peru confirms the "importance of gender and culture, especially cultural definitions of masculinity and femininity, in determining reproductive behaviour", factors providers must consider.[486]

DISTRIBUTION SCHEMES OF REPRODUCTIVE HEALTH COMMODITIES

Social marketing

Programmes that sell contraceptives and other health-related products at subsidized prices through commercial networks are known as contraceptive social marketing programmes. Social marketing also involves the application of marketing research and advertising techniques in the promotional component of IEC interventions. Commercial firms and non-profit agencies, with limited government involvement, run most contraceptive social marketing programmes.

Nearly all contraceptive social marketing programmes have included condoms, since they do not require medical supervision and generally do not have to be registered with the government as a pharmaceutical product.[487] Subsidized commercial sales are a cost-effective way of providing condoms to large numbers of men in developing countries. Because contraceptive social mar-

---

481 UNFPA, "Male Involvement in Reproductive Health".

482 M. Ladjali, "Gender Quality of Care: Common Approaches for Common Goals", WHO, 1998, p. 6.

483 Ibid., p. 8.

484 S. Raju and A. Leonard, eds., *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality* (Population Council South and East Regional Office, 2000), p. 23.

485 "Lessons Learned from the Salud y Genero Programme in Mexico", *Reproductive Health Outlook*, September 2000, www.Rho.org./html/menrh_progrexamples.htm.

486 K. Tolbert et al., " Improving Reproductive Health of Couples", p. 11.

487 J. D. Sherris, "Contraceptive Social Marketing: Lessons from Experience", *Population Reports*, series J, no. 30, Johns Hopkins University School of Public Health, Population Information Program, July/August 1995.

keting programmes use existing distribution systems and retail outlets, they can increase condom availability markedly throughout a country. Coverage in rural areas is generally weak, but is still broader than the distribution of health posts.

Social marketing is a powerful means of reaching men. By using mass media through many channels (print, radio, TV, magazines) social marketing is more likely to reach men than is clinic-based education. Condom advertising and marketing can promote use with both casual partners and wives.[488]

Sales programmes that reduce the costs of condoms have succeeded in selling tens of millions of male condoms in countries that recorded minimal condom use a decade ago. A fivefold increase was achieved in five years in Ethiopia (from 4 million to 21 million sold annually), and in Brazil annual condom sales grew nine times within three years (from 3 million to 27 million).[489] Social marketing uses marketing research to determine condom names, such as "Trust" and "Prudence", with the intent of selling condoms. However, it promotes behaviour change without involving men and women in a dialogue on their safety. In some cases, promotion may even reinforce masculine behaviours rather than changing them.[490] Successful messages tend to emphasize the economic value of small families and depict men as the protectors of their families. In Morocco, a marketing campaign that was used on radio and in the print media depicted condoms as offering men the opportunity to share responsibility for reproductive decision-making.[491]

Marketing campaigns are also useful tools for bringing men to clinics. Profamilia, in Colombia, promotes its services in the mass media and through field workers. In Brazil, Pro-Pater increased the number of vasectomies performed monthly by nearly 80 per cent with television spots and billboards that proclaimed "vasectomy is an act of love".[492]

The Social Marketing for Adolescent Sexual Health (SMASH) programme that took place in Botswana, Cameroon, Guinea and South Africa provides valuable lessons for improving social marketing programmes that target adolescents.[493] Unlike social marketing programmes aimed at adult men, behaviour change was a key component of this programme (see **chapter VII**).

---

488 Johns Hopkins University Center for Communication Programs, "Better Together: A Report on the African Regional Conference on Men's Participation in Reproductive Health" (Baltimore, Maryland, April 1997), p. 11.

489 W. R. Finger, "Condom Use Increasing", *Network* 18, no. 3 (Family Health International, spring 1998), www.fhi.org/en/fp/fppubs/network.html.

490 M. Foreman, ed., *AIDS and Men*, p. 41.

491 Johns Hopkins University School of Public Health, Population Information Programme, "Promoting Male Methods and Men's Services", *Population Reports*, series M, no. 12, July 1994, p. 29.

492 Ibid.

493 USAID and Measurements Communication, "Social Marketing for Adolescent Sexual Health: Results of Operation Research in Botswana, Cameroon, Guinea, South Africa", June 2000, www.Measurecommuncation.org/factsheets/smash/program_lessons.htm.

Partnership with the private sector[494]

In most countries condoms are distributed through a variety of channels, in addition to social marketing and distribution by governments, NGOs and employers. They are sold commercially in pharmacies and other retail outlets, since selling condoms through shops besides pharmacies increases sales. Such outlets include general stores, grocery stores, carry-out stores, social clubs, nightclubs, barber shops, bars, hotels, guest houses, kiosks, open-air markets, gasoline stations, taxis and even river boats. It is strategically important to locate condom outlets where men - including adolescents- gather, for example, military installations, school dormitories, resorts and other tourist spots, transportation centres, truck stops, drug treatment clinics and on the streets, especially in commercial sex districts. Condom vending machines improve accessibility, because they provide anonymity and convenience.

> The *"100 Percent Condom Program" in Thailand intended to make condom use universal among clients of commercial sex workers. The government closed brothels that did not abide by the program's requirements that sex workers decline sex with clients who refuse to use a condom. This program, one of the most successful, is attributed with increasing condom use in commercial sex establishments from about 25 percent to more than 90 percent in four years. STI rates among commercial sex workers declined by more than 85 percent. Recruits surveyed in 1991, the second year of the program, were "much more likely to have used condoms and also made fewer visits to brothels."*[495]

Condoms are offered increasingly in workplaces, as exemplified by an AIDS prevention programme in the Dominican Republic that distributes them to hotel workers. The Barclay's Bank offices in Zambia offer free condoms to employees, and in South Africa, an aluminium company provides condoms in all bathrooms. In Uganda, the army distributes condoms not only on military installations but also at nearby places frequented by soldiers.

Community-based distribution

Community-based distribution programmes have succeeded in distributing contraceptives in remote areas, primarily to women. Such programmes can be easily adapted to serve men and women by including condoms and information on vasectomy. Careful consideration should be given to the recruitment, training and supervision of health workers, since they play an important role in motivating couples and often become role models that help establish healthier reproductive habits in the community.[496] Involving community members in the selection of community-based distribution workers, and ensuring that they are adequately compensated and recognized, can assure good performance, adequate community support and low turnover.

The value of male field workers is increasingly recognized. Males have been particularly effective in promoting use of male methods, educating men and couples, and providing family planning information in areas where social norms or rugged terrain create impediments for female workers. Recruiting men who enjoy community trust and respect, and who interact with other men in

---

494 Adapted from "Closing the Condom Gap", *Population Reports*, series H, no. 9 (Johns Hopkins University School of Public Health, April 1999).

495 Ibid.

496 *Reproductive Health Outlook*, September 2000, www.rho.org/html/menrh_progexamples.htm.

their daily lives, contributes to their effectiveness; in Cameroon, male opinion leaders volunteered.[497]

New Strategies for Reaching Men: Barbershops in the Dominican Republic

In the Dominican Republic, almost half a million men were estimated to have been reached with STD/HIV/AIDS-prevention messages, using barbers as the conduit. The barbers also distributed condoms and were trained in interpersonal communications. They were encouraged to refer their clients with STDs to private and government clinics for treatment. The barbers were selected based on literacy and leadership skills, as well as an interest in community well-being and development. An NGO, Asociacion Dominicana de Planificacion Familiar (ADOPLAFAM), provided the barbers with basic training, including lessons demonstrating how to use a condom and refresher courses; IEC materials; and condoms. The NGO conducted supervisory visits.

The barbers were highly motivated. Few of those who were trained dropped out. They found their involvement brought added prestige and influence in their communities. The extra services also increased the flow of customers for haircuts. Even after the project ended, the barbers continued to sell subsidized condoms through social marketing, refer STD cases and provide information. The fact that they were economically self-sufficient allowed them to sustain their voluntary involvement. The barbers recognized that extramarital relationships were commonplace and that men and their partners needed protection. Regrettably, men with STDs referred by the barbers to private and public facilities for treatment found services lacking. No institutional link had been established between the project and the clinics, which lacked treatment norms, had limited drug supplies and little laboratory support. The health centre staff paid no special attention to referrals from the barbers, and no effort was made to diagnose asymptomatic STDs.

An evaluation of the project concluded that, despite the problems with the referrals, engaging the barbers was a cost-effective means for influencing a relatively hard-to-reach target population.

SOURCE: UNFPA, "Support to HIV/AIDS Related Interventions", *Evaluation Report* no.16, 1999, p. 40.

More than 250,000 barbers in India have been trained as community health workers. They talk about condoms in their shops and distribute them to clients. Village men are more comfortable talking with their barbers than with clinic workers.[498] In Kenya, the Family Planning Association trains volunteers to reach men through several channels. An employee at the Nakuru blanket factory teaches fellow employees about contraception, birth spacing and HIV/AIDS, and distributes condoms and pills to his fellow-workers. He also visits them at home, answers men's questions and encourages couples to make reproductive decisions together. In addition, he refers clients interested in vasectomy or tubal ligation to the clinic.[499]

[497] L. Touré, "Male Involvement in Family Planning", p. 12.

[498] M. Drennan et al., "New Perspectives on Men's Participation", *Population Reports*, series J, no. 46, (Johns Hopkins University School of Public Health, October 1998), p. 29.

[499] Ibid.

In Africa, community-based distribution and sales, often man-to man, have increased men's access to condoms and condom counselling.[500] Providers, however, must be careful in assessing social realities in the communities served. A study in Ghana and Burkina Faso found that community-based distribution can increase access to and use of family planning when it is designed to meet a community's needs in a culturally accepted manner[501]. In Mali, the *Association de Soutien au D veloppement des Activit s de Population* worked with the Centre for Development and Population Activities/ACCESS project to expand community-based family planning services and encourage men's participation. With the backing of traditional leaders, male volunteers were trained to distribute contraceptives and provide information about reproductive health, including STD/AIDS prevention, high-risk behaviours and condom use. The project increased men's interest in the health of mothers and children, and led to greater interest in modern methods for child spacing.[502]

Reaching men in employment-based programmes[503]

Offering family planning information and services at the workplace has many advantages: it is an effective way to reach large numbers of men, who seldom visit health clinics; it is convenient; and it is cost-effective, since employers pay for or share the ongoing costs of the programme. Employment-based programmes are situated in a variety of workplaces, including factories, mines, mills and large plantations, as well as in labour unions and workers' collectives. Most large employers already provide some health care for workers and their dependents, and therefore can add family planning and other reproductive health services at little additional cost. This is what the ICPD had in mind in its encouragement of the private-sector to "continue to devise and implement special programmes that help meet their employees' needs for information, education and reproductive health services, and accommodate their employees' needs to combine work and family responsibilities".[504]

A recent study on workplace programmes found that in a number of developing countries, ministries of labour, employers' organizations and trade unions, as well as individual enterprises, have undertaken various types of activities related to population.[505] These programmes, initially promoted by UNFPA, ILO and FAO, have evolved from narrow family planning services to family welfare, including reproductive health, thanks to government policies. In the Philippines, for instance, the labour code requires establishments with a work force that exceeds 200 workers to provide family planning, education services and family welfare programmes.[506]

---

[500] Johns Hopkins University Center for Communication Programs, "Better Together", p. 11.

[501] Population Council, "Community-based Distribution", *Population Briefs* 5, no. 4 (December 1999), www.popocouncil.org/publications/popbriefs/.

[502] UNFPA, *State of the World Population Report* 2000, p. 53.

[503] Adapted from C. Hein et al., *Population Education and Services in Enterprises*, UNFPA/ILO, 1992, p. 77. (INT/92/P77).

[504] United Nations, report of the International Conference on Population and Development, Cairo (5–13 September 1994) A/CONF.171/13, para. 15.20.

[505] C. Hein, "Population and Programmes in Enterprises: Some Lessons Learned", *Population Education and Services in Enterprises*, UNFPA/ILO (INT/92/P77), p. 1.

[506] M. E. Aganon et al., "Population and Family Welfare Programmes at Enterprise Level: The Philippine Experience", *Population Education and Services in Enterprises*, UNFPA/ILO (INT/92/P77), p. 23.

Current enterprise-based programmes vary considerably among countries and among enterprises, as do the reasons for employers' involvement. Managers cite social responsibility, management philosophy and investment in human resources and financial benefits (derived from reduced absenteeism and a healthier workforce) as common reasons for their interest in providing family education and health services. They also acknowledge that the HIV/AIDS pandemic provided a new impetus for providing preventive educational programmes, and even AIDS treatment. Most programmes provide education in various domains affecting the quality of life of workers and their families, and that can be linked to family size and birth spacing — such as age of marriage and marital relations, maternal care, education of children, nutrition, alcoholism, family budgeting and family resource management. In this way, reproductive issues are placed in the context of work, economic aspirations, leisure and family life.

Lately, it is becoming more acceptable to target young unmarried workers, who often have considerable educational needs related to family issues and reproductive health. For example, a project that started in 1989 in Sri Lanka was established in the Katunayake Free Zone, where the majority of workers are unmarried. Educational sessions on reproduction and family planning held in the zone were very popular with the workers, but there have been some difficulties in terms of access to family planning methods.[507]

Gender issues are also being addressed more frequently in educational activities for workers. This is a particularly encouraging development when men constitute a majority of the target group, as in the case of the Organization of Tanzania Trade Unions, but more work needs to be done on various issues of gender, including how couple communication can best be addressed within educational programmes.

As programmes expand, companies are opting to contract out services. The Association of Labour Unions in the Philippines, for example, has a mobile clinic in the Cebu region to provide family planning and other services at various companies whose workers are union members. The companies visited are primarily of small to medium size, where in-plant medical services are either not available or are limited.[508] Family planning associations in Latin America are beginning to consider selling some of their programmes to the public sector. Profamilia in Colombia has a commercial strategy built into its programmes that requires the adolescent co-ordinator to promote and market services offered to adolescents, parents, teachers and health providers. This strategy has generated contracts with government agencies and the private sector for the sale of medical services including pregnancy tests; educational workshops for private schools; and the sale of contraceptives[509]. In Madagascar, the USAID-funded Appui au Programme de Population/Planification Familiale (APPROPOP/PF) joined forces with the Association

[507] C. Hein, "Population Programmes in Enterprises", pp. 2–8, 13–14.

[508] S. G. Avenido, "Member and Family Welfare Services Provided by the Associated Labour Unions/Trade Union Congress of the Philippines", in ILO Report of Regional Consultative Meeting on Comprehensive Member and Family Welfare Services by Trade Union Organizations (Cebu, 23–27 April 1996).

[509] Meglioli, A., IPPF/WHR, Personal communication, October 2000.

Medicale Inter-enterprises de Tananarivo (AMIT), an HMO, to reduce fertility to a level more consistent with Madagascar's socio-economic objectives and capabilities. The project covered the cost of training, contraceptives, technical assistance and IEC materials, while employers' and workers' contributions to AMIT paid for personnel, infrastructure and service provision. Trained family planning agents provided counselling to their colleagues, in large businesses and factories, and distributed condoms, spermicide ovules and oral contraceptives. Visiting para-medical agents provided injectable contraceptives and referred clients desiring longer-term methods to two AMIT medical centres. The programme succeeded in raising contraceptive prevalence tenfold in the 11 pilot sites, and has been adopted by nine HMOs in five large cities.

Reaching men through organized groups

Sports clubs, union halls, trade association headquarters and prisons are places where men tend to congregate. Outreach programmes should be working with these types of groups.

The Military

One of the largest employers of men is the army. Military personnel have a high risk of exposure to sexually transmitted diseases (STDs), including HIV. In peacetime, STD infection rates among armed forces are generally 2 to 5 times higher than in comparable civilian populations. The difference may be even higher in times of conflict[510]. The common situation in which military male personnel are posted away from their spouses and families for varying periods of time and submitted to peer pressure and a growing sex industry, is an example of a "cultural risk milieu" (see chapters I and V). At the same time, military service presents a unique opportunity in which HIV/AIDS prevention, reproductive health education and gender training can be provided to a large captive audience in a highly organized environment. Such setting offers opportunity for a number of RH interventions such as training military health personnel to improve or expand prevention education, promoting and distributing condoms, expanding STDs treatment, providing counselling and voluntary testing in HIV/AIDS[511]. It also requires addressing the risk-taking culture and attitude towards women in the civilian population and in the army, for instance through supportive gender sensitive groups and new codes of conduct. UNFPA has funded successful projects involving men in the military, with the expectation that these activities will reduce their own risk taking behaviour, the vulnerability of their families and civilian population, and violence against women through men's enhanced awareness of and responsibility for reproductive health.

- **In Ecuador,** the focus was on educating military officers, soldiers in compulsory military service and cadets in military schools. Four stages were adopted — selection of one high school and one military unit; training of officers, teachers and student leaders, including preparation of materials; training of soldiers and students; and extension of training to more high schools and military units, and the provision of services.

510 UNAIDS, "AIDS and the Military", *UNAIDS Point of view*, Best Practices Collection, May 1998.

511 Ibid.

- **In Nicaragua,** military officers, soldiers, women employees and family members, and policemen participated. Activities included materials development, training in reproductive health, including sex education, STD/HIV/AIDS; prevention of violence; and development of national programmes with continuous training of officers and soldiers.
- **In Paraguay,** the project worked with the military and police. Activities included the preparation of training materials, training in reproductive health, and provision of reproductive health services including family planning.[512]

Paraguay: Population, Development and Reproductive Health in the Armed Forces of Paraguay

Every year about 12,000 adolescents around the age of 17, predominantly from poor rural areas, join the army for two years of military training. During this period, they receive health care and participate in a comprehensive educational programme for men that addresses gender and reproductive health issues. The three-tiered strategy, supported by UNFPA, includes: education in population, development and reproductive health issues; reproductive health services through military health centres; and outreach activities for civilian populations in rural areas. Soldiers receive information, training and education on all aspects of sexual and reproductive health, including prevention of unwanted pregnancy, STDs and HIV/AIDS, and domestic violence. They also get condoms. Graduates are expected to disseminate information among peers and family members with the training materials they receive. Courses on reproductive health are also offered to all military health personnel, since they conduct outreach activities covering civilian populations living in nearby rural areas.

Results

The project's initial successes are indicated by a gradual decline in STDs in military units; a drop in the rate of unwanted pregnancies over the past two years in areas where the military has been providing health education and services; the comprehensive development and health improvement of their personnel; trained teachers; and fully equipped consulting rooms and contraceptives accessible to military personnel, their families and rural civilian populations.

Lessons Learned

- A male-exclusive environment helps to create an atmosphere for sharing concerns and discussing male issues, an effective way to incorporate men in these efforts. It is also an efficient channel to reach some of the most vulnerable groups in the population, such as male and female teenagers from remote rural areas.
- Incorporating reproductive health topics in the curriculum and training manuals of military institutions is a key to ensuring the sustainability of such efforts.

[512] T. Horacio et al., "Male Involvement: Regional Specificities" (paper presented at TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, Rome, 9–13 November 1998).

Prisons

Conditions in prison put many men at high risk of catching STDs and HIV. In French prisons for instance, the HIV prevalence is ten times that of the general population and in the United States in 1994, there were 5.2 cases of AIDS per 1,000 prisoners -almost six times the rate in the general adult population.[513] Even though violence, sexual acts and drug trafficking between prisoners are a way of life in jails, the subjects are difficult to raise, due to the denial of sexual activity by administrators and prisoners. A 1993 survey in Rio de Janeiro, Brazil suggested that 73% of male prisoners had had sex with other men in prison.[514] Such sexual activity is "homosexual" in the sense that men are having sex with other men but such relationship is often not between consenting adults. They are characterized by their extreme violence, where cases of rape and even torture are common. Contributing factors to violence include overcrowding. Despite these disturbing and known circumstances, medical providers tend to ignore the problem, fearing that by dispensing condoms they may appear to encourage homosexual activity. For instance, condoms are not provided in countries in the former Soviet Union, where overcrowding can reach 400 per cent of capacity in some jails.[515] The AIDS epidemic is causing some to recommend that condoms and needle exchange programmes be made available to prisoners, but currently few prisons provide such facilities[516]. However, in the United States and the Netherlands, where condoms are available, most prisoners do not use them; those that do are homosexuals. Some countries in Europe are beginning to address the problem of STDs and AIDS in jails, but the taboo surrounding sexual relationships among prisoners, including sexual servitude and "prison marriages", makes it difficult to study the problem and propose programmes to reduce the spread of STDs and AIDS. Furthermore, the issue of overcrowding would have to be addressed to make health education effective.[517]

513 UNAIDS, "Prisons and AIDS", *UNAIDS Point of View*, Best Practices Collection, April 1997.

514 Ibid.

515 H. Reyes, "(Ir)relevance of Condoms in Prisons" (paper presented at the Corrections Health Services Conference, Australia, November 1997).

516 Ibid

517 Ibid.

A New Focus on Men's Health in Australia[518]

A survey conducted in New South Wales, Australia, identified a number of creative, existing approaches to reach men. These include:

- A 12-week group discussion and counselling programme is being offered for men who are going through stressful life events, including divorce and separation, recognizing that men typically do not seek help during these periods.
- Some local health authorities are implementing specific suicide-prevention strategies for young men, and campaigns targeting reducing drunken driving among men.
- Some public health clinics are specifically hiring male nurses, recognizing that many men do not feel comfortable talking to or being assisted by women nurses.
- Some community-based organizations have started support groups for men who were victims of child sexual abuse, recognizing that this issue is often hidden.
- A few clinics offer parenting education for fathers.
- Incorporating reproductive health topics in the curriculum and training manuals of military institutions is a key to ensuring the sustainability of such efforts.
- A province-wide prostrate cancer prevention programme has been started to encourage more men to seek preventive testing and treatment.

[518] G. Barker, "Boys, Men and HIV/AIDS", p. 25.

Chapter 7

Reaching Young Men and Boys

The ICPD recognizes that the "health needs of adolescents as a group have been largely ignored" and urges that "programmes and attitudes of health-care providers…not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse". The Programme of Action understands the urgency of early interventions and is optimistic that "responsible sexual behaviour, sensitivity and equity in gender relations instilled during the formative years [will] enhance and promote respectful and harmonious partnerships between men and women".[519]

Since Cairo, attention to the reproductive and sexual health needs of adolescents has been a priority for population, health and educational professionals, governments, NGOs, donors and religious leaders. Significant resources are being committed to provide diverse services to adolescent men and women for several reasons. The urgency of working with this population is partly driven by the AIDS crisis, which victimizes significant numbers of people between the ages of 15 and 29, and by the size of the population in this age group. In sub-Saharan Africa alone, there are 630 million young people between the ages of 10 and 24. More than half of all the HIV infections in this region are among young people aged 15 24, and about 1.7 million young Africans become infected *every year*.[520]

Other factors contributing to the interest in working with this population are studies that show adolescence as a life-cycle stage in which individual self-identity is formed and risky behaviours occur, among them unprotected sexual relations with multiple partners.[521] In the past, sexual activity was taken for granted, but was controlled by elders and society at large. Today, young men's sexual behaviour is less restricted, and sexual intercourse is occurring at younger ages. Furthermore, in the past, men were more or less obligated to care for the children they fathered.

---

519 United Nations, Report of the International Conference on Population and Development (Cairo, September 1994), paras. 7.34, 7.41, 7.45.

520 Social Marketing for Adolescent Sexual Health (SMASH), "Results of Operation Research in Botswana, Cameroon, Guinea, South Africa", Measure Communication Reports, June 2000, p. 5, www.Measurecommunication.org/factsheets/smash/program_lessons.htm.

521 G. Barker, "Boys in the Hood, Boys in the Barrio: Exploratory Research on Masculinity, Fatherhood and Attitudes toward Women among Low Income Young Men in Chicago, USA, and Rio de Janeiro, Brazil" (paper presented to the IUSSP/CENEP seminar on Men, Family Formation and Reproduction, Buenos Aires, May 1998);.and C. Nzioka, "Obstacles in Managing the Dual Risks of Unwanted Pregnancy and Sexually Transmitted Infections among Young Males in Kenya" (paper presented at WHO Afro Regional Meeting in Pretoria, South Africa, 27–29 September 2000).

Today, few young men take on this responsibility.[522] Finally, the optimism that adults normally associate with young people, and the belief that instilling them with lessons learned will lead to better, healthier and longer lives, surely plays a role in the enthusiasm, creativity and breadth of health-related services offered to today's young people worldwide. However, several factors are hindering these programmes from making a noticeable impact; these include an absence of clearly defined adolescent reproductive health policy, a "project mentality" that limits the number of adolescents reached and imposes an ineffectual time period on innovative initiatives; scattered projects, insufficient documentation and lack of rigorous evaluation.[523]

Adolescence, a time to form young men's identity

UNFPA, UNICEF and WHO define "adolescents" as the population aged 10 19, "youth" as those aged 15 24, and "young people" as between the ages of 10 and 24.[524] Boys generally go through puberty during the ages of 10 23, when hormonal changes drive physical changes, including the production of sperm.[525] However, adolescence, the time in life between childhood and adulthood, is more difficult to define, because the "nature and duration" of this phase is socio-culturally dependent on the context within which it takes place.[526] In some cultures, adolescence is not defined by age, but marked by passages through "certain recognized transition points such as marriage, circumcision or childbirth".[527] Nevertheless, adolescent is a life cycle that is "critical for gender role formation and a time during which notions of appropriate sexual comportment and even awareness and understanding of such issues are shaped and influenced".[528] Some researchers suggest that one's "strategic style", the way one interacts with others, presents oneself to others and affiliates with others, is defined during adolescence. Several longitudinal studies on life trajectories find that some personality traits, identities and strategic styles are tested and confirmed during adolescence and carry forward to some degree into adulthood. [529]

The role that others play in determining young men's identity is confirmed in several studies. Adolescence is the period during which young men make the transition from boys to men. Early in their socialization, boys internalize the "achievement and outward-oriented model of masculinity", which is one of the reasons why they turn to male peer groups for their socialization and identity. Research from a number of countries concludes that adolescent males, especially

---

522 A. S. Erulkar and B. S. Mensch, "Gender Differences in Dating Experiences and Sexual Behaviour among Adolescents in Kenya" (paper presented at 23rd Population Conference of the International Union for the Scientific Study of Population, Beijing, 11–17 October 1997), p. 1.

523 J. Senderowitz, "A Review of Program Approaches to Adolescent Reproductive Health" (draft, USAID/G/PHN, 2000), p. 1.

524 UNFPA, "The Sexual and Reproductive Health of Adolescents: A Review of UNFPA Assistance", *Technical Report* no. 43, 1998, p. 1.

525 G. Barker, "Boys, Men and HIV/AIDS", UNAIDS briefing paper (second draft, Instituto Promundo, Rio de Janeiro Brazil, January 2000), p. 9.

526 G. Ogbaselassie and A. K. Joukhadar, "Adolescent Boys: Special Needs" (paper presented at the UNFPA TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, Rome, 9–13 November 1998).

527 C. Nzioka, "Obstacles in Managing the Dual Risks", p. 2.

528 C. A. Varga, "The Forgotten Fifty Percent: A Review of Sexual and Reproductive Health Literature on Boys and Young Men in Sub-Saharan Africa" (paper presented at WHO Afro Regional Meeting in Pretoria, South Africa, 27–29 September 2000), p. 2.

529 G. Barker, "Boys in the Hood, Boys in the Barrio", p. 4.

men in low-income areas, are more susceptible to peer pressure than adolescent women, and that their peer group plays a more important role in their socialization than it does for women. A study that explored the sexual and reproductive dynamics among male and female Zulu young people found that peers heavily influenced these young men's interest in and practice of sex. [530] This could be due to the absence of fathers or other positive male role models. For young men from poor neighbourhoods in Chicago and Rio de Janeiro, street-based groups become a substitute father figure, to which they turn to discuss their needs and concerns. The absence of adequate places where young men can discuss personal issues — in schools, youth service organizations or at home — contributes to the importance of such peer groups.[531]

Barker's study, which compares poor male youth from Chicago with those from Rio, found that the "values and strategic styles promoted in the street-based peer groups in both cities tend to be calloused and hyper masculine". Showing affection, friendship with girls, respect for girls and caring for children are considered feminine and thus frowned upon. On the other hand, sexual conquests are not only praised, but also demanded as "requisites for membership" in the male peer group. Two other informative themes that emerged from this study provide clues about the needs of adolescent males. One is the absence of models of what respectful and caring male-female relationships look like, and the other is the lack of places to "process" and deal with personal issues in a climate of trust.[532]

The mass media are another source of influence on adolescents. While mass media have an effect on the entire community, young adults are particularly vulnerable to images that portray stereotypical roles.[533] Furthermore, studies indicate that adolescents rely on the media as a source of information on sexual matters.[534] X-rated films and pornographic materials entice their curiosity and their desire to experiment, and influence the sexual behaviour of young men. However, the media's persuasive powers can be used to support health and gender equity.[535]

Young men's sexual and reproductive health needs

Until very recently, little was known about young men's needs, because existing surveys focus on husbands or adult men; most youth-focused studies in Africa centre on female adolescents and young women, or on male and female youth. Such studies ignore gender differences, and thus provide programmers with little information about interventions that young men need and that are appealing to them.[536]

New studies that focus on young men's sexual and reproductive needs are contributing to enriching the general knowledge on several fronts. They confirm the importance peers play in

---

530 C. A. Varga, "The Forgotten Fifty Percent", p. 21.

531 G. Barker, "Boys in the Hood, Boys in the Barrio", pp. 16–17.

532 Ibid., pp. 16–17, 24–25.

533 Pathfinder, "Promoting Reproductive Health for Young Adults through Social Marketing and Mass Media: A Review of Trends and Practices", Focus on Young Adults, Research Series, 16 July 1997, pp. 2–6.

534 UNFPA, *Adolescence Education Newsletter* 1, no. 1, June 1998, p. 10.

535 Pathfinder, "Promoting Reproductive Health for Young Adults".

536 C. A. Varga, "The Forgotten Fifty Percent", p. 4.

influencing behaviours, the fact that boys become sexually involved before girls, around the age of 14, with "little knowledge of their own reproductive health",[537] and their erratic use of condoms (Baker 1998, Maharaj 2000, Varga 2000, Nzioka 2000). Sexual coercion, what some might consider a precursor to gender-based violence, has also surfaced in these studies.[538]

Young men's knowledge, attitudes and behaviours about STDs and risks

Several recent studies found that young men generally know little about their own or their partner's sexuality, hardly communicate with their partners, have misconceptions regarding masturbation and condom use, and do not think about family planning.[539]

In Africa, young men (and women) tended to be more ill-informed than uninformed, and minimized their risk of contracting HIV/AIDS.[540] They understand the "general mechanics of HIV infection; however, specific matters surrounding HIV are not so clearly understood". Young men lack knowledge about the following issues:

- difference between HIV and AIDS
- the concept of "window period" in HIV testing
- connection between STD and HIV infection
- relationship between blood contact and infection
- the inactive phase of infection
- assessment of risk posed by a potential partner
- "myths" such as the role of mosquitoes or utensils in facilitating infection (particularly among young adolescents) [541]

For example, the majority (84 per cent) of Kenyan boys between the ages of 15 and 19 "do not perceive themselves at risk at all or see themselves as having a small risk of contracting HIV/AIDS", in spite of the fact that these boys have multiple partners and that their use of condoms is low and erratic; 80 per cent of them have at one time or another engaged in unprotected sex.[542] Another troubling fact that Nzioka found in Kenya is the "glorification" of

---

[537] S. E. A. Nnko, "Risk Behaviours of Male Adolescents in Tanzania: Motives and Patterns of Their Sexual Relationships" (paper presented at WHO/UNAIDS Afro Regional Meeting in Pretoria, South Africa, 27–29 September 2000), p. 3.

[538] A. J. Ajuwon et al., "Sexual Coercion among Adolescents in Ibadan, Nigeria: The Perspectives of Males" (paper presented at WHO Afro Regional meeting in Pretoria, South Africa, 27–29 September 2000).

[539]Adapted from the following sources: C. Nzioka, "Male Participation in Decision-Making on Family Planning and Modern Contraceptive Use in Kenya", report submitted to the Strategic Component on Social Science Research on Reproductive Health, Special Programme of Research, Development and Research Training in Human Reproduction, WHO, June 2000, p.11 ; C. A. Varga, "The Forgotten Fifty Percent", pp. 21–22; G. Barker, "Boys, Men and HIV/AIDS", pp. 9–10; and IPPF/WHR, "Youth-Friendly Services" *Forum* 14, no. 2 (December 1999): 8–9.

[540] C. Varga, "The Forgotten Fifty Percent", p.6.

[541] Ibid., p. 9

[542] C. Nzioka, "Obstacles in Managing the Dual Risks", pp. 4–6.

acquiring an STD as a badge that confirms manhood:

> *When you get "burnt" [contracting an STD] it means you have been initiated into manhood. You have actually gained experience. Of course I do not want to say it's good but it's one more thing learnt. It makes you mature. You also have to go through difficulties of looking for treatment of a disease you cannot tell just anybody. [18-year-old boy]* [543]

Young men's perceptions regarding sexuality in East and South East Asia, shared at a UNFPA workshop,[544]corroborate findings from other regions. These are as follows:

- The male is basically the initiator in sexual relations.
- For some, having sexual relations in a sign of love and commitment; for others, it is part of being a "real man".
- Peer pressure sexual encounters are boasted of and perceived to be a sign of masculinity.
- Females flirt and wear provocative clothes ("they are asking for it").
- Having sex with a prostitute is a rite of passage into adulthood.

In contrast, Barker found that young men interested in being more progressive, being friends with girls and respecting them, and wanting to be involved partners and fathers, had to find alternative male peer groups. Some of them did so by asking a social service agency, where their partners were participating in a teen mothers' group, to start a support group for young fathers.[545]

Perceptions and use of condoms

Most sexually active adolescents do not use condoms,[546] though it is becoming an acceptable alternative among some young men in the face of the risks for HIV infection.[547]

Misconceptions about condom use abound among boys. Condoms carry a host of negative symbolic meanings that limit their acceptability among this population. Most adolescent boys associate condoms with adults or promiscuous people, yet the same young boys fantasize about having sex with as many girls as possible. "In addition, condoms are widely believed to break easily, and to reduce sexual pleasure. The view that condoms are clumsy and reduce sexual pleasure is also shared by young girls."[548] Men's fear that they will loose their erection while putting on a con-

---

543 Ibid., pp. 14–15.

544 UNFPA/Country Technical Services Team for East and South East Asia, "Report of the UNFPA Inter-country Workshop on Adolescent Reproductive Health for East and South East Asia and the Pacific Island Countries" (Pattaya, 27 April–3 May 2000).

545 G. Barker, "Boys in the Hood, Boys in the Barrio", pp. 16–17, 24-25.

546 S. E. A. Nnko, "Risk Behaviours of Male Adolescents in Tanzania", p. 3.

547 C. A. Varga, "The Forgotten Fifty Percent", p. 8.

548 C. Nzioka, "Obstacles in Managing the Dual Risks", p. 11.

dom is even more pronounced among young men.[549] Other common reasons young men cite for not using condoms include cost, most young people report being unable to afford them; embarrassment, fear that people who known them will discover that they are sexually active; and lack of awareness of sources that supply condoms.[550]

Sexual coercion

Sexual coercion is an act of forcing or attempting to force another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in any sexual activity against his or her will. In a study of adolescent sexuality in Uganda, most males reported that their first sexual act was by consent, in contrast to the number of females who said that their first sexual experienced was coerced.[551] Studies among South African youth reveal that "boys frequently sanction violence and coercion in the context of sexual relationships".[552]

The Nigerian study on coercion found that "male perpetrators resort to coercion because of lack of knowledge and skills for how to resolve conflicts with their female partners.... Typically, a male considers the use of coercion when he fails to convince a girl to go out with him, or if the girl fails to have sexual intercourse with him on demand. Boys interpret a girl's refusal of friendship or sex as evidence of pride or arrogance. Often, friends assist a boy during rape, assault or verbal abuse of a girl, and may even take turns to do the same".[553] Conflict resolution skills, such of those mentioned in chapter V, would be one important way for them to find alternative solutions.

Boys' reaction to pre-marital pregnancies

Workshops[554] on prevailing attitudes about adolescent pregnancy found that boys were quite aware of detrimental practices when they stated that the man:

- takes no responsibility and avoids embarrassment by staying away from his girlfriend.
- suggests abortion because:
  1) he is not ready to assume a parental role and responsibility.
  2) he does not feel obligated to marry the girl.
- feels embarrassed and derides girls in public.
- claims that he does not love the girl and should not be pressured into marriage.

---

549 AVSC International and IPPF/WHR, Literature Review for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms (Oaxaca, Mexico, October 1998), p. 10.

550 C. Nzioka, "Obstacles in Managing the Dual Risks", p. 12.

551 S. E. A. Nnko, "Risk Behaviours of Male Adolescents in Tanzania", p. 4.

552 C. A. Varga, "The Forgotten Fifty Percent", p. 2.

553 A. J. Ajuwon et al., "Sexual Coercion among Adolescents in Ibadan", Nigeria, p. 7.

554 UNFPA/Country Technical Services Team for East and South East Asia, "Report of the UNFPA Inter-country Workshop", pp. 6, 8, 9.

- blames the girl for the pregnancy. The girl's mother is also blamed because of an "inherent assumption that mothers have an inescapable responsibility for educating their daughters" about managing pregnancy prevention.[555]
- escapes from the community to avoid pressure.
- sometimes marries the girl and assumes responsibility.

Similarly, the vast majority of boys participating in a Kenyan study on male adolescent sexual and reproductive health agreed that getting a girl pregnant is morally wrong, and expressed remorse and empathy. They felt guilty, acknowledged that a pregnant girl "becomes an outcast" and "loses everything in life". They also recognize that having premarital sexual relations is good, "but not when it leads to a pregnancy"; "girlfriends are like our sisters and one does not like to see his sister suffer". A few boys took pride and argued that though "most boys would openly manifest repentance for impregnating a girl, covertly they would be feeling good and proud for making a girl pregnant because it signified they are actually men', capable of impregnating a woman".[556] This latter view is widely supported by adolescent males in West Africa.[557]

Adolescent sexual and reproductive health programmes

Many different types of programmes address adolescent sexual and reproductive health. Some concentrate exclusively on service provision, others combine service provision with outreach, educational and promotional activities, and some are breaking ground in embracing the holistic multi-pronged approach envisioned by the ICPD. Most reproductive health programmes for young men encourage responsible sexual behaviour, but few are informed about their needs or aspirations.

Often, NGOs work together with community organizations, by providing educational resources and training. Other types of NGO collaboration are described under "Outreach programmes" below. The Save the Children Adolescent Reproductive Health Projects in Malawi, Bhutan, Nepal and Viet Nam are examples of an approach that emphasizes involvement by several community sectors and works with an array of stakeholders.[558]

Activities at each site differ according to community needs and interests, but most include such activities as developing informational materials; offering career counselling, economic opportunities and credit schemes; holding dialogues with parents; training school teachers and service providers on "youth friendly" services; and training youth as peer educators.

[555] C. Nzioka, "Obstacles in Managing the Dual Risks", p. 15.
[556] Ibid., p. 14.
[557] H. Toro et al., "Male Involvement; Regional Specificities; Cultural Barriers to Male Involvement; Experiences from West Africa" (paper presented at the TSS thematic workshop on Male Involvement in Sexual and Reproductive Heath Programmes and Services, Rome, 9–13 November 1998).
[558] J. Senderowitz, "A Review of Program Approaches to Adolescent Reproductive Health", p. 15.

Content and methodologies of educational programmes targeting young men

While girls are likely to discuss reproduction informally with other female family members, boys confront "embarrassed silence" or moralizing attitudes with regards to reproduction and sexuality. The absence of open, informative communication about these issues, along with the assumption that boys are only interested in sexuality, combine to deny young men the opportunity to explore the significance of their role in relationships and in reproduction.[559] The involvement of male educators and counsellors in sexuality training for boys can help young men address these issues and thus break the silence and consequential myths.[560]

In addition to conflict resolution, helping boys and young men feel comfortable expressing emotions is the newest initiative in efforts to offer boys alternative gender models. One of the key facets of challenging sexism and violence, and developing alternative models of manhood, is helping boys share feelings — both their own and others. As two educators comment, this entails "helping boys learn to express themselves and relate to others in ways traditionally considered to be within the female realm and not masculine attributes; developing behaviour which is often repressed in boys and men (this includes communicating in intimate ways; co-operation rather than competition; being supportive to each other; feeling responsible for the emotional well-being of each other).... Attacking the idea that certain emotions are not masculine and helping boys express their more vulnerable feelings".[561]

One way in which UNFPA supports country efforts in gender equity is through country-specific population education and family life education projects targeted at adolescents. The different terminologies may be a reflection of the concerns and sensibilities surrounding the introduction of sexuality education. The purpose of life skills and family life training is to nurture harmonious family and gender relationships based on communication, negotiation, respect for individual choice, self-esteem and empowerment.

Life skills training: helping boys choose a future

The "life skills" framework, currently used in several countries, emphasizes interactive learning and integrates the acquisition of knowledge (information), attitudes (behaviour and beliefs) and skill building (communication and negotiation).[562] It provides youth with the skills they need to negotiate relationships required for economic survival, and helps them establish roles they will use and responsibilities that will help them when they set up their households.[563] The intent of life skills training is to enable youth to take greater responsibility for their lives by making healthy life choices, resisting negative pressures and reducing risky behaviours.[564] The Centre for

---

559 E. Centerwall, "Sexuality Education for Adolescent Boys", Swedish Association for Sex Education (Stockholm, 1995), p. 14.

560 Ibid.

561 S. Askew and C. Ross, *Boys Don't Cry: Boys and Sexism in Education* (Buckingham: Open University Press, 1998), pp. 75, 87, in "Positive Strategies with Boys to End Violence", by M. Kaufman (paper prepared for Gender, Partnerships and Participation Section, Programme Division, UNICEF, March 2000).

562 UNICEF, "What Is the Life Skills Approach?", "Teachers Talking", September 2000, www.unicef.org/teachers/teacher/lifeskil.htm.

563 J. Foumbi and R. Lubovitch, "Roles of Men in the Lives of Children: A Study of How Improving Knowledge about Men in Families Helps Strengthen Programming for Children and Women", UNICEF, December 1997, p. 27.

564 UNICEF, "What Is the Life Skills Approach?"

Development and Population Activities (CEDPA), with UNFPA support, developed a participatory learning source book, *Choose A Future! Issues and Options for Adolescent Boys*, a programme guide for facilitators and trainers who work with boys aged 12 20. The book helps adolescents deal with the issues described above, by helping them shape their own lives and create their own options. Self-awareness, values identification and reproduction are among the themes in the guide, which is part of a larger advocacy programme involving parents, community members, youth workers and girls.[565]

This life skills teaching methodology can be used in formal and non-formal educational settings, since it promotes discussion, exchange of information and further inquiry. The methodology is used with adults as well as adolescents in parenting classes, with fatherhood groups, among extension workers and in sexuality education. It also considers innovative and interactive learning techniques, but most importantly, it helps instructors feel comfortable discussing sexual topics.[566]

Population education

Population education was designed to meet the needs of school-aged youth and to integrate population content into a wide range of educational channels. UNFPA, in collaboration with UNESCO, FAO and ILO, has established population education programmes in more than 90 countries. Through population education, individual and social implications of population issues are studied and discussed in formal and non-formal education settings. The ultimate aim is to increase understanding of population dynamics at country and world levels, and thus improve an individual's ability to make informed choices.[567]

Population education also promotes non-stereotyped images of men and women, and helps students form positive attitudes and values regarding gender. Approaches in school curricula can foster positive attitudes and encourage students to think about the relationships between gender and their role in the community in a peaceful manner. Fairness, or equitable treatment of males and females, is stressed as an underlying principle. Harmful stereotypes of both sexes are exposed as such and analysed. Classroom debate is one effective way of approaching this issue. Girls and boys are told that they have a right to know the implications of early pregnancy for their future. Alternative role models for women and men are explored in the classroom, and children are encouraged not to view their futures as limited by traditional "male" and "female" job categories. Analysis of gender roles is encouraged, not only occupational roles, but also domestic roles, kinship roles, roles as community leaders, conjugal roles and parental roles.[568]

Family Life Education

(FLE), while similar to population education, focuses more on health (physical, social and mental) and environmental (domestic, community) determinants and effects of fertility and

---

565 CEDPA, *Choose a Future! Issues and Options for Adolescent Boys: A Source Book of Participatory Learning Activities*, November 1998.

566 Focus on Young Adults, "Reproductive Health for Young Adults: School-Based Programs", *Focus,* August 1998, www.pathfind.org/focus.htm.

567 O. J. Sikes, "Reconceptualization of Population Education", Technical Paper no. 2, UNFPA, New York, 1991.

568 Ibid.

population. These programmes can be integrated into school curricula or conducted outside of school. UNFPA has supported FLE programmes with the Boy Scouts Associations in several countries, including Zimbabwe, Kenya, Madagascar, Senegal, Cameroon and Ghana.[569]

Sexuality education

Wide disagreements about sexuality education contribute to the absence of policies and guidelines on adolescent reproductive and sexuality education. The debate is rather broad, questioning all aspects from what to teach and at what age, to where, how and by whom. On the other hand, there is general agreement that pre-HIV/AIDS sexuality education models, which imparted information but did not empower the person to use it, failed in its objective to reduce unwanted pregnancies. Sexuality training curricula for young men should include:

- the differences and similarities between males and females;
- male physiology, including male fertility, the significance of the male hormone in sexuality, erection and ejaculation, sexual intercourse and male dysfunctions; male identity and respect for the body's complex functions;
- sexual exploitation of women: violence, pornography and prostitution;
- ways of loving, which offers young men an opportunity to ask questions about women;
- how women function;
- taboos concerning love and ways to open up the discussion about feelings (most young men are socialized to live up to a gender role that prohibits men from expressing emotions);
- sexually transmitted diseases and pregnancy.[570]

Issues mentioned by high school students participating in "Lenterna", a sexuality workshop held by the Indonesian Planned Parenthood Association, include masturbation, "how often is normal" and its consequences; body image, penis size, pubic hair; losing one's virginity; STDs and sexual orientation.[571]

A review of curricula on sexuality education in the United States identifies the following elements as critical to their effectiveness:

- focus on one or more specific sexual behaviours; give a clear message;
- provide basic, accurate information on risks of unprotected intercourse and protection methods;

---

[569] UNFPA, "The Sexual and Reproductive Health of Adolescents", pp. 30–31.

[570] E. Centerwall, "Sexuality Education for Adolescent Boys", pp. 24–27; and Focus on Young Adults, "Reproductive Heath Programs for Young Adults".

[571] Focus on Young Adults, "Reaching Young Men with Reproductive Health Programs", *Focus*, 1998, www.pathfind.org/focus.htm.

- address social pressures on sexual behaviour;
- incorporate practice of communication, negotiation and refusal skills;
- use a variety of participatory teaching methods allowing students to personalize the information;
- incorporate behavioural goals, teaching methods and materials appropriate to the age, sexual status and culture of students;
- plan enough time to complete important activities;
- deploy trained teachers or peers committed to the programme.[572]

One criticism of initiating sexuality education is the idea that such education will lead to increased promiscuity and earlier sexual activity among youth. There are, however, a number of studies that show that this is a misconception. UNAIDS evaluated the impact of HIV and sexual health education on the sexual behaviour of young people. The study showed that sexual health education programmes delayed initiation of intercourse and reduced sexual frequency, pregnancy, abortion and birth rates. It also reported that the HIV/AIDS prevention curricula encouraged greater monogamy and more consistent condom use. The study revealed: "Despite varying success in achieving programme aims, 14 of the 15 studies did not indicate that sexual health education leads to earlier initiation or greater sexual activity".[573]

Involving parents in their sons' sexuality education

Parents are their children's primary sexuality educators. When surveyed, many parents and young people alike report that they would prefer parents to be the main source of adolescents' information about sexuality and reproductive health.[574] The sexuality education that takes place at home often has a lasting impact. Most parents, including religious parents, need more information and education on what sexuality and sexuality education mean in order to be able to communicate appropriately on these issues. It is very important that the communication between parents and their children be both open and positive — and that it begin as early as possible.[575]

Parental support in the lives of adolescents is a significant preventive factor for early pregnancies or STDs. This presents an opportunity to link the household with societal influences, manifested through education and mobilization of parents and community groups. New programmes are designed to help parents communicate their values about sexuality as well as provide accurate information that is developmentally appropriate. By involving parents in the sexuality education of their children, they are also more likely to see the value of sexual and reproductive health

---

572 J. Senderowitz, "A Review of Program Approaches to Adolescent Reproductive Health", p. 18.

573 UNAIDS, "Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review Update", 1997, p. 12.

574 J. Bongaarts and B. Cohen, eds., "Adolescent Reproductive Behaviour in the Developing World", *Studies in Family Planning* 29, no. 2 (June 1998).

575 UNFPA, "Parents Handbook on Sexuality and Communication Skills", Family Life Education Programme in Ghana, 2000, www.siecus.org.

services that some now oppose. This can be ensured through parent-teacher organizations and provision of support services for parents.[576]

Programme venues: schools

With the number of children enrolled in primary school in developing countries jumping by almost 50 million in the past five years, schools are increasingly efficient ways to reach young people and their families. Pre-existing school-based health or population education programmes, common in many countries, can be adjusted by adding elements on sexuality and reproductive health. School-based programmes usually address such issues as prevention of early pregnancy, HIV/AIDS and STDs.[577]

Schools could provide a safe place for adolescents to discuss personal issues, get advice and explore non-stereotypical gender roles. However, little is known about how ready schools are to embark in this task. Two studies, one in Peru that examines masculine identity[578] and one in Mexico that explores the sexual and reproductive health needs of indigenous youth[579] indicate that schools may need more preparation to promote alternative gender models. The study in Peru illustrates that young men are likely to reject the official school system of reward and punishment, challenge school authorities and embrace an alternative system, which values aggressivity and other stereotypical role models to impress upon peers. In the Mexican study, teachers expressed a need for training on addressing early marriage, unintended pregnancies and other reproductive and sexual health issues so that they overcome their embarrassment and become more comfortable in discussing such sensitive topics with adolescents.[580]

School-based programmes need the support of government and community leaders and parents to succeed. Other key elements are vision, leadership, national guidelines, adaptation to local concerns, ongoing needs assessments and evaluations, time and resources. "Insertion of new content and implementation of new programmes in schools take at least three to five years", the same amount required to measure outcomes resulting from innovative programmes.[581] Effective programmes train teachers in the use of the curriculum and adapt it to meet local needs. Some school-based programmes refer students to local health or counselling services. Debates and discussions are common tools used by students to reflect on the implications of their sexual decisions, the attitudes and values that influence them. Exercises such as these help equip them with the knowledge and skills essential to negotiate safer sex.[582]

---

576 UNFPA, "Strengthening UNFPA's Approach to Sexuality Education" September 2000, pp. 6–7.

577 Focus on Young Adults, "Reproductive Health for Young Adults".

578 J. C. Calligos, "Sobre Heroes y Batallas: Los caminos de la identidad masculina", Escuela para el Desarrollo, Lima, Peru 2000, p. 50

579 J. C. Soto, and A. F. Alvarado., " Salud Sexual y Reproductive en Jóvenes Indígenas de las Principales Etnias de México", IMSS-Solidaridad,2000, Mexico.

580 Paul Bloem, "los Hombres Jóvenes: un Panorama internacional", paper presented at the Latin America Seminar, "Working with young men: Health, Sexuality, Gender and Prevention", Queretaro, Mexico, 28-31 march 2000, p. 17.

581 Ibid.

582 Focus on Young Adults, "Reproductive Health for Young Adults".

UNFPA support enhanced the ability of a public school in Alagoas, Brazil, to integrate a sexuality education programme developed by the Sociedade Civil Bem-Estar Familiar no Brasil (Bemfam).[583] "Planeando tu Vida" (Planning Your Life), developed by the Instituto Mexicano de Investigacion de Familia y Poblaci n, is one the few curricula that have been evaluated. Results show that parents, teachers and students strongly favoured including the course in the national secondary curriculum in Mexico. Students in the experimental group increased their knowledge on contraception and were no more likely to become sexually active than those in the control group, and sexually active students who took the course were more likely to use contraceptives than sexually active control-group students.

Other venues: outreach programmes[584]

Outreach has emerged as an alternative way to reach young people, especially out-of-school adolescents and difficult-to-reach youth. In many developing countries, young men drop out of school at an early age, and are often concentrated in specific industries such as transportation, agriculture and fisheries, and construction, where they can be targeted with programmes. Sexuality education also needs to be made available in other venues outside of schools, especially when political and practical obstacles to school-based sexuality education are too difficult to surmount.[585] Multiple approaches are used to reach this population as exemplified below:

Peer education

Peer education programmes train young men to reach their peers with information, referrals for services and distribution of commodities. Peer educators receive special training in decision-making skills, making client referrals, and providing commodities or counselling services. These programmes are successful in gaining access to hard-to-reach populations such as out-of-school youth, street children and commercial sex workers, because they try to recruit and train educators/counsellors that have the same characteristics as those of the targeted population. Since peer pressure is an important determinant of early sexual initiation, peer educators can provide support to counter such negative coercion. For instance, peer education can provide young men with opportunities to examine the myths that have shaped their attitudes about themselves and about women. Young men generally respond well to peer educators and welcome the opportunity to talk about their feelings and their roles as men; they find the peer educators credible, approachable and helpful.[586]

583 UNFPA, "Strengthening Reproductive Health Services for Adolescents in Latin America", *Project Summary*, July 2000, p. 5.

584 Adapted from Focus on Young Adults, "Reproductive Health for Young Adults".

585 J. Senderowitz, "A Review of Program Approaches to Adolescent Reproductive Health", p. 19.

586 C. Green, "Reaching Young Men with Reproductive Health Programs", *Focus,* December 1998, www.pathfind.org/publications.htm.

Experiences with Peer Education

In Mexico, peer educators of MEXFAM's "Gente Joven" project report that as a result of project activities, more young men are seeking information about contraception. In Namibia, the "Strengthening Male Involvement in Reproductive Health" project trains cadres of peer educators to conduct ongoing educational sessions for other young men within the defence and police forces, soccer clubs, and the Evangelical Lutheran church.

In Ghana, the Red Cross and the Scout Association have organized a peer education programme that provides training in negotiating safer sex, refusal and assertiveness skills.[587]

In Jamaica, peer educators in the Red Cross project, "Together We Can", reported notable improvements in knowledge about HIV transmission and about where young people with STDs can find help. This project was included in an AIDSCAP (AIDS Control and Prevention Project) evaluation, which found that 95 per cent of peer educators had made changes in their own life and behaviour, 31 per cent were practising safer sex and/or were using condoms, 20 per cent had reduced their number of sexual partners, and 19 per cent had changed their own attitudes.[588]

The variety of terms used in reference to these programmes, for example, peer educators, peer counsellors, peer helpers, peer promoters, peer distributors, peer leaders, indicates the wide range of approaches. In recognition of the work they do in motivating young people to obtain the information and services they need, peer educators/counsellors are sometimes called "peer promoters". These promoters usually work with participants in one-to-one or small-group settings. But they may also have other responsibilities, such as making presentations in front of large groups, representing the organizations they work for on boards and councils, and consulting with programme managers.[589] For instance, a peer officer sits on the Governing Council of IPPF. Peer officers worked on a youth manifesto, and participated in the development of the "Sexwise" radio programme, a collaboration between IPPF and the British Broadcasting System that is being aired in Africa, the Arab world, Latin America, South East Asia and China.

Youth centres

Youth centres work with youth to help enhance their life skills, and thus prevent unwanted pregnancy along with other risky behaviours. They also assist pregnant teens and offer parenting, vocational and educational programmes along with recreational activities.[590] Such programmes tend to attract more boys than girls.[591] One successful centre in Haiti, run by Fondation pour la Sant Reproductive et de l'Education Familiale with UNFPA support (FOSREF, Foundation for Reproductive Health and Family Education), offers various activities, including peer education and entertaining education sessions as well as referral to a youth-friendly clinic. Its focus

587 Ibid.

588 J. Senderowitz, "A Review of Program Approaches to Adolescent Reproductive Health", p. 23.

589 Focus on Young Adults, "Using Peer Promoters in Reproductive Health Programs for Youth", *Focus*, December 1997, www.pathfind.org/focus.htm.

590 J. Senderowitz, "A Review of Program Approaches to Adolescent Reproductive Health", p. 31.

591 B. S. Mensch and M. E. Greene, "The Uncharted Passage Girl Adolescence in the Developing World", Population Council, 1998.

on reproductive health may be contributing to its success, a fact that can only be confirmed through more systematic evaluations.[592]

Partnerships between NGOs or community-based organizations (CBOs) that work with youth are increasingly popular. In Kenya, for instance, PATH and the Kenya Scout Association are collaborating on a project that provides life skills to street children at a rehabilitation centre.[593] In the Arab region, UNFPA collaborates with the Boys Scouts Association.

Arab Region: Education in Reproductive Health for Boy Scouts and Girl Guides

Sexual problems in the Arab States region exist much as elsewhere in the world. Recent survey findings indicate that in Morocco and Algeria, unmarried girls abandon about 2,000 unwanted babies every year. Taboos surrounding sexuality and the cult of virginity in most Arab countries lead to great repression, which blocks free communication within the family and society on questions regarding sexuality. Survey results on youth problems in Syria indicated youths' need for sex education.

UNFPA, in collaboration with the World Organization of the Boys Scout Movement (WOBSM)/Arab Regional Office and World Health Organization – Europe and Middle East Regional Office (WHO-EMRO), initiated a project to integrate reproductive health and gender issues into the Boys Scouts and Girls Guides programmes. The Arab Scout Organization works closely with Scouts and Girl Guides associations in 19 countries.

The regional project aims to strengthen peer-counselling training on adolescent reproductive health and sexual health (ARH/SH) issues, upgrade national capabilities in ARH health research and databases, and further reinforce networking through the exchange of successful experiences, training and IEC (information, education and communication) materials.

Training workshops included ARH research, design and production of low-cost IEC materials, and reproductive-health counselling skills. The issues covered included reproductive health, STD/HIV/AIDS, population and fertility, gender and advocacy. The Scouts were trained in narrative research, interpersonal communication skills, communication techniques and peer counselling.

The WOBSM also attended the World Jamboree in Chile, in which various workshops were held to raise the awareness of Boys Scouts about adolescent reproductive health. The topics discussed were adolescent health, STD/HIV/AIDS prevention, premarital exams, selection of a life-partner, health and growth, personality development, social and family issues, gender issues, ethics and values. The workshops highlighted issues such as STD/HIV infection, marriage and family formation through role-plays, illustrative pamphlets/leaflets, wall magazines and exhibitions. The jamboree presented an excellent occasion for boys to learn about various issues of reproductive health.

SOURCE: UNFPA, CST Amman.

592 J. Senderowitz, "A Review of Program Approaches to Adolescent Reproductive Health", p. 31.

593 Ibid., p. 20.

Workplaces

The connection between adolescent reproductive health and jobs is gaining importance. Job-training and skill-building are increasingly integrated into adolescent reproductive health programmes offered by youth service organizations. In Haiti, the Groupe de Lutte Anti-SIDA (Group in Struggle against AIDS), an HIV-prevention programme conducted at Port-au-Prince workplaces ranging from utility companies to bottling plants, has provided HIV-prevention education to nearly 20,000 predominantly male workers between 15 and 49 years old.[594] Factory workers in Thailand participated in a peer education pilot programme that focused on HIV prevention. Results indicate improvements in participants' understanding of risk-reduction and the importance of communicating with partners about HIV/AIDS and safer sex; other findings in the evaluation are an increase in reported communication among partners, and efforts to educate family and community members about sexual health.[595]

In Thailand, the Royal Thai Army instituted an HIV/AIDS prevention and care programme. Utilizing the army's formal command structure and 19 23-year-old conscripts' naturally existing friendship groups, the intervention focused on increasing condom use in brothel settings and with other partners, reducing alcohol consumption and brothel patronage, and improving sexual negotiation and condom use skills. The programme resulted in decreased incidence of STDs and HIV.[596]

Outreach sites such as discos, pool halls, video arcades, the marketplace and local fairs are all places to reach young men with reproductive health information, condoms and services. In Uganda, the Busoga Diocese's Family Life Education programme found that both young and adult men have fewer daily responsibilities than women, and are therefore an easy-to-access audience if outreach is conducted in the places where they "hang out". In Indonesia, a project uses outreach workers to reach young men in bars and on street corners. While most youth were initially negative about condoms and few would take them from the outreach workers, within six months a shift in attitude was noted; positive feedback from young men's partners made the use of condoms "cool".[597]

[594] C. Green, "Reaching Young Men with Reproductive Health Programs".

[595] J. Senderowitz, "A Review of Program Approaches to Adolescent Reproductive Health", p. 26.

[596] C. Green, "Reaching Young Men with Reproductive Health Programs".

[597] Ibid.

Thailand: Male Involvement in Reproductive and Sexual Health and Reproductive Rights for the Adolescents in the Southern Muslim Communities of Thailand

In 1999, Planned Parenthood Association of Thailand (PPAT), with the support of UNFPA, initiated a pilot project in Pattani, the centre of the Muslim population in the four southern provinces of Thailand. Approximately 56 per cent of adolescents drop out of school after completing compulsory education. Women and adolescents are prohibited from learning about sexual health issues due to the conservative norms of the Muslim community. As a result, incidences of STD/HIV, teen pregnancy and drug abuse among the area's adolescents have been increasing. Most drug addicts and HIV-positive individuals are males. In the Southern Muslim community, men are the decision-makers in the families; therefore, PPAT encouraged them to participate in the project.

The purpose of the project was to promote adolescent health and reproductive rights in the Muslim communities of Pattani Province through co-operation of the Provincial Islamic Council, the local Ulamas and peer educators, and to provide reproductive health/family planning services to young married couples through ARH centres and community health volunteers.

The project used a multi-pronged approach of advocacy, IEC and service delivery in reproductive health to reach adolescents and males. PPAT initiated the project by advocating the importance of reproductive health education for adolescents. Issues of reproductive health and male responsibility from the Islamic perspective were discussed with the council to convince its members that reproductive health education is necessary for the area's adolescents to live a healthy and productive life.

Five districts in Pattani were selected for the pilot project and five ARH centres were set up. Exhibitions and video shows on ARH were organized for male adolescents. Parents were invited to a seminar on sexual and reproductive rights of adolescents. PPAT organized training courses on ARH for community health volunteers (CHV) in Muslim villages in order to enable them to provide ARH information and contraceptives to adolescents and young married couples. The strategy attracted large numbers of male adolescents, indicated by their active participation in ARH centre management and the ARH education programme.

Lessons Learned
Local community religious organizations can play a significant role in promoting ARH and rights issues; therefore, it is important to win their support at the beginning of such programmes. In the case of Pattani, the Provincial Islamic Council played a central role in making decisions regarding ARH.

SOURCE: UNFPA Office in Thailand

YOUTH-FRIENDLY REPRODUCTIVE HEALTH SERVICES

Many of the characteristics attributed to "male-friendly" services apply to "youth-friendly" ones. The approach to youth, however, is quite different, since "adolescents rarely think in terms of planning their families" and are concerned about running into someone they know like their "neighbour, or their aunt, or even their mother" if they go to a clinic.[598] "Empathetic, caring, understanding, sensitive service providers" ranks among the top criteria in surveys that ask young people about the kind of services they want. Other important characteristics of youth-friendly services can be broken down into the following categories:

[598] IPPF/WHR, "Youth-Friendly Services".

Characteristics of Youth-Friendly Services

Providers

- staff that is trained to work with young people;
- staff that is trained to respect young people and their needs;
- staff that acknowledge the central importance of privacy and confidentiality to adolescents;
- clinic managers who make sure there is extra time allowed for counsellors or medical staff to discuss young people's special issues.

Health facilities

- separate space or special time set aside for young adult clients;
- convenient hours for young adults, such as late afternoons, evenings and weekends;
- conveniently located facilities;
- adequate space to protect young people's privacy;
- comfortable clinic surroundings, as "unmedical" as possible, and appealing to young people.

Programme design

- drop-in clients welcomed;
- short waiting times and overcrowding avoided;
- low-cost service charges so that young people can afford them;
- boys and young men encouraged to attend, and special male services offered;
- availability of audio-visual and print materials dealing with issues relevant to young adults in waiting area;
- widely publicized availability of special programmes for young people in schools, offices, factories, recreational and other community setting. Such open publicity often helps increase young people's comfort with a programme.

SOURCE: IPPF/WHR, "Youth-Friendly Services"

Less common and more experimental characteristics are peer counsellors working with professional counsellors; hosting informal and formal group discussions; providing a wide range of reproductive health services, for example, sexual abuse counselling, prenatal and post-partum care, and abortion services; peers and adult professionals working in outreach programmes to promote information and commodities such as contraceptives, iron tablets and vitamin supplements.[599]

[599] Focus on Young Adults, "Making Reproductive Health Services Friendly for Young People", *Focus*, December 1997, www.pathfind.org/focus.htm.

Adolescent Reproductive Health in Panama[600]

The Asociación Panameña para el Planeamiento de la Familia (APLAFA), the family planning association in Panama, began a collaborative adolescent sexual and reproductive health programme in David, Chiriquí, with UNFPA, the local Ministry of Health and community leaders. Its objectives were to strengthen the capacity of NGOs and government agencies in Panama, so they can work jointly for the purpose of providing services and IEC activities for adolescents; to improve upon available models for delivery of services and IEC to adolescents; and to increase the number of adolescents that are reached by high-quality sexual and reproductive health services and IEC activities.

Existing community structures, including the Ministry of Health and NGOs, work with youth and schools to promote integration of sexual and reproductive health activities into their daily work, thus improving services, education and information.

Community-based activities include meetings with youth and teachers, and courses and talks for parents and other community members to inform them about project activities, provide information on adolescent sexual and reproductive health, and promote their involvement in the project. Other activities encourage the participation of school administrators and teachers, who are trained in population education, and planning and implementing educational activities. In addition, the Instituto Mexicano de Investigación de Familia y Población (IMIFAP) trained APLAFA staff, personnel from the Ministry of Health and community workers in communicating about sexuality with adolescents, gender considerations in working with young people, adolescents' rights and methods for community work.

APLAFA is currently training youth peer promoters in communicating with peers; contraceptive methods, STD/HIV prevention and teen pregnancy; and making referrals. The project's educational strategies will encourage leaders of NGOs to replicate sex education with adolescents and integrate sexual and reproductive health issues into their work. Youth conferences where young people discuss needs and strategies are an integral component of the project.

Lessons Learned

One of the most valuable lessons learned from this project has been that involving many different groups, including other NGOs, schools and the government, is important to the success of the programme. Other lessons that will be useful in implementing projects for youth include:

- Collaborative projects require a minimum start-up organization period of six months;
- Involving the community in all stages of the programme, from planning to implementation, gives the community a sense of ownership and makes the programme as a whole more effective;
- Working with the Ministry of Health is a good way to create cost-effective and sustainable programmes, as it involves restructuring existing services instead of creating clinics from scratch; and
- directed effort needs to be made to involve parents in the programme.

600 IPPF/WHR, 2000, www.ippfwhr.org.whatwedo/panama.html.

Confidential and timely counselling

Doing a better job at counselling boys and young men through proper sexuality education programmes could help address many issues that emerge later in the life cycle.[601] This, however, is difficult to accomplish for a population that is reticent to talk to adults, and is even less likely to share personal concerns about sexuality and raise questions that may expose their self-doubt.

Hotlines and radio call-in programmes[602]

Adolescents, especially males, get most of their information from uninformed peers. Hotlines and radio call-in programmes give them the ability to ask questions anonymously and get informed answers. Hotlines, also known as "helplines", are phone lines set up to take calls about specific topics. Those commonly used in the health field address such issues as pregnancy, STD and HIV/AIDs prevention and treatment, and rape counselling. Radio call-in programmes involve a host, and occasionally guests, who answer call-in or write-in questions on the air about sexual and reproductive health, suicide prevention, drug abuse and violence. Respondents are trained to discuss the issues in a positive, non-judgemental tone, help callers clarify their values, attitudes and behaviour, and help develop decision-making negotiation and communication skills.

Helplines and radio call-in shows have been very successful in reaching adolescents by providing them with emotional support, confidential information and counselling in a time of crisis:

- They reach large numbers of youth. The Kenyan *Youth Variety Show* reaches more than 3.3 million young people. The *Joven a Joven* hotline for youth in Mexico City receives an average of 4,600 calls per month. More than 150,000 youth tried to call the Dial-A-Friend hotline in the Philippines during its first seven months of operation, and the South African AIDS Helpline received 30,000 calls in 1997.[603] Such programmes reach beyond the targeted audience by attracting youth. The *Talking about Sexual and Reproductive Health Information (TARSHI)* hotline in India is not specifically targeted at youth, yet about 60 per cent of its callers are between 15 and 25 years old.
- They are cost-efficient compared with provider-based counselling and small-group discussions, and the user pays little or nothing.
- They can be structured around convenient times for youth, after school and at night when youth are most likely to use them. Hotlines can be programmed to answer calls with an automated message that provides information 24 hours a day seven days a week.
- They can involve youth by recruiting and training them to respond to callers. The *Sahabat Remaja* (Friends of Youth) hotline in Indonesia found that youth are more comfortable with hotline counselling by peers.

---

601 Family Health International, "Male Responsibility for Reproductive Health", *Network* 18, no. 3 (1998).

602 Focus on Young Adults, "Reaching Adolescents through Hotlines and Radio Call-in Programs", *Focus*, December 1999, www.pathfind.org/focus.htm.

603 Ibid.

- They refer callers to services. In Uganda, peer counsellors of the *Youth Sexual and Reproductive Health Project* hotline are trained and encouraged to escort callers to services at the University Hospital. The *Joven a Joven* hotline has established relationships with psychiatric services, counselling and domestic violence centres, and reproductive health clinics to refer callers who need additional help.
- They raise community awareness. The *Youth Sexual and Reproductive Health Project hotline* in Uganda received many letters of appreciation from community members and youth, evidence of its reach. In India, the *TARSHI* hotline, along with the information materials it distributes at public events, serves as a resource for journalists writing about reproductive health matters. *TARSHI* also collects data on its calls and uses them to advocate around issues related to sexuality.

However, these programmes are challenging to monitor and evaluate. Respecting the callers' anonymity and confidentiality can interfere with record collection about the profile of callers, and the impact of such programmes is difficult to measure.

The written word and the Internet

Newspapers and popular periodicals are another way young people can communicate with trusted adults. In Uganda, *Straight Talk*, a newspaper with a circulation around 100,000 a month, is targeted at readers aged 14 to 19. The "Breaking News" section gives ample space for comments and questions from its young readers, "and the advice provided by the adult editor is forthright. In reply to one question from a male reader, the paper wrote, If you are afraid of having sex with your girl friend then you are not ready yet. Sexual feeling at your age is normal, but you don't have to have sex. Masturbation could help you relieve these tense feelings.' Despite the unusually frank views expressed, the paper is flourishing".[604] Programmes are also beginning to experiment with the Internet and CD-ROMs as a way to make information accessible to young men who are reluctant and uncomfortable discussing intimate issues related to sexuality.

[604] UNAIDS, "Young People and HIV/AIDS", *UNAIDS Briefing Paper*, April 1999, p. 10.

Working with Young Peruvians at the INPPARES 'Future' Youth Centre[605]

The Centro Juvenil "Futuro" of the Instituto Peruano de Paternidad Responsable (INPPARES), the family planning association in Peru, is actively trying to dispel inaccurate information that many youth have about sex, STDs, contraception and conception, such as the "impossibility" of getting pregnant the first time you have sex, believed by 79 per cent of the adolescents they surveyed. The centre has had to be creative to overcome these myths and reach youth in an effective way.

Two years ago, the centre began offering its youth counselling services on the Internet (www.inppares.org.pe/). This new medium is an attractive communication mechanism for youth, not just because of the novelty of new technology, but also because their identity is protected. The Internet service has helped the centre stay in constant contact with both male and female youth at high schools and colleges throughout the country. Currently, the centre responds to approximately 80 inquiries per week, usually addressing youths' concerns and questions about sexuality and contraceptive methods. In addition to the Internet-based counselling, INPPARES has developed an innovative, interactive CD-ROM that teaches youth about STD/HIV transmission, diagnosis and treatment. It offers a confidential way for youth to learn about this sensitive subject that they might feel uncomfortable talking about with medical professionals.

Entertainment-education programmes

Entertainment education is the process of purposely designing and implementing a media message both to entertain and educate, in order to increase audience members' knowledge about an educational issue, create favourable attitudes, and change overt behaviour.[606] The John Hopkins University Center for Communication Programs (JHU/CCP) describes it as "an innovative communication strategy that uses popular entertainment media to communicate about social issues in areas such as health, environment, social justice and peace".[607] The purpose of entertainment-education programming is to contribute to social change — the process of altering the social behavioural system in a certain society. These changes can be on the individual, community or societal level. Six factors determine the effectiveness of entertainment education. These are audience characteristics, organizational factors, media environment, audience research, programme-specific factors and infrastructural factors.[608]

The "Senegal Reaching Men Campaign" focused on combining the benefits from entertainment education and a hotline project in order to encourage men to get involved in family health issues, particularly family planning, STD/AIDS information, and referrals to reproductive health services. It combined three strategies: advocacy with religious leaders (including Islamic brotherhoods) and policy-makers (parliamentarians), a multimedia campaign, and a community-

605 IPPF/WHR, "Working with Young Peruvians at the INPPARES 'Future' Youth Center", *Reaching Out*, spring 2000.

606 A. Singhal and E. Rogers, *Entertainment Education — A Communication Strategy for Social Change* (New Jersey: Lawrence Erlbaum Associates, 1999), p. 9.

607 "Search of the month", September 2000, www.jhuccp.org/info-to-go.

608 A. Singhal and E. Rogers, *Entertainment Education*.

mobilization component working with the community health worker. The way to approach the adolescents was through the hotline pilot project, in conjunction with family planning services, and through a rap concert. In a rap concert to mobilize youth around reproductive health, a series of music, traditional poetry and theatre contests were organized. Adolescents were encouraged to develop rap songs, poems and sketches on reproductive health issues such as STDs and HIV/AIDS. The representatives or artists were trained on the issues, enabling them to incorporate relevant messages in their own work. The rap lyrics that the adolescents presented culminated in a rap concert, which was advertised on radio. The concert was sold out and well attended. The proceeds, in combination with support from JHU/CCP, sustained the hotline that was providing services to youth. This is an example of the entertainment-education strategy being used to finance a hotline system. The rap-song approach is one of the key interventions.[609]

In Haiti, the Foundation de Sant Reproductive et d'Education Familiale (FOSREF), in collaboration with the Center for Development and Health (CDS), initiated a project titled "Youth Reproductive Health". The activities of the project included a sexual responsibility game, a song for music video, three radio spots, three photo novels and other media-support materials. A well-known rap group in Haiti produced the song and video. The video was aired on commercial TV and the song was regularly played on the radio.[610] The song is perceived by the Haitian public as just another song by the group, and not as a song with a health-related message. Everybody, particularly adolescents, knows the song's lyrics.

Family Health International and Ashe, a Jamaican NGO, are working on an innovative curriculum, "Preparing for the Vibes in the World of Sexuality", using drama, music and other techniques to empower and prepare young people for sexual responsibility.[611]

Social Marketing

Adolescents are an important target audience for social-marketing efforts (described in greater detail in chapter VI). A recent evaluation of youth-oriented social-marketing campaigns in Botswana, Cameroon, Guinea and South Africa produce insight into the time and work required to change adolescent behaviours. These findings are summarized in the following textbox.

609 See Web site: www.jhuccp.org/info-to-go/enter-ed/index.stm.

610 Ibid.

611 J. Senderowitz, "A Review of Program Approaches to Adolescent Reproductive Health", p. 19.

Lessons Learned from the SMASH[612]

Changing adolescent behaviour may require intensive programme efforts of at least two to three years. Youth-oriented social marketing programmes that have a short intervention period (one year or less) may be able to improve reproductive health knowledge, which may lead to behaviour change, but are unlikely to have a major impact on behaviour.

Social-marketing programmes targeting youth are most effective if they include a carefully designed mix of mass media promotion and interpersonal (face-to-face) communication. Interpersonal approaches, such as peer education in small groups, are extremely effective in promoting dialogue, but have limited reach unless they are supplemented by large-scale mass media activities. Programmes that rely on mass media have a limited ability to address youth concerns and build confidence. Successful programmes combine both approaches.

A better understanding of the different sexual health concerns of young men and women is likely to increase the effectiveness of adolescent interventions. Programme activities and communication messages may be more effective if adapted to address male and female concerns. Both sexes need to hear consistent messages, if, for example, they are to understand each other when negotiating condom use.

The promotion of condoms for STD or HIV/AIDS prevention requires careful communication strategies to reduce the stigma associated with condom use. The dilemma that programmes face in encouraging condom use among young people is the importance of educating about their effectiveness for preventing disease and using them in high-risk situations, while associating condoms with positive lifestyles to reduce the stigma associated with their use.

Evaluation is needed to measure the impact of programme activities. Research designs that use a control group are ideal though not always feasible. Standardized questionnaires and using a large sample size (e.g., 1,000) can improve these types of evaluations.

612 SMASH, "Results of Operation Research in Botswana, Cameroon, Guinea, South Africa".

Conclusion

Significant changes have occurred in programmes that address men's roles in population and reproductive and sexual health in the past five years, the most notable being:

- a leap in psycho-social knowledge of men's perceptions about sexual and reproductive matters, their socialization process and its impact on men and women;
- the use of a gender approach in sexual and reproductive health;
- the recognition of men's own health and psychological needs;
- the need to integrate STDs/HIV/AIDS with family planning services;
- the need to promote condoms as dual-protection methods against both unwanted pregnancy and STDs/HIV/AIDS;
- more visibility of and commitment to end violence against women and clearer linkages with sexuality and HIV/AIDS;
- an international men's movement mobilizing against violence;
- a movement to bring men closer to safe motherhood;
- the exploration of alternative models of masculinities that fully respect women.

Meanwhile, a proliferation of initiatives, including legislative change, progressive male networks, training of service providers, and attempts at equipping young men and boys with sexuality education, gender training and conflict-resolution skills are contributing to a clearer understanding of the essential elements required to integrate men as partners in reproductive and sexual health programmes.

From this review of research and programmes, a number of priority areas need further attention from UNFPA and its partners to continue the progress made in the areas of advocacy, research and evaluation, as follows:

Advocacy

to create enabling conditions for changing gender roles must take place at the international,

national and local levels. The focus of advocacy efforts should be to:

- Engage community leaders in the broadest sense (government, private sector, religion, media, entertainment) to endorse equal partnerships with men and women. Priority areas for advocacy campaigns are gender equality, men's and women's reproductive and sexual health needs (beyond family planning), and ending harmful practices, including son preference, early marriage, FGM and domestic violence.
- Enact laws, policies and strategies that condemn violence, allow men to take paternity leave and be closer to their wives and children from conception to parenting stages, and promote freer access to condoms. Enlisting men's, women's and youth organizations and service providers to encourage men to seek services, including counseling, will contribute to making men more comfortable with their place in the "private sphere".
- Work with the mass media, educators and service providers to promote alternative male role models, change norms that condone violence and promote tolerance for diversity.
- Another challenge is to reduce hostility against consenting men who engage in same sex behaviour in private. Such hostility hinders adolescents and men's willingness to seek services and report symptoms of HIV/AIDS[613]. Some measures donors can take are to review laws that discriminate against MSM, and to support community organization around prevention programmes.

Research

Additional information is needed on the contextual factors that determine male identity and gender relations in all regions, and on various aspects of risk milieus. More research is also needed towards understanding same-sex behaviour, and its relation to risk taking[614]. There is also a dearth of information on men's feelings about fatherhood, how they cope with a partner's pregnancy and miscarriage, a partner's or a child's mortality/morbidity.[615] Other unanswered questions include men's notions of reproductive health and their entitlements: what are men's perceptions regarding personal rights, privileges and responsibilities? What do they view as women's rights? What is their perception of equal rights between men and women?[616] What are their perceptions of harmful practices and how these can be eradicated?

Dissemination of research and development of a standard terminology.

An emerging body of literature effectively analyzes the causes of violence, with emphasis on unequal power relations and the dominant definitions of masculinity, but this analysis has not been adequately popularized and is underutilized in prevention efforts.

---

613 UNAIDS, "AIDS and men who have sex with men", *AIDS Technical Update*, May 2000, UNAIDS Best Practices Collection , Geneva.

614 UNAIDS, "AIDS and men who have sex with men".

615 Personal communication from Wariara Mbugua, UNFPA, October 2000.

616 R. P. Petchesky, "Conceptual Framework for IRRAG Research on Men", International Reproductive Rights Research Action Group, Phase II Study on Men's Sexuality, Rights and Personhood, April 1999, p. 3.

Although concepts such as gender relations, men as partners, masculinities, sexuality education and dual protection are no longer new, and have recently been embraced by the population field, the language associated with these complex concepts remains fluid and calls for standardization. Such standardization would contribute to creating a common understanding worldwide.

Evaluation and indicators

There is a serious need for standard qualitative and quantitative indicators with which to rigorously evaluate men's programmes. The indicators that are developed should evaluate process changes vis- -vis men's sexual behaviour, respect for their partner's choices, couples dynamics, health seeking and caring for the health of their partners.

Information sharing

Sharing current information more effectively remains an area that needs strengthening, and requires further attention and financial support. Innovative experiences in Nordic countries need to be popularized worldwide. Sharing research findings and solutions to common problems, and duplicating successful programmes continues to be a successful strategy for advancing the ICPD agenda.

For instance, regional clearinghouses or depositories of information such as the Facultad Latino Americana de Ciencias Sociales (FLACSO), Population Council regional offices, and others in Africa and Asia should get increased support from UN agencies such as UNAIDS and UNFPA.

The Internet is a useful tool for facilitating the transfer of knowledge, but language and connectivity may be issues. All efforts should be made to ensure that developing countries have access to existing content and the ability to publish their own experiences.

Building new partnerships in emergency and conflict situations

A closer collaboration between governments, populations, health care organizations, and refugee and relief agencies experienced in providing services to men and women in emergencies, would help strengthen initiatives in this area. Such partnerships would enrich the general knowledge about the urgent reproductive and sexual issues that emerge in refugee camps, war zones, and in other emergency circumstances, and the strategies that most successfully respond to reproductive and sexual health needs under these conditions.

Strengthening gender-sensitive men's networks

National, regional and some international networks have evolved from the various conferences that addressed male involvement in the past five years. These networks should be strengthened to play a role in the advocacy work described above, create a debate, and allow men to own the issues and their solutions.

As a gender specialist declares: "There are many men trying to stop various forms of violence against women and girls, men who challenge the definition of women as men's property, men who challenge the patriarchy — and the kind of masculinity that supports it. These are the men we need to learn more about, to recognize and work with. These are the men we need to raise our sons to be like."[617]

The contents of this report testify to the tremendous amount of work that has been done by UNFPA and other organizations in building partnerships with men over the past five years. Men are increasingly interested in improving the quality of their family life, achieving sexual and reproductive health, and establishing constructive partnerships with women. The population field is coming to terms with the fact that half of the population was neglected in addressing issues of reproduction and sexuality. Now is the time to make every effort to correct this oversight by studying models, examining strategies and assessing programme designs, while cautiously moving forward to integrate men in a manner that does not threaten women's health and rights.

[617] R. F. Hayward, "Needed: A New Model of Masculinity to Stop Violence against Girls and Women" (paper presented at the WHO Global Symposium on Violence and Health, Kobe, Japan, 12–15 October 1999; in final report and lead document, UNICEF workshop, "Ending Gender Violence and Reaching Other Goals: What Do Men and Violence Have to Do with it?" New York, 23–24 March 2000.

Bibliography

Aganon, **M**. **E**., et al. "Population and Family Welfare Programmes at Enterprise level: The Philippine Experience". *In Population Education and Services in Enterprises*. UNFPA/ILO (INT/92/P77), 1994.

Agarwal. **B**. "Gender and Command over Property: A Critical Gap in Economic Analysis and Policy in South Asia". *World Development* 22, no. 110 (1994): 1455–78.

——. "AIDS and the World II", eds. Jonathan M. Mann and Daniel J.M. Tarantola, Oxford University Press, 1996

Ajuwon, **A**. **J**., et al. "Sexual Coercion among Adolescents in Ibadan, Nigeria: The Perspectives of Males". Paper presented at WHO Afro Regional meeting in Pretoria, South Africa, 27–29 September 2000.

Askew, **Sue**, and **Carol Ross**. Boys Don't Cry: *Boys and Sexism in Education*. Buckingham: Open University Press, 1998.

Avenido, **S**. **G**. "Member and Family Welfare Services Provided by the Associated Labour Unions/Trade Union Congress of the Philippines". In ILO Report of Regional Consultative Meeting on Comprehensive Member and Family Welfare Services by Trade Union Organizations, Cebu, 23–27 April 1996.

AVSC International. "Men as Partners: Ideas from Four Continents". *AVSC News*. Spring 1997.

——. "Men as Partners Initiative: Summary Report of *Literature Review* and Case Studies". New York, 1997.

——. "Men as Partners in Reproductive Health". *Workshop Report*. Mombassa, Kenya, May 1997.

——. *Introduction to Men's Reproductive Health Services*. New York, 2000.

AVSC International and IPPF / WHR. *Five Case Studies Prepared for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms*. Oaxaca, Mexico, October 1998.

——. "Male Participation in Sexual and Reproductive Health: New Paradigms". *Literature Review*. Oaxaca, Mexico, October 1998.

——. "Male Participation in Sexual and Reproductive Health: New Paradigms". *Symposium* Report. Oaxaca, Mexico, October 1998.

Banakole, **A**., and **S**. **Singh**. "Couples' Fertility and Contraceptive Decision-Making in Developing Countries: Hearing the Man's Voice". *International Family Planning Perspectives* 24, no. 1 (1998): 15.

Banjos, **N**., et al. "La Promotion du préservatif comme contraceptif". *ANRS Information*, no. 19 (July/August 1996): 47.

Barker, **Gary**. "The Misunderstood Gender: Male Involvement in the Family and in Reproductive and Sexual Health in Latin America and the Caribbean". Chicago: John D. and Catherine T. MacArthur Foundation, January 1996.

——. "Boys in the Hood, Boys in the Barrio: Exploratory Research on Masculinity, Fatherhood and Attitudes toward Women among Low Income Young Men in Chicago, USA, and Rio de Janeiro, Brazil". International Union for the Scientific Study of Population (IUSSP) Committee on Gender and Population, Centro De Estudios de Problacion (CENEP). Paper presented at the Seminar on Family Men, Family Formation and Reproduction, Buenos Aires, 13–15 May 1998.

——. "Boys, Men and HIV/AIDS". UNAIDS Briefing Paper (second draft). Instituto Promundo, Rio de Janeiro, Brazil, 18 January 2000.

——. "Exploratory Operational Definitions of Gender Equitable Behavior by Young Men". Notes from Dissertation Research. July 2000.

Bauni, **E**. **K**., and **B**. **O**. **Jarabi**. "Family Planning and Sexual Behavior in the Era of HIV/AIDS: The Case of Nakuru District, Kenya". *Studies in Family Planning* (March 2000).

Bawah, **Ayaga A**., et al. "Women's Fears and Men's Anxieties: The Impact of Family Planning on Gender Relations in Northern Ghana". *Studies in Family Planning* 30, no. 1 (1999).

Becker, **Stan**. "Couples and Reproductive Health: A Review of Couple Studies". *Studies in Family Planning* 27, no. 6 (1996): 291–306.

——. "Measuring Unmet Need: Wives, Husbands or Couples?" *Family Planning Perspectives* 24, no. 94 (1999): 172–80.

Becker, **Stan**, and **J**. **C**. **Robinson**. "Reproductive Health Care: Services Oriented to Couples". *International Journal of Gynecology and Obstetrics* 61, no. 3 (1998): 275–81.

Beckman, **L**. "Communication, Power and the Influence of Social Networks in Couple Decisions on Fertility". In *Determinants of Fertility in Developing Countries*, edited by R. A. Bulatao et al. Vol. 2, *Fertility Regulation and Institutional Influences*, pp. 415–43. New York: Academic Press, 1983.

Berer, **Marge**. "Men". *Reproductive Health Matters* 7 (May 1997): 10.

Bilac, **Elisabete D**., et al. "The 'Family Man': Conjugality and Fatherhood among Middle-class Brazilian Men in the 1990s". WHO / HRP, Universidade Estadual de Campinas–Nucleo de Estudos de Populaçao, January 2000.

Blanc, **A**., et al. "Negotiating Reproductive Outcomes in Uganda", p. 214. Calverton, Maryland: Macro International, December 1996.

Brooks, **M**. "Men's Views on Male Hormonal Contraception". *British Journal of Family Planning* 24, no. 1 (April 1998): 7–17.

Bruce, **J**. "Fundamental Elements of the Quality of Care: A Simple Framework". *Studies in Family Planning* 21, no. 2 (1990): 61–69.

CARE. "Strategies to Involve Men in Reproductive Health Care: From Farm Management to Family Management". *Frontiers in Reproductive Health*, Electronic Library, 1990–1999, May 1999.

Casterline, **John**. Personal communication, Geneva, 2000.

Cates, **W**., and **K**. **Stone**. "Family Planning, Sexually Transmitted Diseases and Contraceptive Choice: A Literature Update, Part 1". *Family Planning Perspectives* 24, no. 2 (March/April 1992).

Cates, **W**., et al. "Dual vs. Duel(ing) Protection against Unintended Pregnancy and Sexually Transmitted Infections: What Is the Best Contraceptive Approach?" Family Health International. Manuscript prepared for submission to *British Medical Journal*, 2000.

Cazes, **Daniel**. "Work among Men in Latin America: Investigation and Practices, Results and Experiences". Paper presented at Seminar on Men, Family Formation and Reproduction, IUSSP, Buenos Aires, Argentina, 13–15 May 1998.

CEDPA. *Gender Equity: Concepts and Tools for Development*. Washington, DC, 1996.

——. *Choose a Future! Issues and Options for Adolescent Boys: A Source Book of Participatory Learning Activities*. Washington, DC, November 1998.

Centerwall, **E**. "Sexuality Education for Adolescent Boys". Swedish Association for Sex Education, Sweden, 1995.

Chikara, **Florence T**. "The Role of IEC in Reinforcing or Changing Gender Stereotypes and Promoting Gender Equality". In *Sexual and Reproductive Health and Rights of Women*. IPPF Discussion Paper, issue 1, 1995.

Clark, **Sam**, et al. "Increased Participation of Men in Reproductive Health Programs". Report for the Royal Ministry of Foreign Affairs, Oslo, Norway, 21 February 1999.

Coeytaux, **Francine**. "Celebrating Mother and Child on the Fortieth Day: The Sfax, Tunisia, Postpartum Program". *Quality/Calidad/Qualite,* no. 1. New York: The Population Council, 1989.

Cohen, **Sylvie I**., and **Doris D'Cruz Grote**. "Communication and Gender: Some Reflections Based on Experiences from UNFPA, UNICEF and UNAIDS". Presentation at UNAIDS Communication for Behaviour and Social Change Workshop, Geneva, August 2000.

Connell, **R**. **W**. "La Organización social de la masculinidad". In *Masculinidad/es, Poder y Crisis*, edited by Teresa Valdés and José Olavarría. Santiago: Isis Internacional, Ediciones de las Mujeres no. 24, 1997.

Cook, **Rebecca J**. "Gender, Health and Human Rights". *Health and Human Rights* (Harvard School of Public Health) 1, no. 4 (1995): 357–58.

CORIAC posters. More information at: coriac@laneta.apc.org.

Coulter, **Angela**. "Paternalism or Partnership: Patients Have Grown Up — and There's No Going Back". *British Medical Journal* 319 (1999): 719.

Danforth, **Nick**, and **Cynthia P**. **Greene**. "Involving Men in Reproductive Health: A Review of USAID-Funded Activities". USAID Poptech Report no. 96-070050, April 1997.

Danielson, **R**. "Couple-Friendly Care: Paradigm for Reproductive Health Promotion". Paper presented at the annual meeting of the American Public Health Association, San Diego, California, November 1995.

Das Gupta, **M**. "Selective Discrimination against Female Children in Rural Punjab, India". *Population Review* 13, no. 1 (1987): 77–100.

Dixon-Mueller, **Ruth**. "The Sexuality Connection of Reproductive Health". *Studies in Family Planning* 24, no. 5 (September/October 1993).

Douthwaite, **M**. "Male Involvement in Family Planning and Reproductive Health in Pakistan: A Review of the Literature". *Research Report* no.7. Population Council, Islamabad, Pakistan, March 1998.

Drennan, **M**., et al. "New Perspectives on Men's Participation". *Population Reports* (Johns Hopkins University School of Public Health), series J, no. 46, October 1998.

Egero, **Bertil**. "Considerations on Male Involvement". Presentation at UNFPA Gender Advisory Panel, New York, 23–25 March 2000.

Erulkar, **A**. **S**., and **B**. **S**. **Mensch**. "Gender Differences in Dating Experiences and Sexual Behaviour among Adolescents in Kenya". Paper presented at the 23rd Population Conference of the International Union for the Scientific Study of Population, Beijing, 11–17 October 1997.

Ezeh, **Alex**, et al. "Men's Fertility, Contraceptive Use, and Reproductive Preferences". *Demographic and Health Surveys Comparative Studies*, no. 18. Calverton, Maryland: Macro International Inc., 1996.

Family Health International. "Male Responsibility for Reproductive Health". Network 18, no. 3 (spring 1998). www.fhi.org/en/fp/fppubs/network.

——. "Reasons to Have Confidence in Condoms". Adapted from "The Latex Condom: Recent Advances, Future Directions". *Network* 18, no. 3 (1998). Revised 8 October 1999. www.fhi.org/en/fp/fppubs/network/.

Fapohunda, **Bolaji M**., and **Naomi Rutenberg**. "Expanding Men's Participation in Reproductive Health in Kenya". Nairobi: African Population Policy Research Centre, 1999.

Fathalla, **M**. "Reproductive Health: A Global Overview". *Annals of the New York Academy of Sciences*, 28 June 1991.

Fawcus, **Susan**, et al. "A Community-Based Investigation of Avoidable Factors in Maternal Mortality in Zimbabwe". *Studies in Family Planning* 27, no. 6 (1996): 319.

Figueroa, **Juan Guillermo**. "Some Reflections on the Presence of Males in the Reproductive Process". Based on presentations made at the Seminar of Studies on Masculinity, University

Programme of Gender Studies, Autonomous National University of Mexico (Figueroa and Liendro), 1994; and at the Seminar on Fertility and the Male Life Cycle in the Era of Fertility Decline, IUSSP, Zacatecas, Mexico, 1995.

Focus on Young Adults. "Using Peer Promoters in Reproductive Health Programs for Youth". *Focus*, www.pathfind.org/focus.htm, December 1997.

——. "Reproductive Health Programs for Young Adults: Outreach Programs". *Focus*, www.pathfind.org/focus.htm, August 1998.

——. "Reaching Adolescents through Hotlines and Radio Call-in Programs". *Focus*, www.pathfind.org/focus.htm, December 1999.

Foreman, **Martin**, ed. *Men and AIDS: Taking Risks or Taking Responsibility?* London: Panos Institute and Zed Books, 1999.

Foumbi, **J**., and **R**. **Lubovitch**. "Roles of Men in the Lives of Children: A Study of How Improving Knowledge about Men in Families Helps Strengthen Programming for Children and Women". UNICEF, 1 December 1997.

Green, **Cynthia**. "Reaching Young Men with Reproductive Health Programs". *Focus*, December 1998. www.pathfind.org/publications.htm.

Green, **Cynthia**, et al. "Male Involvement in Reproductive Health, Including Family Planning and Sexual Health". *Technical Report* 28. UNFPA, New York, 1995.

——. "Involving Men in Reproductive Health: Policy Implications for Developing Countries". Paper presented to the American Public Health Association, New York, 1996.

Greene, **Margaret E**. "The Benefits of Involving Men in Reproductive Health". Paper presented at AWID and USAID, November 1999.

Greene, **Margaret E**., and Ann Biddlecom. "Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles". *Population and Development Review* 26, no. 1 (2000): 96.

Greene, **Margaret E**., and **André Mayouya**. "Conceptual Frameworks and Data". Paper presented to TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, FAO / WHO / UNFPA, Rome, 9–13 November 1998.

Gupta, **Geeta Rao**. "Gender, Sexuality, and HIV/AIDS: The What, the Why and the How". Plenary address, 12th International AIDS Conference, Durban, South Africa, July 2000.

Hawkes, **Sarah**. "Providing Sexual Health Services for Men in Bangladesh". *Sexual Health Exchange* 3 (1998): 14.

——. "Why Include Men: Establishing Sexual Health Clinics in Rural Bangladesh". *Health Policy and Planning* 13, no. 2 (1998): 121–30.

Hayward, **Ruth Finney**. "Needed: A New Model of Masculinity to Stop Violence against Girls and Women". Paper presented to the WHO Global Symposium on Violence and Health, Kobe, Japan, 12–15 October 1999.

Hein, **C**., et al. *Population Education and Services in Enterprises*. UNFPA/ILO (INT/92/P77), 1992.

Heisi, **Lorie**. "Violence, Sexuality and Women's Lives". In *Conceiving Sexuality: Approaches to Sex Research in the Postmodern World*, chap. 7. New York: Routledge, 1995.

Heise, **Lorie**, **Jacqueline Pitanguy**, and **Adrienne Germain**. "Violence against Women: The Hidden Health Burden". *World Bank Discussion Papers*, no. 255, 1994.

Helzner, **Judith**. "Male Involvement in Reproductive Health". *Planned Parenthood Challenges* (**IPPF**), p. 5, 1996.

Herdt, **G**. "Sexual Cultures and Population Movement, Implications for AIDS/STDs". In *Sexual Cultures and Migration in the Era of AIDS: Anthropological and Demographic Perspectives*. Oxford: Clarendon Press, 1997.

Hirsch, **Jennifer S**., and **Constance A. Nathanson**. "Amor and Infidelidad: The STD/HIV Prevention Implications of Changing Ideas about Marriage and the Importance of Sexual Fidelity in Western Mexico". Paper presented at APHA, November 1999.

ILO. "Lessons Learned from UNFPA/ILO Programmes about Reaching Men", p. 5, undated.

International Planned Parenthood Federation (**IPPF**). *Planned Parenthood Challenges* 2, 1996.

——. "Statement on Sexually Transmitted Disease and Reproductive Health", 1997.

IPPF / **Western Hemisphere Region**. "Men in Latin America: How they View Family Planning, Sexual Health, and Reproductive Health". Report of Focus Groups, 1997.

——. "The Flip Side: Involving Men in Sexual and Reproductive Health". *Forum* 14, no. 2 (December 1998): 4–5.

——. "Youth-Friendly Services". *Forum* 14, no. 2 (December 1999): 8–9.

——. "What Is a Man?" *Forum* 14, no.1 (January 1999): 15–16.

——. "Confronting Domestic Violence". *Forum* 14, no.1 (January 1999): 7–8.

——. BASTA! (spring 2000): 7.

——. "Working with Young Peruvians at the INPPARES 'Future' Youth Center". *Reaching Out* (spring 2000).

International Research on Women. Plenary address, 12th International AIDS Conference, Durban, South Africa, July 2000.

Isiugo-Abanihe, **Uche C**. "Reproductive Motivation and Family-Size Preferences among Nigerian Men". *Studies in Family Planning* 25, no. 3 (1994): 150–51.

Janneke, **H**. **H**. **M**., et al. "Men's Attitudes toward Vaginal Microbicides and Microbicide Trials in Zimbabwe". *International Family Planning Perspectives* 25, no. 1, 1999.

Johns Hopkins University Center for Communication Programmes. *Reaching Men Worldwide:*

Lessons Learned from Family Planning and Communication Projects, 1986–1996. Working Paper Series, no. 3, January 1997.

——. "Better Together: A Report on the African Regional Conference on Men's Participation in Reproductive Health", April 1997.

John Hopkins University School of Public Health. "Promoting Male Methods and Men's Services". *Population Reports*, series M, no. 12, July 1994.

——. "New Perspectives on Men's Participation". *Population Reports*, series J, no. 46, October, 1998.

——. "Closing the Condom Gap". *Population Reports*, series H, no. 9, April 1999.

——. "Search of the Month", September 2000. www.jhuccp.org/info-to-go.

Johns Hopkins University / **Population and Communication Services** and **Académie pour le Développement de L'Education** (**AED** / **SARA**). "Les Hommes: partneraires-clés de la santé de la reproduction". Report of the First Conference of Francophone Countries on Male Involvement in Reproductive Health, Ouagadougou, Burkina Faso, 30 March–3 April 1998.

Karra, **M**., et al. "Male Involvement in Family Planning: A Case Study Spanning Five Generations of a South India Family". *Studies in Family Planning* 28, no. 1, March 1997.

Kaufman, **Michael**. "The Construction of Masculinity and the Triad of Men's Violence". *In Beyond Patriarchy: Essays by Men on Pleasure, Power and Change*, edited by M. Kaufman. Toronto: Oxford University Press, 1985.

——. "Las experiencias contradictorias del poder entre los hombres". *Isis International*, Chile, 1997.

——. "Involving Men and Boys: A Necessary Step in Ending Violence against Women and Girls". Paper presented at Namibia's National Conference on Men against Violence against Women, Windhoek, Namibia, 23–25 February 2000.

——. "The Seven P's of Men's Violence". In final report and lead document, UNICEF workshop, "Ending Gender Violence and Reaching Other Goals: What Do Men and Violence Have To Do with it?" New York, 23–24 March 2000.

——. "Conflict Resolution: Finding Better Ways to Help Boys and Girls Solve Problems". Paper prepared for Gender, Partnership and Participation Section, Programme Division, UNICEF, 31 March 2000.

——. "Positive Strategies with Boys to End Violence". Paper prepared for Gender, Partnerships and Participation Section, Programme Division, UNICEF, March 2000.

Khadijat, **L. Mojidi**. "Increasing Male Participation: Lessons from Mali, Kenya and Nigeria". In *Grassroots to Global Networks: Improving Women's Reproductive Health*. Paper presented at the ACCESS Lessons Learned Conference, CEDPA, Washington, DC, 18–19 June 1998.

Kim, **Y. M.**, and **D. Awasum**. "What Are the Particular Aspects of Counselling Male Family Planning Clients? A Case from Kenya". Paper presented at the American Public Health Association Men and Reproductive Health Task Force Workshop, November 1996.

Kimmel, **Michael**. "Working towards Gender Equality: Where Are the Men?" Presentation made to Men and Gender Equality Working Group, UNDP, New York, 12 August 1999.

Kisekka, **M**. "Involving Men in Operationalizing Reproductive Health Programmes: Addressing Gender Based Issues". UNFPA Regional Consultation, Africa, Addis Ababa, Ethiopia, 25–30 January 1997.

Ladjali, **Malika**. "Gender Quality of Care: Common Approaches for Common Goals". WHO, Geneva, 1998.

Laudari, **Carlos**. "Gender Equity in Reproductive and Sexual Health". Paper presented in Rome, FAO / WHO / UNFPA, November 1998.

Leach, **F**. "Gender Education and Training: An International Perspective". *Gender and Development* 6, no. 2 (1998): 9–18.

Leslie, **J**., et al. "Female Nutritional Status across the Life-span in Sub-Saharan Africa: Prevalence Patterns". *Food and Nutrition Bulletin* 18, no. 1 (1997): 20–43.

Lutaol, **Thomas**, et al. " Trends and Determinants of Contraceptive Use in Rakai District, Uganda, 1995–98". *Studies in Family Planning* 31, no. 3 (2000): 217–27.

Magnani, **Robert J**. "The Impact of the Family Planning Supply Environment on Contraceptive Intentions and Use in Morocco". *Studies in Family Planning* 30, no. 2 (1999): 120–32.

Maharaj, **Pranitha**. "Prevention on Unwanted Pregnancy and HIV Infections: perspectives of Young Men and Women. School of Development, Durban (undated)

Marcham, **Christina**, et al. "Dual Protection: Reappraising the Condom as Contraception". WHO, Department of Reproductive Health and Research, October 1999.

Mason, **Karen O**., et al. "The Husband's Role in Determining Whether Contraception Is Used: The Influence of Gender Context in Five Asian Countries". Paper presented at IUSSP, Buenos Aires, Argentina, 13–15 May 1998.

Matalama. **M**. **I**. "Gender-Related Indicators for the Evaluation of Quality of Care in Reproductive Health Services". *Reproductive Health Matters* 6, no. 11 (1998): 11.

Mbizvo, **M**., and **M**. **Bassett**. "Reproductive Health and AIDS Prevention in Sub-Saharan Africa: The Case for Increased Male Participation". *Health Policy and Planning* 11, no. 1, 1996.

Mensch, **Bruce S**., and **Margaret E. Greene**. *The Uncharted Passage: Girl Adolescence in the Developing World*. Population Council, 1998.

Messersmith, **Lisa J**., et al. "Who's at Risk? Men's STD Experience and Condom Use in Southwest Nigeria". *Studies in Family Planning* 31, no. 3 (2000): 203–16.

Mohiddin, **A**. "Partnership: A New Buzz-word or Realistic Relationship? Africa and Partnership On-line (Society for International Development) 41, no. 4, 1998. www.sidint.org/publications/development/vol41/no4/41-4b.htm.

Moore, **Henrietta**. *Identity: Personal and Socio-cultural*. Stockholm: Almquist & Wiksell International, 1998.

Mundigo, **Axel**. "Determinants of Unsafe Induced Abortion in Developing Countries". Paper presented at the Meeting on Priorities and Needs in the Area of Unsafe Abortion, WHO, Geneva, 28–29 August 2000.

Muñoz, **Norori V**., and **J**. **Muñoz Lopez**. "Conceptualizing Masculinity through a Gender-Based Approach". *Sexual Health Exchange* 1998, no. 2: 3–6.

Murray, **Christopher J**. **L**., and **Alan D**. **Lopez**, eds. *The Global Burden of Disease*. Global Burden of Disease Series, vol. 1. Boston: Harvard University Press, 1996.

Muzskat, **Malvina**, et al. "When Three Is Better Than Two". WHO/HRP, Universidade Estadual de Campinas–Nucleo de Estudos de Populaçao, January 2000.

Nash, **Herndon**. "Men Influence Contraceptive Use" *Network* (Family Health International) 18, no. 3, 1998.

Ncube, **J**. "Sex the Shocking Truth". *Drum* (Durban, South Africa), 13 July 2000.

Ndong, **Isaiah**, et al. "Men's Reproductive Health: Defining, Designing and Delivering Services". *International Family Planning Perspectives* 25, supp. (1999): 53.

Neaz, **A**. "Converting Bangladesh's Influential Religious Leaders". *Planned Parenthood Challenges* 2, 1996.

Ngom, **Pierre**. "Men's Unmet Need for Family Planning: Implications for African Fertility Transitions". *Studies in Family Planning* 28, no. 3 (1997): 192–202.

Nnko, **S**. **E**. **A**. "Risk Behaviours of Male Adolescents in Tanzania: Motives and Patterns of Their Sexual Relationship". Paper presented at the WHO/UNAIDS Afro Regional Meeting in Pretoria, South Africa, 27–29 September 2000.

Noel-De Bique, **D**. "The Caribbean: NGO Partnerships for Advancing Male Responsibility in Implementing the Goals of the ICPD". In *HERA: Health, Empowerment, Rights & Accountability, Confounding the Critics: Cairo, Five Years On*. Conference Report, Cocoyoc, Morelos, Mexico, 15–18 November 1998.

Nzioka, **Charles**. "Male Participation in Decision-Making on Family Planning and Modern Contraceptive Use in Kenya". A report submitted to the Strategic Component on Social Science Research on Reproductive Health, Special Programme of Research, Development and Research Training in Human Reproduction, WHO, June 2000.

——. "Obstacles in Managing the Dual Risks of Unwanted Pregnancy and Sexually Transmitted Infections Among Young Men in Kenya". Paper presented at the WHO/UNAIDA Afro Regional Meeting in Pretoria, South Africa, 27-29 September, 2000

O'Brien, **Jon**. "Men and Family Planning: So, What Did They Talk About?" *Reproductive Health Matters*, no. 3 (1994): p. 101.

Osama, **S**. "Addressing the Gender Dimension Involving Men with Special Reference to Sudan". In "Operationalizing Reproductive Health Programmes: Report of Workshop", pp. 20–21. UNFPA, Regional Consultation Arab States, Rabat, Morocco, 24–28 November 1997.

PATH. "Involving Men in Reproductive Health". *Outlook* 14, no. 3 (1997): 1.

Pathfinder. "Promoting Reproductive Health for Young Adults through Social Marketing and Mass Media: A Review of Trends and Practices", pp. 2–6. Focus on Young Adults, Research Series, 16 July 1997.

Petchesky, **Rosalind P**. "Sexual Rights: Inventing a Concept, Mapping and International Practice". Paper presented at the Conference on Reconceiving Sexuality, Rio de Janeiro, 14 April 1996.

——. "Conceptual Framework for IRRAG Research on Men". International Reproductive Rights Research Action Group. Phase II Study on Men's Sexuality, Rights and Personhood, April 1999.

Pfannenschmidt, **S**., et al. "Through a Gender Lens". Washington, DC: US Agency for International Development, October 1997.

Population Council. "Male Community-Based Development Agents Effective at Reaching Men with Family Planning Message". *African Alternatives* 2, no. 1 (August 1995): 6.

——. "Male Involvement in Family Planning: A Challenge for the National Programme Workshop". *Frontiers in Reproductive Health*, Electronic Library 1990–1999, June 1996.

——. "Case Studies from India Examine the Status of Men as Supportive Partners in Reproductive Health". News Release (case studies from the project, "Halting AIDS on the Highway", Atanu Majumdar, Bhoruka Public Welfare Trust, Calcutta, India), 8 August 2000. www.popcouncil.org/news%5Fviews/menasparatnersrls.htm.

——. "Integrating Men into the Reproductive Health Equation: Acceptability and Feasibility in Kenya". The Robert H. Ebert Program on Critical Issues in Reproductive Health, 2000.

——. "Male Circumcision and HIV/AIDS: Directions for Future Research". *Reproductive Health and Family Planning*, Horizons, June 2000.

——. "Meeting Women's Health Care Needs after Abortion". *Frontiers in Reproductive Health Brief*, no.1, August 2000.

——. *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality*, edited by Raju Saraswati and Ann Leonard. South and East Asia Regional Office, 2000.

——. "Perception of Male Members about Reproductive Health Matters: Preliminary Evidence from a Tribal Area of Gujarat". In *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality*, edited by Raju Saraswati and Ann Leonard. South and East Asia Regional Office, 2000.

——. Seminar on Male Involvement in Reproductive Health: Summary of Research Findings and Future Directions, Alexandria, Egypt, Population Council Asia and Near East Operations Research and Technical Assistance Project, 4–5 May 1998.

——. "The Tostan Story: Breakthrough in Senegal Ending Female Genital Cutting". *Frontiers in Reproductive Health*, July 2000. www.popcouncil.org/rhfp/tostan.html.

Population Council / **Inopal III**. "Introduction of Multimedia as an Information Tool for Sexual and Reproductive Health Education". *Frontiers in Reproductive Health*, Electronic Library 1990–1999. Lima, Peru, 29 October 1998.

Pulerwitz, **J**. "Involving Men in HIV/AIDS and Reproductive Health Programmes". Presentation of Horizons project findings at the MotherCare meeting on Key Behaviour in Maternal Health and Survival, Washington, DC, May 2000.

Ransom, **Elizabeth**. "Men's Roles in Women's Health and Safer Motherhood". Paper presented at the Population Association of America, 2000.

Reproductive Health Outlook, September 2000. www.rho.org/html/menrh_progexamples.htm.

Reyes, **H**. (I)relevance of Condoms in Prisons". Paper presented at Corrections Health Services Conference, Australia, November 1997. www.icrc.org.

Ringheim, **Karin**. "Male Involvement and Contraceptive Methods for Men, Present and Future". Paper presented at the American Public Health Association, November 1996.

——. "Reversing the Downward Trend in Men's Share of Contraceptive Use". *Reproductive Health Matters*, 1999.

Rix, **D**. "Male Sexual Education in a Danish Perspective". *Planned Parenthood Challenges* 2, 1996.

Robey, **B**., and **M**. **Drennan**. "Male Participation in Reproductive Health". *Network* 18, no. 3, 1998.

Rogow, **D**., and **S**. **Horowitz**. "Withdrawal: A Review of the Literature and an Agenda for Research". *Studies in Family Planning* 26, no. 3 (1995): 140.

Rosenzweig, **R**., et al. " Male Involvement, Couple-Friendly Care, Relationship Awareness, and Gender Partnership in Reproductive Health". Paper presented at American Public Health Association, November 1996.

Ross, **John A**., and Elizabeth Frankenberg. "Findings from Two Decades of Family Planning Research". Population Council, New York, 1993.

Roudi, **F**., and **L**. **Ashford**. *Men and Family Planning in Africa*. Washington: Population Reference Bureau, 1996.

Sadik, **Nafis**. "Human Rights and Global Needs: Ethical Considerations in Population Policies". Statement made at the CORDAID Symposium, Netherlands, January 1998.

Sathar, **Zeba A**., and **John B**. **Casterline**. "The Onset of Fertility Transition in Pakistan". Working Paper no. 112, Population Council, New York, 1998.

Senderowitz, **J**. "A Review of Program Approaches to Adolescent Reproductive Health" (draft). USAID / G / PHN, 2000.

Severo, **C**., et al. "Factories, Port Authorities and Vineyards: Why Do They Care? Enterprise-Based Distribution of Family Planning Services in Madagascar: Results of the First 18 Months". Paper presented at American Public Health Association, 1997.

Shepard, **Bonnie**. "Masculinity and the Male Role in Sexual Health". *Planned Parenthood Challenges* 2, 1996.

Sherris, **J**. **D**. "Contraceptive Social Marketing: Lessons from Experience". *Population Reports* J-30, JHU /SPH / PIP, July / August 1995.

Silberschmidt, **Margarethe**. "Rethinking Gender Relations: An Investigation of Men, Their Changing Roles within the Household and the Implications for Gender Relations in Kissii District, West Kenya". In CDR *Research Report* no. 16. Copenhagen: Centre for Development Research, 1991.

Singhal, **A**., and **E**. **Rogers**. *Entertainment Education: A Communication Strategy for Social Change*. New Jersey: Lawrence Erlbaum Associates, 1999.

Social Marketing for Adolescent Sexual Health (**SMASH**). "Results of Operation Research in Botswana, Cameroon, Guinea, South Africa". Measure Communication Reports, June 2000, www.Measurecommunication.org/factsheets/smash/program_lessons.htm.

Steele, **C**., et al. "The Language of Male Involvement: What Do You Mean by That?" *Populi*, November 1996.

Stölen, **Kristiane**. "Gender Sexuality and Violence in Ecuador". Paper presented at Nordic Symposium on Gender and Social Change in the Third World, Ganavolden, Norway, 1990.

Swedish International Development Agency. "Men's Voices, Men's Choices". Seminar report, Lusaka, Zambia, 1999.

Tawab, **N**. **A**., et al. "Effects of Husband Involvement on Post-abortion Patients' Recovery and Use of Contraception in Egypt". Population Council Operations Research/Technical Assistance Project and the Egyptian Fertility Care Society, 1997.

Thuo, **Margaret**. "Male Involvement and Participation in Reproductive Health in Uganda: Summary of the Research Findings". UNFPA Country Support Team Addis Ababa, 1999.

Tolbert, **K**., et al. "Improving Reproductive Health of Couples: Men, the Ignored Partners". *Frontiers in Reproductive Health*, Electronic Library 1990-1999, Population Council, 1998.

Toro, **H**., et al. "Male Involvement: Regional Specificities". Paper presented at TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services, Rome, 9–13 November 1998.

Touré, **Lalla**. "Male Involvement in Family Planning: A Review of the Literature and Selected Programme Initiatives in Africa". USAID / HHRA, November 1996. www.usaid.gov/regions/afr/hhraa/male.

Tweedie, **Ian**. "Walking the Stereotype Tightrope: Lessons Learned from Communication Approaches to Men's Participation in Zimbabwe". Report from the meeting on Changing Communication Strategies for Reproductive Health and Rights. The Health and Development Policy Project, Population Council, Washington, DC, 10–11 December 1997.

UNAIDS, "AIDS and Men who Have Sex with Men", AIDS Technical Update, UNAIDS Best Practices Collection, 2000.

——. "AIDS and the Military", UNAIDS Point of view, Best Practices Collection, 1998.

——. "Communication Framework for HIV/AIDS: A New Direction". United Nations Programme on HIV/AIDS and Pennsylvania State University, 1999.

——. "Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review Update", 1997.

——. "Prisons and AIDS", UNAIDS Point of View, Best Practices Collection, 1997.

——. "Report of a Workshop on Planning for Gender and AIDS Mainstreaming". Geneva, 14–17 June 1999.

——. World AIDS Campaign, 2000. www.UNAIDS/World.

UNFPA "Expert Consultation on Operationalizing Reproductive Health Programmes: Africa". *Workshop Proceedings*, Addis Ababa, Ethiopia, 25–30 January 1997.

——. "Expert Consultation on Operationalizing Reproductive Health Programmes: Arab States". *Workshop Proceedings*, Rabat, Morocco, 24–28 November 1997.

——. "Expert Consultation on Operationalizing Reproductive Health: Asia and the Pacific". *Workshop Proceedings*, New Delhi, India, 22–26 November 1997.

——. "Expert Consultation on Operationalizng Reproductive Health Programmes: Latin America and the Caribbean. Lima". *Workshop Proceedings*, Lima, Peru, 3–7 November 1997.

——. "Male Involvement in Reproductive Health: Incorporating Gender throughout the Life Cycle". *TSS Occasional Paper*, no. 1, June 1998.

——. "The Sexual and Reproductive Health of Adolescents: A Review of UNFPA Assistance". *Technical Report* no. 43, 1998.

——. TSS Thematic Workshop on Male Involvement in Reproductive Health, November 1998. www.fao.org/sd/wpdirect/wpre0123.htm.

——. "Implementing the Reproductive Health Vision: Involving Men in Reproductive Health". *Evaluation Findings*, issue 24 (July 1999): 5.

——. "Lives Together, Worlds Apart: Men and Women in a Time of Change". In *State of the World Population*, 2000.

——. "Ethics, Religion and Reproductive Health". E-mail message from Fatou Sarr Diop, January 2000.

——. "Legislative Commitments to Sexual and Reproductive Health and Rights: A Five-Year Review of the Cairo and Beijing Conferences in Latin America and the Caribbean". 2000.

——. "Strengthening Reproductive Health Services for Adolescents in Latin America". *Project Summary*, July 2000.

——. "Parents Handbook on Sexuality and Communication Skills". Family Life Education Programme in Ghana, 2000. www.siecus.org.

UNFPA and **ECO**. "The Role of Men in Population and Reproductive Health Programmes". *Conference Report* (Baku, Azerbaijan, 21–24 September 1998), June 1999, p. 50.

UNFPA and **PATH**. "Sexual Health". *Outlook* 16, no. 4 (February 1999): 7.

UNFPA / **Country Technical Services Team for East and South East Asia**. "Report of the UNFPA Inter-country Workshop on Adolescent Reproductive Health for East and South East Asia and the Pacific Island Countries". Pattaya, 27 April–3 May 2000.

UNFPA / **CST**. *Report of a Sub-regional Workshop on Access and Quality of Reproductive Health Services*, vol. 1. Addis Ababa, Ethiopia, 2–10 October 1997.

UNFPA et le Groupement des Associations Islamiques Nigériennes pour la Planification Familiale et la Promotion de la Femme en Islam (**GAIPFI**). *Islam, Population et Développement, Place de la Femme dans l'Islam, Islam et Santé de la Reproduction*, pp. 5, 19–27. Niamey, Niger, 1998.

UNICEF. "Men in Families". 1995.

——. "What is the Life Skills Approach?" "Teachers Talking", September 2000. www.unicef.org/teachers/teacher/lifeskil.htm.

United Nations. "Report of the International Conference on Population and Development". Cairo, 5–13 September 1994. A/CONF.171/13, 18 October 1994.

——. "Report of the Fourth World Conference on Women". Beijing, 4–15 September 1995. A/CONF.177/20, 17 October 1995.

——. "Key Actions for the Further Implementation of the Programme of Action of the ICPD". A/S-21/5/Add.1, 1 July 1999.

——. "Preliminary Analysis of the Beijing+5 Outcome Document". Division of Women. www.un.org/Womenwatch/daw/followup/analysis.htm.

Valdés, **T**., and **J**. **Olvarríra**. "Ser hombre en Santiago de Chile: a pesar de todo, un mismo modelo". *In Masculinidades y equidad de género en América Latina*, edited by T. Valdés and J. Olavarría. FLACSO, UNFPA, Santiago, 1998.

Van Dam, **J**., and **M**. **C**. **Anastasi**, "Male Circumcision and HIV/AIDS: Directions for Future Research", Report of a meeting, Washington, DC, Populations Council, June 2000.

Varga, **C**. **A**., "The Forgotten Fifty Percent: A Review of Sexual and Reproductive Health Literature on Boys and Young Men in Sub-Saharan Africa". Paper presented at the WHO Afro Regional Meeting in Pretoria, South Africa, 27–29 September 2000.

Villareal, **M**. "Construction of masculinity(ies): Implications for Sexual and Reproductive Health". Paper presented at the TSS thematic workshop on Male Involvement in Sexual and Reproductive Health Programmes and Services. UNFPA, Rome, 9–13 November 1998.

Wall, **Lewis L**. "Dead Mothers and Injured Wives: The Social Context of Maternal Morbidity and Mortality among the Hausa of Northern Nigeria". *Studies in Family Planning* 29, no. 4 (1998): 341.

Wegner, **M**. **N**., et al. "Men as Partners in Reproductive Health: From Issues to Action". *International Family Planning Perspectives* 24, no. 1, March 1998.

WHO. "Definitions and Indicators in Family Planning, Maternal & Child Health and Reproductive Health Used in the Regional Office for Europe". March 1999.

——. "Management and Care of Women Victims of Violence". Orientation Workshop, Kigali, Rwanda, 11–14 February 1997. WHO/HSC/PV1/99.8, 1999.

WHO / **HRP**, "Men in Nepal Ignoring Risks from Unprotected Casual Sex". *Social Science Research Policy Briefs*, series 1, no. 2, October 1999.

——. "Improved Services and Counselling Reduce Risk-Taking Behaviour and Increase Condom Use in Shanghai, China". *Social Science Research Policy Briefs*, series 1, no. 3, June 2000.

WHO / **UNAIDS** / **UNFPA**. "Joint WHO/UNAIDS/UNFPA Policy Statement: "Dual Protection against Unwanted Pregnancy and Sexually Transmitted Infections, including HIV", 1999.

Wilkinson, **David John**, et al. "Using the Newspaper to Disseminate Vasectomy Information in Kenya". *Knowledge into Action: A Guide to Research Utilization* 14, no. 2 (1993–94): 165.

Wolff, **B**., et al. "The Role of Couple Negotiation in Unmet Need for Contraception and the Decision to Stop Childbearing in Uganda". *Studies in Family Planning* 31, no. 2 (2000): 124–37.

Wouters, **A**. Trip report from Zambia. UNFPA CST, Harare, Zimbabwe, 15 January 1999.

Yinger, **Nancy**. "Unmet Need for Family Planning: Reflecting Women's Perceptions". In *Reproductive Health Effects of Gender-Based Violence Policy and Programme Implications*. UNFPA, New York, 1998.

Yinger, **Nancy**, and **Elaine Murphy**. "Illustrative Indicators for Programming in Men and Reproductive Health". Draft presented at Inter Agency Gender Working Group Plenary Meeting, 6 October 1999.