Involving Men in Reproductive Health: Contributions to Development

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Background paper to the report *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*

MillenniumProject

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This background paper was prepared at the request of the UN Millennium Project to contribute to the report *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*. The analyses, conclusions and recommendations contained herein are the responsibility of the authors alone.

Front cover photo: TK

Acknowledgements

We are grateful for the assistance of many individuals who provided us with research materials, gave us things to think about, helped with editing, and offered suggestions and constructive criticisms: Michèle Burger, John Holveck, Brian Greenberg, James Rosen, Dean Peacock, Andrew Levack, Dumisani Rebombo, Nhlanhla Mabizela, Lissette Bernal, Rabbuh Raletsmo, Gary Barker, Marcio Segundo, Ravi Verma, Ravai Marindo, Arodys Robles, Ellen Weiss, Hortensia Amaro, and Alison Lee. We hope we have not inadvertently omitted anyone from this list and apologize sincerely if we have.

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1. INTRODUCTION

Men's intimate involvement in sex and reproduction cannot be disputed. Yet for much of its history, the population field focused almost exclusively on the fertility behavior of women, paying little attention to men's roles in its study of the implications of population growth and fertility rates.[1] As a consequence, population policy was implemented almost exclusively through basic family planning programs serving women. If men were involved, they were involved in a limited way, often to ensure contraceptive continuation and acceptability[2] or to promote the diagnosis and treatment of sexually transmitted infections.[3]

Since the 1994 International Conference on Population and Development in Cairo (ICPD), international family planning has slowly given way to a different paradigm. International family planning has expanded from its emphasis on the delivery of clinical services to married women of reproductive age. This emphasis has made important contributions to the health and well-being of women and their families. But in recent years, the limitations of this model have increasingly been recognized, and a new, more comprehensive approach to reproductive health formulated.

Several changes have occurred at once. First, family planning programs are now expanding beyond their traditional contraceptive focus to address the prevention and treatment of sexually transmitted infections, the reduction of maternal morbidity and mortality and counseling and treatment of sexual problems. The second change is that programs now have a mandate to serve the needs not only of married women, but adolescent boys and girls, men, and unmarried women of all ages. The third important shift has been a move toward a broad, development-oriented concept of health that moves away from a narrow focus on service delivery and acknowledges the social relationships that constrain health more fully.

There has been a formal recognition that more equitable relations between men and women and reproductive rights are important ends in themselves as well as the central means of reducing fertility and achieving population stabilization. The HIV and AIDS epidemic sharpened the recognition that existing reproductive health programs were having a limited impact in helping countries achieve overall reproductive health and development goals.[4] The 1994 ICPD Programme of Action, agreed to by 179 countries, unequivocally links programs to improve sexual and reproductive health with efforts to address the gendered values and norms that harm both men's and women's health and impede development. In this sense, the newer concept of reproductive health has helped to situate sexuality and reproduction within a broader development agenda. Reproductive health goes beyond the health sector, and is more than a women's health issue.

Involving men has been a prominent part of the shift from family planning to the broader reproductive health agenda. Men obviously make up a significant new clientele for programs. They constitute an important asset in efforts to improve women's health. And efforts to involve them in ways that transform gender relations and promote gender equity contribute to a broader development and rights agenda. While international family planning programs were essentially about women's health, reproductive health as it has now been formulated goes beyond health to broader development issues.

This paper begins by outlining the key issues involving men in reproductive health entails and presents a conceptual framework within which to consider male involvement efforts. The second major section reviews existing data on men – their health needs, their attitudes, and their practices – and identifies gaps in our knowledge of men's experiences. Programmatic activities have their limits when policy context does not support male involvement, so the next section reviews work at the policy level to support and institutionalize male involvement in reproductive health. Next, the paper reviews programs that involve men in varied aspects of reproductive health, highlighting the evolution of programming, and emphasizing best practices and success stories. Monitoring and evaluation shape and motivate programs, and also exert a conservative influence on programs, inhibiting change despite the paradigm shift in the field described above. The next section thus reviews recent efforts to conceptualize program "success" and approaches to measuring it. A brief conclusion reviews what we have learned from the diverse examples of work to promote men's involvement in reproductive health. The basic argument of this entire document is that men's roles in sexual and reproductive health must be recognized, understood and addressed much more extensively than they have to date, and that doing so will have implications well beyond reproductive health for other aspects of development.

2. CONCEPTUAL FRAMEWORK

The Millennium Development Goals and reproductive health

The Millennium Development Goals lack an explicit objective on reproductive health, but it is widely understood that its goals cannot be achieved without taking sexual and reproductive health into account. The tendency to see reproductive health as a women's health issue has contributed to a narrow, clinical focus limited to the health sector. Yet we know that social relationships determine people's ability to manage their sexual and reproductive lives, with implications not only for their health, but also for a myriad of other life choices.

Involving men in reproductive health is central to the achievement of rights within and beyond the health sector. It is obvious that woman-centered MDG goals 3 (promoting gender equality and empowering women) and 4 and 5 (improved child and maternal health) are mutually reinforcing. Indeed, they cannot be attained independently of one other. A key interim report of the Millennium Project points out that the third development goal of promoting gender equality and empowering women "cannot be achieved without the guarantee of sexual and reproductive health and rights for girls and women."[5] This is because a commonly used dimension of women's empowerment measures their control over sexual relations; their ability to make childbearing decisions and their use of contraception and access to abortion.[6] In addition, "greater economic independence for women, increased ability to negotiate safe sex, [and] awareness about the need to alter traditional norms about sexual relations . . . [are] essential for halting and reversing the spread of HIV/AIDS. . . ."[7]

Research conducted on how to achieve the MDGs provides much to buttress a broader interpretation of reproductive health. The Interim Report on Task Force 4 on Child Health and Maternal Health, for example, points to the reality that,

> "the non-biological aspects of health and health care carry particular significance in the area of maternal health. Sexuality and reproduction – each separately and both together – lie at the heart of many of the intimate, the economic, and the institutional arrangements that drive development."[8]

Social and institutional relationships shape people's health because they reflect the power and resources upon which individuals can draw to protect their health and prevent and treat disease. By "resources" the authors mean a broad range of elements including money, prestige, social networks, education, information, legal claims, and so on, all of which are strongly influenced by sexuality and reproduction. These resources help to determine agency, or people's potential to determine the course of their own lives, which is at the core of sexual and reproductive health and rights.

Evidence of the need to involve men in sexual and reproductive health

Often overlooked in the general appreciation of the interdependence of MDGs 3, 4 and 5 is the role played by men and their relationships with women. There is little excuse for overlooking men in this regard. Ten years ago, the 1994 United Nations International Conference on Population and Development (ICPD) stressed "male responsibilities and participation" in sexual and reproductive health. The conference's 20-year Programme of Action advises that

> efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; [and] prevention of unwanted and high-risk pregnancies.[9]

A growing body of ethnographic and anthropological qualitative research has been reinforcing these recommendations, examining even more closely the impact of men, as individuals, as social gatekeepers and as powerful family members who enforce cultural practices, often to the detriment of women's reproductive health.[10]

Gender inequities are widespread

The grand recommendations that emerge from international meetings do not simply get realized, but are struggled over every day in men's and women's lives.[11] The ICPD Programme of Action recognizes that gender roles are strongly reinforced in cultural beliefs and practices, and that the social construction of masculinity and femininity profoundly shapes sexuality, reproductive preferences, and health practices. The extensive research on women's subordinate status in most societies that informs the Programme of Action points to widespread patterns of male prerogative and power, visible in social discrimination such as lower levels of investment in the health, nutrition, and education of girls and women.[12] Institutionalized legal disadvantages for women underpin laws that keep land, money and other economic resources out of women's hands[13] by foreclosing protection and redress, contribute to violence against women.[14] Discrimination has negative implications for women's health, reducing, for example, their timely access to health services during labor and delivery,[15] their use of antiretroviral treatment to reduce mother to child transmission of HIV because of fear of disclosure,[16] or their ability to control the type and frequency of sexual practices, to initiate and refuse sex, and to negotiate

condom use to prevent HIV and STIs.[17]

Acknowledging these realities, advocates have fought for the recognition of women's human rights, including the rights to decide freely whether, when, and with whom to have children, and the rights to determine whether, with whom, and under what circumstances to engage in sexual relations. The exercise of these "social rights," which are integral to reproductive and sexual rights, is highly dependent on the social and economic circumstances or *enabling conditions* that make women's choices and negotiation with men possible.[18] As conceived of at the ICPD, the enabling conditions for the promotion of women's reproductive rights and equity will also lead to fertility decline and improved reproductive health.

By increasing people's ability to control their childbearing, reproductive health programs can reduce *unwanted* fertility. By increasing women's alternatives to childbearing, reducing child mortality, and influencing social norms, including increasing the value of girl children, multi-sectoral development policies influence the numbers of children people *want.* Population and development policies require coordinated efforts across multiple sectors to address the gender biases in access to resources (jobs, credit, land, and education, for example) that leave women economically dependent on men and undermine their rights.

Gendered social expectations have many implications for women's and men's reproductive lives. Social norms favoring male children and promoting women's economic dependence on men, for example, contribute to high rates of fertility in many settings. Inability to negotiate sex, condom use, or monogamy on equal terms leaves women and girls worldwide at high risk of unwanted pregnancy, illness and death from pregnancy-related causes, and sexually transmitted infections.[19] Combating sexually transmitted infections and the heterosexual spread of HIV is impossible without involving men.[20]

Why men's roles were neglected

This large body of evidence on the legal, educational, economic, and health consequences of gender norms did not significantly influence population and reproductive health policy until recently. Research on population and reproductive health tended to describe women's disadvantaged position without mentioning men's roles, usually because the data used were collected only from women.[21] Incomplete knowledge and powerful assumptions made it possible for the field to avoid addressing gender inequities and expressions such as violence in its work on reproductive health. The demographic research that informed family planning programs justified the conceptual omission of men by pointing to the difficulties and uncertainties of using men as research subjects or informants. Researchers had to grapple with the ill-defined span of men's sexual lives, their assumed inability to report on their progeny, the analytic challenges posed by polygyny and extramarital partnerships, the unlikely chance that they would be at home to be interviewed by a survey taker, and the frequency with which children ended up in the custody of their mothers at the end of a marriage.[22]

The assumption that families are all similar to a standard Western model, in which women have the primary role in childbearing and rearing, and in which men and women are assumed to communicate openly and agree completely about reproductive matters. This model assumes, moreover, that partners have a shared childbearing experience, i.e., that either the relationship is

monogamous and that all childbearing occurs within that union, or that the outside experience of the other spouse has no influence over childbearing in the current relationship. The cultural variability of reproductive health conditions, however, makes this model inappropriate in settings where polygyny, marital instability, infidelity, imperfect communications, and women's subordination are widespread, which is virtually everywhere.[23]

The social and cultural norms and practices that undermine women's—and men's—health have yet to be fully addressed in reproductive health programs. The persistent challenge is how to translate the rhetorical support for gender equity into a more holistic approach to sexual and reproductive health and rights. Despite growing rhetorical support for incorporating gender equity efforts, woman-focused contraceptive delivery is still very much the norm in most reproductive health programs. Many male involvement efforts are also still narrowly focused on increasing contraceptive prevalence among both men and women. These limited approaches sidestep widespread male control over sexuality and reproduction, and only dimly reflect equity objectives for involving men. Programs attempting either to influence men's sexual behavior and reproductive health or address the limits on women's choices posed by male control over sexuality and reproduction have been few and far between. This paper demonstrates that involving men without acknowledging and addressing gender biases may result in interventions that inadvertently consolidate male power over reproductive and sexual decision-making.

The evolution of "male involvement"

Male involvement is central to improving reproductive health and to the incremental process of achieving gender equity. But "male involvement" is an ambiguous concept, and many responses to the call for involving men are more limited than what was envisioned by the ICPD's Programme of Action or by health and rights advocates. Programs diverge in their ultimate purpose in involving men, and in how they involve them. This section assesses the wide range of male involvement efforts according to their objectives and outcomes as organized in the framework above. It provides examples of each of three basic types of reproductive health programming involving men; the framework is summarized in Box 1. Not every program fits neatly into one of the three categories listed here, but the typology is a useful way of distinguishing between differing ultimate objectives.

Before Cairo, international family planning programs concerned themselves more with the obstacles to contraceptive use that arose from women's low status rather than women's status itself.[24] In the mid-1990s, concern arose about this "unfinished transition," or the uneven improvements in women's lives that had been promised by family planning advocates of fertility decline.[25] Bangladesh's family planning program, for example, may have avoided addressing gender inequities by taking family planning to women in *purdah* at their homes, placing responsibility disproportionately on "compliant" female patients and clients and avoiding dealing directly with men.[26] By "restricting the dissemination of information through selected gender-specific channels or by reinforcing gender stereotypes that for cultural reasons are not likely to be challenged or discussed openly,"[27] many programs have worked *around* gender inequities, marginalizing men and minimizing male participation.

The traditional woman-focused approach to family planning dominated the field in the years before the Cairo ICPD and in many respects still does. This approach has focused on providing

contraceptive methods to women in order to reduce fertility and population growth. Examples of this model can be found in Bangladesh,[28] Thailand,[29] and Latin America.[30] The measures of program success that arose from this approach endure today and emphasize contraceptive prevalence among women, and women's fertility rates.

An approach that emphasizes **men as clients** emphasizes the need to provide reproductive health services to men in much the same fashion that women have received these benefits. [31] There is no doubt that men have their own set of unmet reproductive health needs and concerns that need to be addressed. But it reflects a limited interpretation of male involvement if it simply advocates a remedial focus on men who have been excluded from traditional reproductive health programs. If programs choose merely to provide services for men, they miss the central point that men's and women's social positions constrain their reproductive roles. This approach to family planning can potentially accept men's dominant position in certain cultural settings as a given in a focus on their needs— rather than on gender relations — to improve reproductive health.

An approach that addresses **men as partners** reflects the view that men can improve – and impede – women's contraceptive use and reproductive health.[32] These programs view men as allies and resources in efforts to improve contraceptive prevalence rates and other dimensions of reproductive health.[33] While making important contributions to reproductive health, like the focus on men as clients, this approach does not address the gender inequities that constrain health. These two approaches miss the opportunity to address the relationships between women and men and the sharing of responsibility and action. Each lacks the potential to support broader social change.

The third approach, emphasizing **men as agents of positive change** reflects the intent of the Cairo ICPD. This acknowledges the fundamental role men play in supporting women's reproductive health and in transforming the social roles that constrain reproductive health and rights. Many interventions offer men the opportunity to examine and question the gender norms that harm their health and that of their sexual partners. It seeks to move toward gender equity by shaping the way services are delivered. This approach emphasizes *how* services are provided and looks to reinforce gender equity rather than specifying which reproductive health services should be provided and to whom. The interventions that involve men as agents of positive change are relatively few in number. They serve the interests of men as well as women by increasing men's choices, their possibilities for learning and development, and the survival and well-being of family members.[34]

Box 1. Approaches to Involving Men in Sexual and Reproductive Health

APPROACH	PURPOSE & ASSUMPTIONS	PROGRAMMATIC IMPLICATIONS
TRADITIONAL FAMILY PLANNING FOR WOMEN	Increase contraceptive prevalence; reduce fertility Inclusion of men is not necessary from an efficiency standpoint	Contraceptive delivery to women, in the context of maternal and child health
----------1994 Cairo International Conference on Population and Development ----------		
MEN AS CLIENTS	Address men's reproductive health needs	Extend same range of reproductive health services to men as to women Employ male health workers
MEN AS PARTNERS	Men have central role to play in supporting women's health	Recruit men to support women's health, e.g., teach husbands about danger signs in labor, how to develop transportation plans, the benefits of family planning for women's health
MEN AS AGENTS OF POSITIVE CHANGE	Promote gender equity as a means of improving men's and women's health and as an end in itself Addressing inequity requires full participation and cooperation of men	Paradigm shift in *how* programs are structured and services are delivered, whatever they are Broader range of activities, working with men as sexual partners, fathers, and community members

The next section describes what survey and qualitative data can tell us about men's sexual and reproductive lives in the developing world. In the subsequent sections on male involvement policies and programs and how to assess their impact, we will return to this framework.

3. WHAT WE KNOW ABOUT THE SEXUAL AND REPRODUCTIVE BEHAVIOR AND HEALTH OF MEN IN DEVELOPING COUNTRIES

What do we know about men's sexual and reproductive health knowledge, attitudes and behavior? Until recently, the answer to this question would have been "not much." Drawing on information now available from an impressive number of comparative surveys carried out in developing countries we discuss the larger social and economic context of men's behavior and attitudes and point to the reproductive health costs for both men and women when programs do not reach out to men in sexual and reproductive health.

For years, data existed only on married women of reproductive age, but in the past 10 years or so nationally representative surveys of men aged 15–54 have been carried out in about 40 developing countries.[35] These surveys were undertaken mainly in response to the global challenges created by the HIV/AIDS epidemic, based on an understanding that the epidemic could not be addressed without attention to men. The Demographic and Health Surveys (DHS) provide a wide range of quantitative information about men's sexual and reproductive knowledge and behavior, information that can be compared across regions and countries.

These data have their limitations. The surveys do not include boys younger than age 15, many of whom are already sexually active. The samples exclude many men living in situations that make them particularly vulnerable to sexual health risks (men in the military, in prisons, displaced men, migrants and those living in refugee camps). The few surveys carried out in Asia, the Middle East and North Africa tend to leave out unmarried men, a disadvantage given the fact that most men do not marry until their 20s and that most single men are sexually active, often with more than one partner. And perhaps most importantly, the data collected in the DHS are an imperfect basis for examining the links between men's social and economic status and their sexual and reproductive behavior where we know there are significant gradients among women.[36] Nevertheless, the surveys provide good data on men in the prime of their sexually active and fathering years, of a type and quality unavailable until the early 1990s. This section draws heavily from a review of these data conducted by the Alan Guttmacher Institute.[37] Here are the bare bones of what these surveys tell us about men's sexual and reproductive behavior and knowledge.

The basics of what we know about men's sexual and reproductive lives and health

While male sexual and reproductive behavior varies widely across the developing world and among social and ethnic groups within a single country, some broadly similar patterns across regions do emerge. In almost all of 39 developing countries for which recent information is available, the majority of men 20–24 report having had sexual intercourse before their 20th birthday. A substantial proportion first had sex before their 15th birthday. Among unmarried men aged 15–24 who have ever had sex, 2 to 6 in 10 had two or more partners in the past year. Despite these high levels of youthful sexual activity, in most Sub-Saharan African countries, fewer than half of sexually active men 15–24 use a contraceptive method or rely on their partner's method, compared with about two-thirds in parts of Latin America and the Caribbean.

Among men in their late 20s and 30s, contraceptive prevalence is lower in Sub-Saharan Africa than in other regions, reflecting these men's continued desire for children. In developing countries where men 40-54 report moderate or high levels of contraceptive use, methods used by women (especially female sterilization) predominate. Vasectomy is extremely rare in all developing countries except China. A large fraction of married men aged 25–39, particularly in Sub-Saharan Africa, report that they have not discussed family planning with their partners.

Marriage is rare among adolescent men and uncommon among men in their early 20s around the world. Marriage, including cohabitation and consensual union, becomes common among men in their late 20s and is almost universal among those in their 30s. Almost all men aged 40–54 have married—some more than once. The more educated men are, the later they defer marriage. Men's reported number of sexual partners varies considerably by country. In most countries, a majority of all men aged 25–39 had only one sexual partner in the past year, in most cases their spouse. Yet 7–36 percent of married men had had one or more extramarital partners, and some 15–65 percent of unmarried men this age (representing only a small proportion in this age-group) had had more than one partner within that time period. Similarly, some 4–23 percent of married men 40–54 have had one or more extramarital partners in a recent 12-month period.

Strikingly few men in their teens or early 20s have become fathers, but half of them have done so by their mid-to-late 20s. The vast majority of men in their 40s and early 50s have had the number of children they want. Many have experienced the breakup of marriage, some are living with or supporting children from earlier marriages, and some are entering new marital relationships.

The prevalence of curable and incurable STIs (including HIV/AIDS) is higher in Sub-Saharan Africa and in Latin America and the Caribbean than in other regions. The estimated annual prevalence of curable STIs among men and women 15–49 ranges from almost 119 infections per 1,000 people in Sub-Saharan Africa to 71 in Latin America and the Caribbean, to 50 in South and South-East Asia and 21 in North Africa and the Middles East.[38] And of the 18.6 million male adults and children living with HIV/AIDS in the world, 12.3 million live in Sub-Saharan Africa, 3.8 million in South and Southeast Asia and 1.3 million in Latin America and the Caribbean.[39]

Fewer than a third of men in many developing countries know that two ways of avoiding STIs are condom use and either abstinence or having only one, uninfected partner. The proportion of men 15–54 who know that condom use is a way of preventing HIV/AIDS varies widely in developing countries—from 9 percent in Bangladesh to 82 percent in Brazil. The dimension of the possible risk pool for the transmission of STIs, including HIV/AIDS, can be approximated from the survey data. Among all men 15–54 in Sub- Saharan Africa and in Latin America and the Caribbean, 4–18 percent had two or more partners in the past year and did not use a condom the last time they had intercourse. Some men with STIs do not inform their sexual partners. In some developing countries, at least three in 10 men 15–54 who had an STI in the past year did not tell their partners; in Benin and Peru, six in 10 did not. Of sexually active men 15–24 in Benin, Mali, Niger and Uganda who had had an STI in the past 12 months, only half or less informed their partners.[40]

Still, many men with STIs take action to avoid spreading the infection. In Brazil and Peru, for example, about two-fifths of such men aged 15–54 said they avoided having intercourse while they were infected, and in the Dominican Republic, more than one-half said they did so. Roughly one in 10 infected men in a few countries reported that they continued to have intercourse but used a condom, and almost four in 10 in a few Sub-Saharan African countries reported that they had taken some kind of medicine, although it is not possible to determine whether the drug was appropriate for their particular infection. However, one-third of infected men in Nigeria and Peru, and almost one-half in Burkina Faso—but only one in 10 in the Dominican Republic—said they did nothing to avoid infecting their partner.

In some parts of the developing world, men may be prepared to use condoms but unable to obtain them, especially young men, and those with limited resources or living in rural areas. When sexually experienced Sub-Saharan African men 15–24 were asked if they knew where to obtain condoms, only half or fewer of those in rural areas of Guinea, Mali, Mozambique, Niger, and Chad knew of a source.[41] Today, an estimated 6–9 billion condoms are distributed each year for family planning and for STI prevention,[42] but many more (perhaps 19–24 billion a year) are needed to protect populations from unplanned pregnancies, HIV and other STIs.[43] Differing regional levels of risk of unintended pregnancy can be clearly seen in the fact that some 20–46 percent of men 25–54 in Sub-Saharan Africa and 15–30 percent of those in Latin America and

the Caribbean do not want a child soon or do not want any more children but are not protected against unplanned pregnancy.

Men exert important influence on their partners' reproductive health

The policy and programmatic implications of the DHS findings are urgent not just for men themselves but also for their families, especially their wives and female sexual partners. Men can influence their partners' reproductive health in various ways.

Men's influence on family formation and contraception

There can sometimes be discordance between women's and men's desire for children, including the desired number and the timing of women's pregnancies and births. Partner communication about sex, desired family size and contraception can be poor or nonexistent. Some women do not know or incorrectly assume what their husband's wishes on family size and family composition are; and some men do not know their wife's wishes because the couple does not discuss this issue. In the absence of discussion, both men and women may fail to achieve their childbearing goals, and sometimes coercion can result. Condoms, periodic abstinence and withdrawal require communication and negotiation between partners to be used effectively. Male partners may also significantly influence the use of other female methods. Men may control the economic resources required to access these methods, may indirectly impede or directly prohibit women from attending health facilities to obtain these methods, or may not approve of women's actual use of these methods. Some women use contraceptives secretly to avoid confrontation with their unsupportive partners.

Men's influence on abortion

Few studies directly address men's roles in women's abortion decisions and experiences, however some indirect evidence is available. In developing countries, where abortion is largely banned and many terminations are performed in unsafe circumstances, many women end unwanted pregnancies because of unstable relationships with the men in their lives. In many countries, being in a troubled or fragile relationship ranks high among the reasons women give for seeking abortions. A 1992-1993 hospital based survey of abortion patients aged 15-35 in Honduras found that it was the leading reason, and a study among abortion providers in Northern Nigeria indicated it as the second most commonly cited reason in Nigeria in 1996. Other studies in Chile (in 1988), Honduras (in 1992–1993), Mexico (in 1967–1991) and Nigeria (in 1996) show that the proportion of women seeking abortions because of troubled relationships is fairly high (20–42%).[44]

Many women seeking abortions say their primary reason is that they do not want to be single mothers. This response suggests that many of these pregnancies result from extramarital relationships or relationships between unmarried people; that the man may have threatened to abandon the woman if she had the baby; and that the breakup of a relationship may have been imminent. Hospital-based studies in Brazil, Guinea, Kenya, Mali, Mozambique and Nigeria indicate that unmarried women account for six in ten having clandestine abortions or suffering abortion complications each year.[45] In Tanzania, roughly three-quarters of women seeking abortion are unmarried, and one-half of unmarried adolescent women seeking abortion have been in the relationship for less than one year.[46]

Men's influence on pregnancy and childbirth

Men can affect women's access to prenatal care and women's obstetric outcomes in their roles as partners, neighbors, community leaders, and health providers. In some patriarchal settings, women are not permitted by their husbands or fathers to leave home to obtain care unless accompanied by male family members and unless attended by female health providers. Poorly informed men in underserved rural areas may not fully recognize the grave symptoms during labor that should convince them to take their wives to secondary or tertiary health centers for care. Violence against women is known to increase during pregnancy. Men behaving irresponsibly or unsupportively may be a source of chronic stress for women, a condition known to negatively affect the course and outcome of a woman's pregnancy. For lack of information, men may perpetuate harmful local myths about good health practices for women during pregnancy. Because men mediate women's access to economic resources in many parts of the world, women's nutritional status, especially during pregnancy, may depend heavily on partners and male relatives. Male health providers may be distant, unsympathetic and autocratic in their treatment of women during pregnancy and delivery.

The contexts of men's lives influence their sexual and reproductive behavior and attitudes

Men's sexual and reproductive lives – and the impact of their choices on women and children – do not unfold in a vacuum. Rather, a wide range of societal and individual factors shapes, and often constrains, men's aspirations and behavior as partners, husbands, fathers and sons. The broader context of men's lives in many developing countries is increasingly characterized by deepening poverty and by rapid social, cultural and economic change. Gaping regional differences in income are stark indicators of inequality worldwide. The average annual per capita income in Sub-Saharan Africa is $1,277, it is $2,647 in Asia and $2,647 in the Middle East and North Africa ($4,718) and $5,895 in Latin America and the Caribbean.[47] These figures conceal vast inequalities within countries. Poverty places a heavy burden on many fathers, husbands and sons, because in most societies men are expected to be the major providers in the family. Some desperately poor men might ask themselves: "If I cannot provide for myself, should I have a family?" or "If I cannot provide for my dependents, am I a man?"[48]

Life expectancy is another summary measure that reflects the gap in living conditions between rich and poor countries. In Sub-Saharan Africa, average life expectancy at birth for males is as low as 37–39 years in Malawi, Mozambique, Zambia and Zimbabwe and still only 56 years in Ghana. By comparison, male life expectancy is in the mid-to-high 70s in most industrialized countries.[49] In the Sub-Saharan countries hardest it by HIV/AIDS, male life expectancy fell dramatically between 1985 and 2000. In contrast, during the same period, male life expectancy increased by seven or more years in industrialized countries and in many countries of Asia, the Middle East and North Africa, and Latin America and the Caribbean. Reduced prospects for a long life—a function not only of the extent of the AIDS epidemic, but also of persistent poverty, violence, poor health and malnutrition —can affect men's attitudes toward how prudently they spend their lives and how assiduously they avoid risks today.

Men are more likely than women to engage in certain risky behaviors. For example, in most of the world's regions, the total DALYs lost to alcohol and drug use is many times higher among men than among women. In 2000, traffic accidents, violence, war and self-inflicted injuries accounted for 13 percent of DALYs among men in Sub- Saharan Africa, compared with 7–9

percent in Latin America and the Caribbean, India, China and the industrialized countries.[50] Many men in developing countries, especially young men, have no paid work, and many of those

Migration and Mobility Can Increase Sexual Health Risks for Men

Population movements involving migrants, refugees, displaced persons and men employed in long-distance transportation or shipping help to drive the spread of HIV/AIDS and other sexually transmitted infections (STIs). Male migrants often spend extended periods without their wives and children, and usually with male peers. Separation from families, release from traditional constraints on sexual behavior and the anonymity of city life all serve to support a commercial sex industry and to foster casual sexual relationships, which help spread infection.

Out of loneliness, boredom and need, men away from home are vulnerable to risky sexual relationships. Men of all backgrounds who are away from home for long periods use the services of female sex workers and have sexual relationships with other women, many of whom may also be working and living far from their home communities. Furthermore, these men and women tend to change their place of work quite frequently. But as sex workers and their clients return home and resume sexual relationships with regular partners, they create the potential for a "double diffusion" of disease.

Long-distance truck drivers are particularly vulnerable to contracting and transmitting STIs: Truck stops are magnets for commercial sex workers and for local residents seeking to earn money by having sex with men passing through. Lacking medical services and deportation or prosecution if they seek preventive care or treatment, many transient workers, illegal migrants, urban migrants and sex workers who have STIs are untreated.

In most countries, locations containing high concentrations of male transients are often associated with a thriving commercial sex industry. These hot spots include transit areas; workplaces employing large numbers of transient workers; rural trading centers; ports and harbors; mining, lumber, industrial, plantation and construction sites; sites along transport routes; truck stops; and border crossing points. Because of the sexual networks created, these hubs have STI prevalence rates that are well above national averages.

living in the world's most economically stagnant regions leave home to seek jobs. Separation from their families and freedom from traditional cultural controls on their behavior can cut men off from community support and influence, and may prompt some men to engage in unsafe sexual relationships before or outside marriage.[51]

Men want information and services and also need relationship skills and opportunities to question gender norms

Many men, especially the young, do not understand the full extent of their own needs and how their lack of knowledge affects those close to them. Men in developing countries need to be educated about the risks their behavior can pose for their own health and that of their sexual partners. In Sub-Saharan Africa, for example, out of 22 countries with nationally representative surveys, in only eight do at least 80 percent of men 15–24 know that HIV can be transmitted from mother to child.[52] Young men's needs for comprehensive family life education is perhaps among the most pressing priority. Qualitative studies from many parts of the world suggest that young men who have no access to information and guidance about sexuality and protective sexual behaviors are ill prepared to navigate their sexual lives.[53]

Many men need access to effective testing and treatment for STIs. In Benin, Ethiopia, Gabon, Malawi, Uganda and Zimbabwe, more than two-thirds of all men 15–19 who have never been tested for HIV say they would like to be. Only small proportions of men 15–19 have ever been tested for HIV—1 percent in Ethiopia, 3–4 percent in Benin, Uganda and Zimbabwe, and 7–9

percent in Malawi and Gabon. In the absence of accessible STI services, some men who become infected with STIs try to treat themselves. Some buy the correct drugs but dose themselves incorrectly, risking leaving STIs partially untreated.[54] Others seek care from pharmacists,[55] quacks, herbalists, and providers of traditional health care with no formal training.[56] Some men in developing countries say they prefer these sources because they are affordable and because these providers are more respectful and less judgmental than providers in government and private clinics.[57]

Data on what partners know about each other's views and preferences show that there is often little communication, even within long-standing relationships. Improving men's understanding of their own motivations, fears and desires, their ability to broach topics relating to sexuality, and their respect for their partners' wishes is central to improving reproductive health.

What we still don't know about men

Qualitative research and small-scale local studies in a number of developing countries reveal the range of problems related to men's relationships with women, their sexual lives and their roles as fathers. In a *favela* of Rio de Janeiro, a majority of young men participating in focus group discussions report incidents of men being violent toward the women in their homes.[58] Ethnographic studies in 186 societies finds that only 2 percent of father have 'regular' close relationships with their children during infancy, and that poverty only militates further against this relationship, as fathers are compelled to migrate in search of work.[59] Changes in work opportunities and women's status affect men's sense of their own masculine identity and sexuality.[60]

Qualitative work can tell us about men's views of their sexual and family roles and practices. In Gujarat, India, a program attempting to involve men in an effort to reduce high levels of maternal mortality found that men believe that a man must not be present during his wife's labor. Also, all family members, including women, are reluctant to have men donate blood for their wives—even in critical situations—for fear that this will physically weaken the husbands.[61] A study in rural Kenya found that sexual debut occurred at a very early age, even as young as 10, and that sexual experience was perceived as an integral part of initiation into manhood. Failure to have sex carried a risk of being looked down upon by one's peers.[62] Among an urban, low-income population in Porto Alegre, Brazil, 28 percent of men, compared to 8 percent of women, practice anal sex, not as a means of contraception but for increased male pleasure.[63] In an area of Nepal abutting India, a study of men 18–40 having had casual sex in the past 12 months (26 percent of residents and 33 percent of non-residents) cites one participant, an 18-year-old unmarried student, saying: "I have had sex with many girls and . . . some may have had relations with others . . . I never used a condom as the brain does not work while enjoying sex."[64]

Studies like these suggest the need for more research into the cultural, social and economic factors associated with men's sexual and reproductive behaviors, in all parts of the world. Information is particularly lacking on men's attitudes toward sex, marriage and reproduction, as well as their motives for some behaviors—for example, frequenting sex workers without using condoms in settings where STIs (including HIV/AIDS) are prevalent. Few studies exist on the extent to which men use condoms correctly and consistently; documenting these aspects of condom use matters greatly in the search for effective methods of disease prevention. We know

little about men's experience of coercion and sexual violence, either as victims or perpetrators. Men's roles in decision-making regarding pregnancy and abortion, their roles during the prenatal period and their roles in raising their children, as well as whether and how these roles are changing, are also essentially undocumented. We are relatively uninformed about men who have sex with men, very young men, and sexually active older men. And we still know very little about men's sexual and reproductive behavior, knowledge and attitudes for a large proportion of the world's population, including China, much of the rest of Asia, the Middle East and North Africa.

4. POLICIES THAT ENCOURAGE MALE INVOLVEMENT

Given what we now know about men's sexual and reproductive lives, and the ICPD Programme of Action's eloquent call for including men in reproductive health, to what extent have countries taken up the challenge of addressing men's roles? We start with a look at efforts taken at the policy level. Cairo's broad references to male involvement envision the transformation of relationships between men and women is perhaps best addressed in policies, where countries lay out their intentions and priorities and commit to actions and expenditures addressing the social constraints to health. The existence of policy gives citizens recourse to call for change when programs and activities are not developed or budgets are not allocated to promised priorities. National policy to address the social relationships that limit health creates the context for legislation and programs that support men's constructive engagement in sexual, reproductive and family life.

But policy is a slippery fish. Some policies provide a general statement of good intentions in which a nation can state what is important, but without necessarily committing itself to concrete actions. Others define specific activities and the institutions to carry them out. The impact of policy is often difficult to evaluate, as improvements in health may be attributed to other, simultaneous changes. This analysis takes the broadest definition of policy and looks at the national and international frameworks, national policies, legislation and norms that provide the context for programmatic activities involving men.

"Male involvement policy" is elusive, so a better place to start is the articulation of principles acknowledging gender inequities and stating the need to involve men in overcoming them to improve health. A high level commitment of this kind can be implemented across various sectors. The general tendency is to endorse gender equity at the highest levels, but to have little to say about men and their potential roles in achieving it. Reference to men is notably absent from most national development policies that refer to reproductive health and even to gender inequality. A few important counterexamples for other countries do exist, however, and they are described here.

International frameworks for gender equity and male involvement

The International Conference on Population and Development has been the primary point of reference regarding sexual and reproductive health for the past decade. But it is not the only framework that has provided guidance on the sexual and reproductive roles of men and how they might be addressed in policies and programs.

Convention on the Elimination of All Forms of Discrimination against Women – CEDAW

The Convention on the Elimination of All Forms of Discrimination against Women or CEDAW, established in 1979, repeatedly addresses the links between women's reproductive roles and discrimination.[65] One of its main objectives is to call on countries "to incorporate the principle of equality of men and women in their legal system, abolish all discriminatory laws and adopt appropriate ones prohibiting discrimination against women." It notes that stereotypes, customs and norms impede the advancement of women, and states that, "a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality of men and women."

The CEDAW targets cultural norms that define the domestic sphere as the domain of women and the public sphere as the domain of men. Article 5 calls on governments to take all appropriate measures:

> (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;
>
> (b) To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases.

Thus the CEDAW is just as explicit – perhaps more so – as the ICPD in affirming the equal responsibilities of both sexes in family life and their equal rights with regard to education and employment as key to overcoming discrimination against women.

Convention on the Rights of the Child

The Convention on the Rights of the Child (CRC) provides another important perspective from which to appreciate and reinforce the roles of men, in this case as fathers in their children's lives. The Convention defines an important series of rights from the perspective of children that have implications for how we think about men's family roles.[66]

- The right to have a name, to be registered, and to have nationality (Articles 7 and 8)
- The right to know their parents, to be cared for by them, and not to be separated from them (Articles 5, 7, and 9)
- The right have someone to whom to turn in case of mistreatment (Articles 32-39, and 41)

The state also assigns to parents the responsibility to fulfill their duties and rights (Articles 3, 4, 5 and 17). Supporting men's roles as fathers is a key step toward realizing the goal of incorporating men as more central figures in sexual and reproductive health. While the language of the CRC does not refer specifically to fathers or male roles, it conveys the importance of both fathers and mothers.

Millennium Development Goals

An overarching MDG needs assessment and costing paper lays out the full range of interventions required to achieve the MDGs – interventions that go beyond the set of outcome targets defined by the Goals. It notes that, "while no concrete MDG Targets exist for sexual and reproductive health… the corresponding interventions are critical inputs for achieving the MDGs."[67]

Capacity building essential to elimination of gender disparities

The Millennium Project sees capacity building as an essential step toward eliminating gender disparities. They identify a number of specific categories to be covered in identifying national interventions:

- Increasing awareness and providing education about sexual and reproductive health and rights
- Preventing practices that are harmful to sexual and reproductive health and promoting rights through legislation and community-based awareness programs
- Strengthening of legislation to allow and decriminalize abortion and to allow women the right to plan their families
- Effective monitoring and implementation of laws protecting women's rights, and
- Providing comprehensive sexuality education at the school and community level that promotes gender equality and human rights

Source: Sachs, J, J. McArthur, G. Schmidt-Traub, C. Bahadur, M. Faye, and M. Kruk. 2004. *Millennium Development Goals Needs Assessments: Country Case studies of Bangladesh, Cambodia, Ghana, Tanzania and Uganda*. United Nations, Millennium Project: 45.

Elsewhere the authors state that, "interventions relating to reproductive health are included in the analysis since they are instrumental for meeting many of the other Goals."[68] The authors therefore identify interventions across maternal and reproductive health as essential to the achievement of the other Goals. They view sexual and reproductive health as so central to the promotion of gender equity that they list "awareness building and education about the importance of reproductive and sexual rights, *targeted to men and women*" in their list of interventions. Among the men they mention are government officials who play an important role in carrying out the laws: "While enforcement of laws is not directly costed, sensitization and training campaigns targeted at judges, civil servants, police force members and other administrators have been included in the analysis since they are the primary enforces, interpreters and implementers of the law."[69] This sensitization is to be pursued by undertaking mass media campaigns, large-scale community-based programs to discourage FGM and other harmful practices, and sexuality education in schools and communities that would involve boys and men.

The Millennium Development Goals have prompted important national review processes supported by the United Nations. The country needs assessments and reports on progress in meeting the MDGs provide insights into national priorities and responses. The tendency is to focus on women in calls for improved reproductive health and gender equity, with some references to the need to collect data on both sexes.[70] An exception is Yemen's Millennium

Report of 2003, which refers explicitly to the need to train both female and male health professionals to improve maternal mortality.[71]

Poverty Reduction Strategy Papers

The national process of preparing Poverty Reduction Strategy papers (PRSPs) has provided another important opportunity to call for male involvement in reproductive health and development. In a call for more effective integration of divergent aspects of development, the World Bank and International Monetary Fund in 1999 proposed the Comprehensive Development Framework. As part of this, they initiated the use of Poverty Reduction Strategy Paper (PRSPs), poverty alleviation strategies that countries would develop through national participatory processes. These papers and annual progress reports are meant to provide guidance for lending and debt relief to the 81 International Development Association and 42 heavily indebted poor countries (HIPCs).[72]

PRSPs are important in setting the tone for government programs and donor contributions and lending.[73] A World Bank review found that while reproductive health is widely addressed in the PRSPs, the scope and quality of this inclusion and the linkages made between poverty and reproductive health linkages vary widely. A notable exception is Vietnam's PRSP. The document acknowledges that, "gender inequality is also a variable to increase the birth rate and HIV transmission rate due to the fact that women have less voice and self-defense ability in sexual relations."[74] The document mentions the low percentage of men with an awareness of their responsibility in family planning, and proposes to "develop proper policies to encourage men in applying contraceptive methods."[75] Among the major policies and measures specifically mentioned in Vietnam's PRSP is the need to "attach special attention to publicize family planning to couples in the high fertility age, targeting male (sic)."[76] Still, its objectives, targets and monitoring indicators do not explicitly mention men, though they provide the room for defining male-related indicators.

National policies

Political leadership bridges the gap between rather abstract international frameworks and specific national policies. In documents like national development plans, or ministerial speeches to the nation and the world, references to men's roles in reproductive health may be viewed as statements of intention. While we cannot measure the direct impact of this general guidance on health outcomes, leadership in this arena can provide an important impetus or affirmation for more concrete policies. A prime example was President Museveni's widely-recognized leadership on HIV/AIDS in Uganda. His call for men to take greater responsibility for their sexual and reproductive health and that of their partners is described in the box below.

The role of political leadership: The case of Uganda

In 1986, President Yoweri Museveni, Uganda's civil war hero, declared that the nation was still at war and the enemy was AIDS. He devoted himself to public education on HIV, and his frequent radio AIDS messages in particular urged men to be sexually responsible. In a 2001 keynote address to the organization that sponsors the Africa Prize for Leadership, a prize the country of Uganda and President Museveni had won in 1998, Museveni spoke about gender inequalities, saying, "Permit me to tell you the obvious. In the fight against HIV/AIDS, women must be brought on board. In sub-Saharan Africa, most women have not yet been empowered and men dominate sexual relations."

Women are subordinate to men along many dimensions in Uganda. For example, statutory divorce laws in Uganda favor men over women. Men's grounds for divorce are much broader than women's, and men may claim damages from persons charged with having committed adultery with their wives, implying that only the husband's rights have been violated and indicating the women's subordinate status within marriage.

In recognition of the role of poverty and women's vulnerability to HIV, the Museveni government promoted women's political participation, developed both macro- and micro-credit schemes for women, and fostered government and NGO programs that promoted gender equity. Museveni recognized women's vulnerability to infection from unfaithful husbands, and this prompted him to promote "zero grazing," or faithfulness to one's sexual partner and avoidance of extramarital affairs; he used himself as an example of faithfulness.

A proposed Domestic Relations Bill is meant to address domestic violence, but there is much controversy about whether it sufficiently tackles this social problem. President Museveni went so far as to propose a law – unfortunately, unsuccessful – against spousal rape to the Parliament. Concern about older men preying on younger women led to a law on defilement. It allows for the arrest and death penalty for "sugar daddies," but few men have been punished under this law.

HIV prevalence in Uganda peaked in 1991 at about 15 percent of the adult population and declined to 5 percent as of 2001. Trend data reveal epidemiologically important behavior changes in Uganda, especially in higher age at sexual debut, reduced numbers of sexual partners and dramatic increases in condom use. Significantly, much of the most substantial behavior change occurred among men.

Sources:

Museveni, Y. Keynote address, Oct. 13, 2001. Africa Prize for Leadership. www.thp.org/prize/01/ceremony/museveni.htm, accessed November 2003.
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Bessinger, R., Akwara, P. 2003. "Trends in Sexual and Fertility Related Behavior: Cameroon, Kenya, Uganda, Zambia and Thailand. Revised Draft." Calverton, Maryland: ORC Macro.
Murphy, E., M.E. Greene and T. Duong. forthcoming. "Defending the ABCs of AIDS Prevention: Another Feminist Perspective." Unpublished manuscript.

At the Hague Forum in 1999, several governments made statements expressing their commitment to involving men in reproductive health. Ethiopia's Vice Minister of Economic Development and Cooperation stated that, "We acknowledge that male involvement in reproductive health including family planning is of critical importance if the policy objectives have to be realized as planned. In this line efforts are now being made to reach men, especially industrial workers at places of work."[77] The extent to which statements like this translate into action is varied, but Ethiopia had already taken steps to address men in its 1993 population policy, even before the Cairo ICPD. The strategies for operationalizing that policy included

conducting communication campaigns to promote male involvement in family planning, and providing a broader range of contraceptive methods with particular attention to increasing the availability of male oriented methods.[78]

The HIV/AIDS pandemic has sharply highlighted the costs of omitting men from reproductive health education and services. Cambodia's policy on Women, the Girl Child and STI/HIV/AIDS is an outstanding policy response. Developed by the Ministry of Women's and Veterans' Affairs, the policy states that, "recognition of gender and gender inequality should not lead to a sole focus on women. Globally, we have learned that HIV/AIDS projects that have focused solely on women in recognition of their need for empowerment have failed or been unsustainable because they have failed to involve men."[79] It lays out the following as its main principle:

> [The Ministry] recognizes that this is a gender-based pandemic and that the spread of HIV/AIDS among women and girls can be slowed only if concrete changes are brought about in the sexual behavior of men… Accordingly, MWVA places prevention, care, support and protection of women and the girl child plus the need to change the behavior of men on the agenda for policy-makers and service-providers through this 'Policy on Women, the Girl Child and STI/HIV/AIDS.'

This remarkable statement provides the impetus and support for Ministry activities in education, prevention and service provision.

Nearly 30 years of civil war in Guatemala came to an end in 1996 with peace accords that emphasized economic and social development as a way of addressing social inequities of all kinds. The 1996-2000 Presidential Action Plan for Social Development, created in collaboration with civil society organizations, led to the creation of Guatemala's Law of Social Development and Population of 2001.[80] Article 4 calls for the promotion of gender equity, and Article 15 specifically addresses responsible fatherhood and motherhood, and the free and full exercise of the basic rights of both married and single fathers and mothers. The health sector is charged with reproductive health programs that serve both men and women. The education sector is responsible for sex education that covers responsible motherhood and fatherhood and is, "oriented toward the development of values and moral and ethical principles sustained by love, understanding, respect and dignity, and toward developing healthy lifestyles and personal behavior based in an integrated concept of human sexuality in its biological, psychosocial and human development aspects."

Youth policies tend to pay systematic attention to young men as well as women. The widespread social exclusion of Jamaican men — with their higher school dropout rates, lower life expectancy, worse employment opportunities — has led to solid attention at the policy level with an emphasis on male education, male role models and fathering. Jamaica's multisectoral National Youth Development Policy (NYDP) takes on broad youth development themes. Assessments of each sector describe the relative situation of young men and young women. Crime and violence are big problems in Jamaica, and the policy addresses young men's roles as both perpetrators and victims. Though young women are more likely to be beneficiaries of reproductive health programs, young men also need services and support. Alongside its more standard recommendations for youth policy, the NYDP defines as a *strategic objective for health*

to "Promote gender equity and the transformation of societal norms and cultural practices of masculinity and femininity."

Kenya's Adolescent Reproductive Health Development Policy addresses gender roles and their effects on sexual and reproductive health, noting that, "Expectations about what it means to be a man or a woman, which are an integral part of the socialization process, leave many youth and adults ill prepared to deal with their sexuality or protect their health… Stereotypes of submissive females and powerful males restrict access to health information, hinder communication between young couples, and encourage risky behaviour among young women and men in different, but equally dangerous, ways."[81] Ultimately, the policy notes, these gender disparities and power imbalances between men and women increase adolescents' vulnerability to sexual health threats. Tanzania's broad youth policy also mentions the need, "To promote the lives of youth, female and male, by developing them in the areas of economy, culture, politics, responsible parenthood, education and health."[82] The document assigns to the Ministry of Health the responsibility of strengthening sexual health education for both boys and girls.

Laws, norms and regulations

Laws, norms and regulations are essential for carrying policy through into action. While there are many different laws affecting men's roles in reproductive health in one way or another, this analysis focuses on sexuality education that reflects an appreciation of the social obstacles to health, norms and regulations that make actual reproductive health services and information more readily available to men, and efforts to support men's roles as fathers.

Promotion of gender equitable attitudes among young men and women

In much of the world, sexuality education focuses on efforts to dissuade young people from engaging in sex rather than preparing them to negotiate relationships.[83] The Scandinavian countries provide almost the only exception to this rule. In both Denmark and Sweden, for example, sexuality is treated as open and natural from a young age, and a national system of sex education exists and reaches virtually everyone.[84] This system provides young people not only with basic information on the physiological aspects of sexuality and reproduction, but the chance to consider and discuss their feelings and the relational aspects of sexuality.

An important new subset of national efforts to address gender norms works with men in the police and armed forces, requiring governments to allow recruits to participate. Many live with notions of masculinity that are harmful to their health. Men in the Ghana Police Service, for example, are placed at high risk of HIV by the time they spend away from home and the stresses of their work. A project funded by USAID is working with these men as well as the military in Cambodia and Nigeria to promote HIV prevention.[85] UNFPA has worked with numerous countries to institutionalize a reproductive health component into military training.[86] This has been an important opportunity to provide young men with information and services, and to inculcate expectations of their leadership roles in the communities where they work.

Health system norms and regulations

Though most reproductive health and HIV policies cite references to research on gender and HIV, most stop short of outlining specific steps for working with men. The ambitious policy commitments to combat gender inequities and involve men are not consistently reflected in

health system norms and regulations.[87] In the absence of specific guidelines and training on men's roles, programs and providers can easily exclude men from routine services.

Botswana's family planning policy guidelines and standards provide a good model of how to address men in the clinical aspects of the health system. Men are the first in a list of "special groups" on whom it is especially important to focus.[88] Their guidelines for involving men include these elements:

- To promote male involvement, family planning service providers shall make a deliberate effort to educate the male and provide appropriate non-medical methods more freely.
- Condoms and spermicides as well as family planning counselling and education shall be made available to men.
- Clients shall be encouraged to bring their partners for family planning session and discussions in order to enhance communication between them.
- Family planning providers shall use a variety of educational methods to motivate the male such as providing IEC materials, displaying the various methods available, showing films or slides of the health and social-economic benefits of family planning, using kgotla meetings to provide information and identifying already motivated men to assist in motivating others.
- The current service delivery shall be flexible to allow scheduling of family planning sessions and discussions during non-working hours.

These proposed clinical activities with men are very important. These should be linked to other activities that address the social dimensions of sexual and reproductive health as Kenya proposes to do. "Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan 2000-2005" describes how gender norms make men vulnerable to HIV — via the celebration of promiscuity, substance abuse, and migration and family separation — and mandates the involvement of men in HIV/AIDS work. The two most promising routes for implementing male involvement are first, "to engender the technical components of HIV prevention, e.g., syndromic management of STI, VCT, condom promotion, i.e., promote both the male and female condom, HIV prevention with youth, hard to reach groups such as truckers, sex workers and men who act as the bridge population between casual sex partners and their wives, partners or girlfriends"; and second, "to build capacity among decision-makers and donors regarding the gendered dimensions of HIV infection, prevention, treatment, care and support."

Support of fatherhood

While services for men address men's sexual roles and sexuality, laws regarding paternity more fully acknowledge men's roles in reproduction and family life. A cluster of policies and laws support fatherhood, though they often by necessity reflect and try to solve men's frequent disengagement from partners and children. Legislation on "responsible fatherhood" includes genetic testing for paternity, mandating child support and acknowledgement. Other supportive legislation includes paternity leave, the right for men to be involved in the lives of their children, and the inclusion of fathers in the birthing process when mothers wish them to be present or involved.

Developed and developing countries have been remarkably similar and consistent in doing rather little to support men's roles as fathers until quite recently. In the past twenty years, however,

several European countries have enacted and strengthened progressive legislation regarding parental responsibilities and paternal rights. Most countries in the European Union now offer paid paternity leave of at least two weeks after a child's birth.[89] The Scandinavian countries have offered fathers incentives to take at least one month of paid leave in addition to the eleven months that mothers usually take. In Romania, a National Action Plan for Equal Opportunities between Men and Women contains some specific provisions regarding men's active participation in family life as well as measures that support single parent households. These national policies demonstrate an active commitment to strengthening the role of men within the family.

Costa Rica's Responsible Fatherhood Legislation of 2001 is remarkable in its integration with existing legislation and institutions, including the Family Code.[90] Nearly a third of Costa Rican children had previously been unrecognized by their fathers, with all of the implications for name, support and inheritance that this implied. Recognizing that this was jeopardizing the basic rights of children, the government took action and adopted the innovative Law of Responsible Fatherhood, the first of its kind. The new legislation guarantees children their right to know their parents and to be supported by them. The general intention of the law is to expand men's roles beyond biological paternity to cultural fatherhood, and indeed the Ministry of Public Education take responsibility for "promote the shared responsibility of fathers and mothers in the raising, care and attention of sons and daughters…" Through its Institutional Commission for Responsible Fatherhood, it links activities carried out through various educational programs, including Religious education, Integral Sexuality Education, the Office of Gender Equity, and the Technical Council on Childhood and Adolescence. The legislation, which also mandates genetic testing where paternity is in question, and identifies the institutions responsible for conducting the tests and registration of the child appears to have had a direct impact on reducing the number of children unrecognized by their fathers, which dropped from 29.3 percent in 1999 to 7.8 percent in 2003.[91]

The policies sampled here that support positive roles for men in their sexual and reproductive lives do not represent the full range by any means. But they do offer promising ideas for ways that men could be involved more centrally in other countries and contexts.

5. PROGRAMMING FOR MALE INVOLVEMENT IN REPRODUCTIVE HEALTH

We have learned a great deal about the conditions of men's lives and about the focus on gender equity that frames the discussion of male involvement at the policy level. What have the programs developed to involve them in sexual and reproductive health look like? An important impetus for new program strategies was the realization that existing reproductive health programs were having limited effects on women's health and were missing opportunities to engage men. A clearer appreciation was also emerging of men's common roles as primary decision makers in the lives of women and young girls. Given that reality, men need to be more substantially engaged in addressing the gender norms that contribute to gender-based violence or the spread of HIV, for example.[92] Guided by these insights, innovative program models have emerged over the past ten years that seek to involve men on a broad range of issues such as adolescent health, family planning, safe motherhood, HIV and STI prevention, diagnosis and treatment, male reproductive health needs, and fatherhood.

A typology of approaches to male involvement

Though the number and variety of efforts to involve men in reproductive health has burgeoned in recent years, three main program approaches have characterized most male involvement efforts. For purposes of clarity and comparison these approaches can be identified as 1) Involving men as clients; 2) Working with men as supportive partners; and 3) Men as agents of positive change. The three approaches, outlined briefly in the introduction to this paper, differ primarily in how they address the gendered social roles of men. The following section briefly describes each approach and its implications for programs.

Involving Men as Clients

As we saw in the introductory framework, programs to "involve men" that evolved since Cairo have typically utilized one of a few main strategies. In the **men as clients** approach, men are encouraged to use reproductive health services to meet their own needs and to reduce the reproductive health burden on women. These programs reflect a recognition of men's reproductive health needs and the reality that improving men's health has positive effects for their sexual partners.

An example is the Family Planning Association of Kenya (FPAK)'s Male Involvement Project, a large-scale program that involved men in family planning through a variety of channels, including the workplace. Workplace motivators informed men about contraception, birth spacing, and HIV/AIDS, sold men contraceptives, conducted home visits to answer men's questions, and referred interested men to the local FPAK clinics for vasectomies.[93] The Asociación Dominicana de Planificación Familiar trained barbers on proper condom use and provided informational materials for men. These barbers were able to reach almost half a million men with messages about preventing HIV/AIDS and other sexually transmitted diseases. The extra services increased barbers' flow of customers for haircuts, and even after the project ended, the barbers continued to provide referrals and information and sold subsidized condoms.[94] In Colombia, Profamilia established three men's clinics providing a wide range of services including general medical exams, reproductive health and urological services, infertility testing and treatment and services regarding divorce, separation, and child support.[95]

Working with Men as Involved Partners

The second type of program, which works with **men as partners**, is guided by the realization that men can be key allies in achieving better reproductive health for their sexual partners. Programming for men as supportive partners of women reflects men's roles as primary health decision makers in the family and recognizes men's greater access to information and resources. Many of these programs address men and women's reproductive health needs within the context of their relationship as a couple and encourage men to communicate openly with their partners; others try to reach out to men as primary gatekeepers and decision makers in communities.[96]

Programs of this type have typically been implemented to address "traditional" reproductive health areas like family planning and maternal health. These programs have worked with men and women together to develop emergency plans for labor and delivery, counseling men to support their partners in the use of PMTCT services, and encouraging men to accompany their partners for post-abortion services and counseling. More recently, these programs have also

started addressing broader challenges to health like gender-based violence and female genital cutting. The Senegalese NGO Tostan, for example, has received world renown for its work involving men as allies in eradicating female genital cutting and in reducing early marriage among adolescents. By involving local religious, and community leaders, they have been able to catalyze over 1200 villages to sign a declaration to ban FGC and early marriage.[97]

In conjunction with local organizations in Benin, PATH used drama to persuade men to support their wives' desire for contraceptive services. The performances were followed by discussions with male and female audience members, and led to a significant decrease in the number of children desired by both men and women.[98] The Ministry for Women's Empowerment along with UNFPA and the Center for Communications Program at Johns Hopkins University, created a large mobilization campaign – including radio and television spots led by a famous singer, community mobilization events, and training for providers – to inform men about maternal mortality.[99]

Existing service delivery programs have also designed specific activities to reach men. Baseline research in Zimbabwe indicated that women wished their partners to attend clinic with them more regularly. In response, the Population Council supported a project called Mira Newako – "Stand proudly by your partner" – to create support in the community for male participation. Outreach workers used role-playing and picture cards to promote discussion in the community about male involvement, and distributed educational materials about pregnancy to men. As a result, more men attended antenatal services with their partners over time.[100] In Zambia, work among male leaders to promote PMTCT among other men in their communities has led to higher levels of male involvement in PMTCT decision-making and use of VCT services.[101] Program managers in Kenya have similarly informed male partners about PMTCT services by providing community education on PMTCT in places where men congregate, organizing support groups for men, and inviting men to clinics for HIV counseling and testing.

Research in India has shown that men want to support their partners during pregnancy, labor, and delivery and that the more information they have, the more likely they are to participate in routine care and during the antenatal, delivery, and postnatal periods.[102] Thus another example of the "men as supportive partners" approach is Deepak Charitable Trust's Pati Sampark – "meeting husbands" – involving men in antenatal care.[103] Implemented by male and female outreach workers, as well as trained midwives, Pati Sampark's aim was to motivate husbands to support their wives' clinic attendance and to ensure the consumption of iron and calcium supplements at prescribed times. Male outreach workers visited the husbands of pregnant women who were not attending monthly antenatal clinics and informed them about the importance of antenatal care and taught them to identify the symptoms of high-risk pregnancy. Mobilizing resources and transportation to a medical facility when a woman goes into labor is often men's responsibility. The Mother Friendly Movement in Indonesia – and the Alert Husband program – have helped communities establish emergency transport systems for women in labor, and to recognize the need for this support.[104]

India's Employee's State Insurance Corporation (ESIC), a government-affiliated insurance agency for low-income workers, trained providers to counsel couples and individuals on various reproductive health topics. Couples also received antenatal testing and, if necessary, treatment

for syphilis. Family planning use increased among participating couples, who also reported more communication and joint decision-making.[105]

In the Caribbean, several pioneering interventions have reached out to men as fathers.[106] The government of St. Kitts-Nevis has organized 13-week courses for men on parenting topics the men themselves identify. In Jamaica, Youth Now – a project focusing primarily on the needs of adolescents and young men – has launched a program of community-based activities for fathers and sons in an inner-city community. Organizations in both Belize and Dominica have organized parenting courses for men in prison.

Working to change men's attitudes, a large media campaign in Jordan encouraged men to use family planning methods by emphasizing spousal communication, the equal value of the girl child, the safety, effectiveness and reversibility of modern methods, their acceptability within Islam, and improved quality of life through family planning.[107] A program in Pakistan reached out to community and religious leaders to encourage men to use family planning and to plan for safe pregnancy and delivery.[108] A large number of organizations in South Africa have joined forces as part of a project called "South African Men Care Enough to Act." The effort has focused on mobilizing men to become active participants in fighting AIDS and to take greater responsibility for their own sexual health, as well as that of their partners.[109]

Men as agents of positive change

Programs that support **men as agents of change** reflect the perspective that gender roles and norms can harm both men's and women's reproductive health. These programs explicitly call for a critical understanding of gender roles and the recognition that male involvement programming needs to go beyond 'involving' men by motivating them to actively address gender inequities. This is done by challenging attitudes and behaviors that compromise not only men's health and safety, but that of women and children. The emphasis of these programs is on helping men to understand how gender norms can negatively affect their lives and those of their partners and families. Once men are given opportunities for self examination, they are challenged to develop healthier alternatives to prevailing notions of gender and masculinity, particularly those that affect their reproductive health and that of their families. These programs are often the most difficult and time intensive to implement because they require men to question and address entrenched social norms and attitudes in the face of social pressure. Some of these programs have gone even further and have asked men to catalyze and engage other men in active discussions about healthy alternatives to existing social norms.

Salud y Genero, based in Mexico, sensitizes men to the detriments of socialized masculinity, especially violence, and how they affect both men and women.[110] They emphasize that risk-taking behavior and the inability to understand and express emotions can lead to unsatisfactory life outcomes such as the failure to form intimate relationships with their sexual partners and children and inattention to their own mental, physical, and reproductive health. The organization uses all-male or mixed-gender groups to work with men facing social and economic issues. Peru's ReproSalud, a reproductive health project implemented by Movimiento Manuela Ramos, has designed workshops for male educators where men to reflect on their masculinity so they can help other men think more critically about sexual and reproductive health. The workshops have

been an enormous success and demonstrate that men value the opportunity to discuss violence, alcoholism, sexuality, and fatherhood and to contemplate living differently.[111]

An intervention being implemented in India and Egypt by CEDPA works with young men to challenge gender inequities and expand life options, using an empowerment model. In this project, some of the issues addressed with young men included reproductive health issues, unemployment, legal rights, and relationship issues. The program was implemented through vocational training classes, remedial tutoring classes, gyms, clubs, and other community organizations.[112] Another group, Program H, is currently being implemented in Latin America and other countries by four organizations: Promundo, Ecos, Instituto Papai, and Salud y Genero. It works with young men to help them question traditional norms related to masculinity and encourages them to adopt more gender-equitable attitudes and practices.[113] In the Philippines, Harnessing Self-Reliant Initiatives and Knowledge (HASIK) uses gender training with men as a way of organizing against violence. Some men in the communities in which they work have formed groups to reach other men and intervene with abusive partners.[114]

These programs have been implemented in many venues and may utilize creative and innovative means to involve men. This includes reaching out to community and religious groups, such as imams in Guinea and traditional monks in Cambodia.[115] In Cambodia, for instance, the national NGO RACHA trained Buddhist monks to provide basic reproductive health information on a variety of topics to groups of men. Existing cultural practices have also been expanded upon to reach men and support more gender equitable attitudes and behaviors. Kenya's Chogoria Hospital initiated a program called "Climbing to Manhood," which used traditional male circumcision rites to provide information to young men.[116]

In Haiti, the Groupe de Lutte Anti-SIDA (Group in Struggle Against AIDS) or GLAS implemented an HIV prevention program at various workplaces, ranging from utility companies to bottling plants, in Port-au-Prince. The GLAS program decided to use an approach called transactional analysis (TA), which teaches adults how to abandon often painful and self-defeating strategies, and how to develop different attitudes for dealing with life's problems. In the GLAS case, the TA helped men to think about their dominating attitudes and the reasons for their actions. It gave them a greater sense of responsibility for their own behavior, an appreciation of the importance of parenting, and greater respect for their life partners.[117]

The Conscientizing Male Adolescents (CMA) program in Nigeria has taken a long-term approach to involving men in changing gender inequity in issues related to reproductive health. Young men in the CMA program focus on sexism and critical thinking skills in the context of gender-based oppression, sexual rights, violence, power within the family, intimate relationships, sexual health, human rights, and democracy.[118] The Pan American Health Organization is using soccer as a way of working with young men in various countries in Latin America to develop alternative, healthier models of masculinity.[119]

Promoting partnership between women and men to combat violence against women in Yemen

Yemen is ranked 133 out of 148 countries in the Human Development Report (UNDP, 2001). Three quarters of women are illiterate. Fertility is high at 7.3, and the maternal mortality rate is 1,400 deaths per 100,000 live births (IPPF, 2004). Gender stereotypes are encouraged in schools, with girls socialized to be obedient and voiceless, and boys to be strong, dominant, provide for their families and be guardians of their female counterparts. Yemen has a nascent women's movement lead by the Yemeni Women's Union, an NGO with branches throughout the country.

Project background and core principles

In 2000, Oxfam GB in Yemen initiated a program to combat violence against women, but met with very limited success. Two years later, in 2002, it collaborated with Oxfam Great Britain's Gender Equality and Men (GEM) project. This time, they began with a workshop in which partnering NGOs representing men and women met to develop a conceptual framework for partnerships between men and women. The core components of this partnership were shared goals, cooperation, commitment, complementary roles along power and gender lines, and building trust.

One of the critical strategies was the formation of advocacy groups in several provinces that were able to attract men in leadership positions, including policemen, judges, lawyers, academics, media representatives, and government officials. These groups worked on such issues as promoting the rights of men and women, monitoring and documenting cases that violate women's rights including domestic violence and harassment at work, and awareness raising on gender-based violence.

Establishing common goals, fostering cooperation and understanding complementary roles

To gain the support of key male actors, the Yemeni's Women Union organized dialogues with men where they presented the arguments that some women's problems cannot be resolved without the support of men and that women's issues concern men. These dialogues helped the Women's Union and the advocacy groups develop common goals.

The Women's Union also recognized women's difficulties in raising gender issues with men and embraced men in supporting their cause. This is how they involved men like Mr. Alademeei, a human rights activist who worked with police and members of the security force to raise their awareness of how Islamic code, national policies and International Human Rights Conventions protect the rights of men and women.

While the male advocates worked with public officials, the Women's Union worked complementarily to defend survivors of gender-based violence. The involvement of male leaders in the advocacy groups gave moral support to women lawyers who previously had been harassed when defending survivors in court. Men's advocacy also transformed the way people thought about women's rights, and helped them see these rights as the concerns of both men and women. By talking with male peers in decision-making positions, members of the advocacy groups have recruited other men to defend the rights of women and collaborate with women to reduce gender-based violence.

Working with religious leaders and building trust

The dialogues initiated by women's organizations with key policy holders, including officials from the Ministry of Endowment, the institution responsible for enforcing Shari'a laws, has helped build trust between men and women in pursuing common goals. The Ministry of Endowment has asked the Women's National Committee to identify messages on violence and women's rights that they would like the mosques to relay during Friday prayers.

Lessons learned

This program successfully worked around social, cultural and religious constraints. People developing work under similar circumstances should seek to minimize the negative and build on the positive. They would also do well to establish partnerships between NGOs and men in leadership positions to develop effective alliances to defend and promote women's rights.

However, to achieve successful partnerships and identify common goals, program planners have to evaluate the dynamics of gender inequality in great detail. Also important from the beginning is to identify issues that are important to women yet allow program planners to work with men and boys to open up more space for women in highly restrictive situations.

Sources: Elsanousi, M.M. 2004. "Strategies and Approaches to Enhance the Role of Men and Boys in Working for Gender Equality: A Case Study from Yemen." *Gender Equality and Men: Learning from Practice*. Oxford: Oxfam GB.

Men As Partners: South African Men Respond to Violence Against Women and HIV

South Africa has one of the world's fastest growing AIDS epidemics. In many parts of the country, approximately 30% of adults are estimated to be HIV positive. Gender-based violence also plagues South Africa, with up to a third of women beaten by an intimate partner. South African Police Service statistics document 51,249 cases of rape reported to police nationally in 1999, giving South Africa the highest per capita rate of reported rape in the world. Rape Crisis Cape Town believes the real figure is at least 20 times higher – the equivalent of one rape every 23 seconds.

Men As Partners History and Mission

In 1998, recognizing the urgent need for a response to HIV/AIDS and violence against women, and acknowledging the importance of men to achieving this goal, EngenderHealth and the Planned Parenthood Association of South Africa (PPASA) initiated a Men As Partners (MAP) program. The goal of the program was twofold: to challenge the attitudes, behaviors, and values of men that compromise their own health as well as the health and well being of their partners and families; and to encourage men to become actively involved in preventing gender-based violence as well as in HIV/AIDS related prevention, care, and support activities. The MAP program was launched in eight of South Africa's nine provinces, establishing a presence in communities across the country, including urban, semi urban and rural communities.

Fundamentals of the MAP Program

The cornerstone of the MAP program in South Africa is the implementation of educational workshops with groups of men in a wide variety of settings and from many walks of life: workplaces, trade unions, prisons, faith-based organizations, community halls, sporting arenas. In their very design, the workshops reflect a commitment to dealing with the complexities of gender roles and the challenges associated with shifting long-held attitudes, values and practices. Most workshops are typically a week long and are often residential. Unlike many other programs with a single issue focus, the workshops address the complexities of gender roles in men's lives, touching on violence, sexual and reproductive health, parenting, support and care for people living with AIDS, social justice, and always on men's roles and responsibilities related to ending violence and creating healthy, thriving communities.

Workshop activities constantly refer back to gender. For example, an activity about HIV will explore the ways in which gender roles can increase the likelihood that men engage in unsafe sex or deter men from playing an active role in supporting those left chronically ill by AIDS. Similarly, facilitators might use roleplays to examine men's attitudes towards health seeking behaviors and challenge the notion that a "real man" only uses health services when he's already seriously ill. Interactive values clarification activities help workshop participants share and discuss their attitudes towards family planning, antenatal care and parenting, and examine how gender roles restrict the choices available to both men and women. A common question workshop facilitators ask during the discussion of any activity is, "how does this issue affect men and women differently?"

Building a "Big Tent" to Reach Larger Numbers of Men

Faced with the growing devastation wrought by HIV/AIDS and violence against women, EngenderHealth and its collaborating partners have worked hard to expand the reach of the MAP program. Their two strategies have been first, to build capacity within the NGO sector to reach greater numbers of men and second, to promote community based efforts to mobilize men in the service of social justice. EngenderHealth has established close working relationships with organizations capable of reaching millions of South African men. These include the Solidarity Centre, an umbrella organization that works with the three major labor federations representing over three million union members; the AIDS Consortium representing 800 community based HIV/AIDS organizations; the South African National Defense Force, with a membership of about 65,000; and five of the largest universities in the Western Cape. To ensure that the MAP approach is integrated into more clinical settings, EngenderHealth works with Hope Worldwide, a national NGO working in the area of HIV/AIDS prevention, care and support; on VCT and MTCT with the Perinatal HIV Research Unit at the Chris Hani Baragwanath Hospital (the world's largest) in Soweto; and with the large Esselen Street Clinic, reaching immigrant communities in inner city Johannesburg.

In developing these partnerships, MAP workshops have undergone a number of changes and have become more focused on providing participants with the skills and motivation needed to promote and sustain change in their personal lives, in their organizations and in their communities. The workshops build skills, focusing on day-to-day strategies men can utilize to promote gender equity and positive male involvement and mobilize their communities.

Sources: Mehta, Manisha et al. 2004. Lessons Learned from Engaging Men in Clinics and Communities," *Gender Equality and Men: Learning from Practice*. Oxford: Oxfam GB; Peacock, Dean. 2003. *Men as Partners: South African Men Respond to Violence Against Women and HIV/AIDS*. New York: EngenderHealth; The Impact of HIV/AIDS on Adult Mortality. 2001. Medical Research Council, South Africa; Jewkes, Rachel et al. 2000. Violence Against Women in South Africa: Rape and Sexual Coercion. Crime Prevention Research Resources Center.

6. MEASURING OUTCOMES AND PROGRAM EFFECTIVENESS

Evaluating the impact of programs that focus on men and sexual and reproductive health (SRH) is vital to determining the relative success of different strategies, as well as to provide evidence that attempts to "involve" men lead to any success at all. Despite the substantial calls for men's involvement in sexual and reproductive health, however, few detailed evaluations of interventions have been conducted or published.

One of the reasons for the lack of good evaluation data is the lack of clarity in how to measure impact. This lack of clarity reflects ambiguity in the objectives of the programs. Should evaluations now focus on women's health, men's health or gender equity? Programs that contribute to gender equity are challenging to evaluate, and appropriate indicators and methodologies are still under development. This section of the paper addresses these challenges by describing new developments in program evaluation, especially programs that address men as agents of change, and suggests new indicators and ways of moving forward.

Evaluating male involvement programs

As we have seen, the men as clients approach has been to target men specifically with services and activities, and this work has been relatively well evaluated. One well-evaluated program example targeted Senegalese transport workers for their own sexual and reproductive health and disease prevention and conducted a two-year evaluation of their peer education program.[120]

The men as partners approach is a bit more challenging to evaluate. One of the few examples of a well-evaluated program is the Men in Maternity program in India.[121] The Men in Maternity study investigated the feasibility, acceptability, and cost of a model of maternity care that encouraged husbands' participation in their wives' antenatal and postpartum care. The intervention included individual or group counseling, separately for men and women, couple counseling, and STI syndromic management for both men and women. Of six sites, three were assigned the intervention and three were observed as controls. More than 300 couples in each of the control and interventions groups – so over 600 couples in all – completed pre- and post-intervention surveys. The program resulted in a significant improvement in family planning knowledge and behaviors of both men and women, and men accompanied their wives to the clinics and participated actively in the intervention.

Programs that involve men as agents of positive change are the most challenging to implement and evaluate, and are relatively few in number. Puntos de Encuentro of Nicaragua, as part of its communication for social change program, conducted an evaluation of its male-focused media campaign to reduce intimate partner violence.[122] Surveys were administered to 2000 men pre- and post-campaign, and 600 women post-campaign. Post-intervention, men exposed to the campaign felt that violence negatively affects the community, and that men can prevent violence, more than those not exposed to it. Also, a third of men surveyed spoke with their female partners about the campaign and almost two-thirds spoke with other men. EngenderHealth's Men as Partners (MAP)[123] program in South Africa similarly seeks to work with men on an individual basis to encourage them to examine how current gender roles can compromise their own health as well as that of their partners. It then supports them to take action in their own lives and in their communities to express healthier and alternative definitions of masculinity.[124] In conjunction

with several other organizations, MAP has also instituted a series of community activities to encourage other men to question existing attitudes and behaviors that may put them and their partners at risk.[125] An independent evaluation of the impact of MAP's distinctive program in South Africa is currently being conducted.[126]

A few programs focused on influencing gender-related norms and behaviors have combined activities at both the individual and community level and seem to have been quite successful. One promising example that has undergone a relatively rigorous evaluation is Program H, based in Rio de Janeiro, Brazil.[127] The intervention study examined the effectiveness of activities to improve young men's attitudes about gender roles and sexual relationships and to reduce HIV risk behaviors and partner violence. The quasi-experimental study compares the impact of different combinations of program activities to identify which are particularly vital to success. Three groups of young men 14 to 25 years old, with a mean age of 17 (at baseline, n = 780), were followed over approximately one year. One intervention arm included interactive group education sessions for young men led by adult male facilitators. A second arm combined this with a community-wide "lifestyle" social marketing campaign to promote condom use, using gender-equitable messages that also reinforce the messages promoted in the group education sessions. A third arm was a control group, which received a less intensive intervention after the control period was complete, to ensure that all participants benefited from some activities.

Support for equitable gender norms increased for both intervention groups, with no corresponding change in the control group, supporting the contention that the intervention had an impact on these attitudes. Key HIV/STI-related outcomes such as reported STI symptoms and condom use also improved for young men in the intervention groups, and the change was often greater for young men exposed to the combination of group education activities and the community-based lifestyle social marketing campaign. This finding highlights the importance of reinforcing interpersonal communication on gender equity with messages at the community level. Findings suggest that directly addressing gender and relationships in an HIV/STI prevention intervention for young men can result in positive outcomes for both young men and young women.[128]

Another promising program that combines multiple activities is Stepping Stones.[129] Stepping Stones is a communication, relationships, and life skills training package, which also covers HIV prevention and sexual and reproductive health. Designed originally for use in non-literate rural communities in sub-Saharan Africa, Stepping Stones has been widely adapted and used in Africa and Asia. The Stepping Stones process involves working with peer groups divided by age and sex, bringing the groups together to discuss their varied perspectives, and presenting requests for change from each peer group to the whole community. Working with individuals and peers helps create the knowledge and skills that are prerequisites for behavior change, and presenting requests to the community creates the supportive environment that is necessary to effect and sustain behavior change. Findings largely based on qualitative interviews from program participants and facilitators indicate that Stepping Stones has resulted in both improved gender, inter-generational, and peer relationships, and a reduction in negative health outcomes such as gender-based violence and alcohol consumption.[130]

Evaluations few and far between… and incomplete

Despite these positive examples, many gaps in evaluation data for interventions on men and reproductive health still exist. A recently published review examines the lessons learned from men's involvement since the Cairo conference as documented in published evaluations of interventions that have targeted heterosexual men.[131] Twenty-four studies met the criteria for inclusion, i.e., reported on sexual and reproductive health interventions, targeted heterosexual men and contained any evaluation data. The authors conclude that there is some evidence that media approaches may be a successful strategy, and that most studies cited report that men have responded positively to being involved in interventions. However, they conclude that there is a pressing need for more and better evaluations to examine not only the process of men's involvement, but also the impact of the evaluations on the lives of both men and their families.

Another recent review of sexual and reproductive health programs for men that attempt to influence negative gender norms drew on research presented at a conference that had sought representation from evaluated projects.[132] This review similarly found that programs are often limited to pilot projects, evaluations are uncommon and of poor quality, and these rarely assess program impact on social norms, despite programs' explicit efforts to influence them.[133]

A number of very important questions about male involvement and sexual and reproductive health remain. Some studies indicate that men's involvement may lead, for example, to increased uptake of contraception, but it remains unclear whether this leads to more equitable gender norms or the empowerment of women. Other studies have shown positive change in attitudes towards gender norms as reported by men, but precisely how these attitudes affect key health behaviors and outcomes and to influence them remains unclear. Does male involvement help men become capable of resisting social norms of male dominance, or isolate them from their peers? What are the effects of male involvement on the lives of men beyond straightforward health outcomes? Finally is long-term attitudinal change sustainable? We are unable to answer these questions given the lack of long-term, large-scale evaluation efforts.

Potential negative effects of programs that fail to address gender inequities

Without taking into account the role of gender dynamics in evaluations of men & reproductive health programs, unintended and unwanted outcomes can be missed. For example, mass media messages can reinforce stereotypical gender roles. This was one of the earliest lessons learned from a campaign to promote men's use of family planning in Zimbabwe.[134] The campaign, which relied on sports players to promote family planning to men, succeeded in reaching men and encouraging their participation. Some messages used sports motifs to reinforce the concept of teamwork – such as by presenting the spouse as a 'teammate.' The messages may also have reinforced men's intention to take more control in their relationships, such as through the message "play the game right – once you're in control, it's easy to be a winner." An unintended consequence of the campaign was that men who heard its messages were more likely to believe that they alone should make family planning decisions.

The reproductive health field has not yet answered the questions posed above for two principal reasons. First, gender equity has not been viewed as part of health, and has therefore not been carefully measured. Second, those programs that have attempted to address the issue directly have not, for the most part, sought to operationalize definitions of complex concepts like "more gender equitable" or "more male involvement." This technical challenge is made all the more

difficult by the need to be sure measures are appropriate in a given cultural context. What precisely do these terms mean and how can we measure them? The best ways to measure "gender-equitable" norms and behavior, or the related concepts of "male involvement" or "power in sexual relationships", are being tested, and are still under development. Qualitative studies are often vague in defining these terms. Few empirical studies measure these constructs directly, and instead often use proxy variables. Studies rarely use measures that have been evaluated for their psychometric properties (i.e., how valid and reliable they are) and cultural appropriateness. Without this information, it is difficult both to determine the prevailing levels of gender-related attitudes, norms and behavior in the community are and the effectiveness of any program that hopes to influence those factors.

Evaluation and measurement strategies that take gender equity into account

The programs mentioned above have related but divergent goals and would need to be evaluated differently. Different study designs would be needed to evaluate a national mass media campaign and a peer-led interpersonal communication intervention. Different indicators would be required to evaluate the impact of male involvement programs on condom negotiation skills and on gender-related attitudes. Different designs and indicators would be needed to measure individual-level outcomes versus community-level outcomes.

The 'gold standard' for study designs is the true experimental design, such as a randomized control trial (RCT), where different groups are randomly assigned exposure to an intervention and another 'control' group receives no intervention.[135] One example of this design is a study from Turkey on the role of fathers in postpartum family planning.[136] Program staff randomly assigned 333 woman expecting their first child into three groups: one with couple-oriented activities where the partner was invited to participate in group education sessions, one for mothers only, and the third with no intervention. Follow-up surveys revealed that use of modern contraceptives was higher in the intervention groups, and highest in the couple-oriented group. However, there were no significant differences at follow up related to gender dynamics, such as who made household decisions on family planning, and postpartum woman and child's health.

An experimental design is a very difficult standard to meet, however, as program participants cannot often be randomly assigned the intervention. An ethical preference also exists to provide intervention activities to all people participating in the study, through either a "delayed intervention," where the control group receives the successful intervention after the study is complete, or through offering two different combinations of activities, called a comparison group, instead of a control group. A quasi-experimental study, where two or more groups are exposed to intervention activities related to men and sexual and reproductive health and/or act as a control, is therefore a good alternative to the true experimental design. If the program is community- or health center-based, two or more similar communities or health centers can be selected and compared. Some of the studies described above were examples of quasi-experimental designs, e.g., Men in Maternity study in India, Program H study in Brazil.

To demonstrate change in response to an intervention, key indicators – including those related to gender equity – need to be measured before (baseline) and after (endline) the intervention is implemented. To indicate likely change related to male involvement activities, the intervention group should report more change regarding key outcomes like clinic attendance by men than the

control group. Some type of basic evaluation is both feasible and strongly recommended for every program, such as comparing responses of participants before and after a program. The MAP program in South Africa, which engages men in communities to address gender norms, gender-based violence, and reproductive health issues, includes, at a minimum, this type of basic evaluation in its work.

Complex concepts like "gender-equitable" norms or "male involvement" are multi-faceted and challenging to capture. In general, combinations of items are preferable to individual items because adding together items that cover multiple dimensions of complex concepts often explain underlying phenomena better. There have been attempts at measurement, within the widely-used Demographic and Health Surveys, for example, but there is no currently accepted 'gold standard' for these concepts. The few program evaluations that do measure these concepts rarely use measures that have been evaluated for their psychometric properties and cultural appropriateness. Even those that are carefully developed and evaluated don't always reach the accepted standard of reliability. For example, one measure used in a study of HIV risk among youth in Haiti included five items related to beliefs about cultural norms on multiple sexual partners, virginity, and condom use, adapted from qualitative research conducted with adolescents in developing countries.[137] While researchers used a careful and appropriate process to develop the measure, they ultimately found that the combination of gender-related statements were not sufficiently reliable to utilize in a scale, so they instead had to use individual items only in the analysis.

Distinguishing between related but different concepts is very important. "Gender norms" differ from "male involvement" and "power in sexual relationships." The key is to be clear about what a given program is trying to bring about, and to define and operationalize these concepts well in a questionnaire. One way to measure attitudes towards "gender norms" might be respondents' agreement or disagreement with statements like "Men need multiple sexual partners even if things with their partners/wives are fine," or "Women should tolerate violence to keep the family together." A measure of male involvement might be the proportion of antenatal clients who are accompanied by their partners, or the proportion of men who assist their pregnant partners with chores around the home. A measure of "power in sexual relationships" might be levels of decision-making power a woman has over important issues such as when to leave the home, or when and if to have sex.

The carefully derived Sexual Relationship Power Scale (SRPS) measures interpersonal power among women.[138] Its design was based on a literature review, focus group discussions with Latina, African-American, and White women in the United States, and pretests of scale items with a census of female clients in a community health clinic (n = 388). The 23-item scale is comprised of two subscales that measure issues related to "Relationship Control" and "Decision-Making Dominance" within the relationship. It possesses good internal consistency reliability and predictive validity. The SRPS reflects theoretical perspectives that explicitly address interpersonal power and incorporate a gender-oriented perspective. The SRPS has been found in multiple studies to be significantly associated with important heath outcomes such as condom use, intimate partner violence,[139] and HIV status.[140] To date, the SRPS has been successfully used with various populations, including women and men, youth and adults, and in a number of cultural contexts. Interestingly, the same questions related to power in sexual relationships have been useful for both men and women in certain contexts, as with adolescents in New York, but

the scale sometimes is more reliable and relevant for women, as in the case of adults in South Africa.

Direct measurement of these important concepts is possible. Research from psychology and other disciplines has long devised measures for subjective states like depression and other conditions once thought to be unmeasurable.[141] Yet when seeking to measure complex concepts like gender norms or power in relationships, it is important to avoid being too mechanistic. Quantitative measures of these multi-faceted and culturally-shaped factors inherently require some assumptions and a degree of simplification. Not all the nuance can be easily captured in a quantitative measure. Thus combining quantitative measures with qualitative methodologies like in-depth interviews with both men and women about how programs have affected their daily lives can provide useful additional detail and explanation.

One such intervention study using both quantitative and qualitative methodologies is currently being conducted in Tanzania. Based on research with women on violence, HIV risk, and HIV status disclosure,[142] this follow-up intervention study tests an intervention to reduce adolescent male's HIV risk behaviors and reduce partner violence so that adolescent females were 'enabled' to negotiate safe sexual relationships. The intervention combines drama-based communication with peer-support activities. The quasi-experimental design compares young men who participated in the program with those who did not. Changes in male attitudes and behaviors related to condom use, monogamy, forced sex and partner violence, as well as increases in women's ability to negotiate safe sex and to choose an HIV test are all measured quantitatively. Focus groups with young men and their girlfriends or other young women in the community are also being held. Through these interviews, researchers elicit the pros and cons of the program from the perspective of the young men, as well as confirmation from their partners that change is actually taking place.

Measuring the perspectives of both men and women is important for understanding how they feel about changes in gender roles or increasing male involvement. A study in Zimbabwe that focused on increasing male involvement in pregnancy and antenatal care found that female and male respondents had different expectations of men's involvement in pregnancy. Men felt that their primary roles were to provide financial support, attend the initial antenatal visit, and be receptive to information from a health provider. Women defined male involvement more broadly to include those elements, as well as to provide emotional support, express concern about their well-being, and help with domestic chores.[143]

It is important to measure both attitudes towards increased gender equity and male involvement as well as actual behavior change. Men's and women's divergent perspectives from this research in Zimbabwe highlighted a number of barriers to promoting male involvement. For example, increased male involvement in pregnancy, by definition, encroaches on a realm primarily considered women's domain. According to some female respondents, too much male involvement would mean a loss of power. For example, a husband's accompaniment to ANC would infringe on a woman's freedom to travel away from home and interact with other women. The formative research also revealed that men, women, and health care providers were supportive of increased male involvement overall for the positive health benefits for mother and baby, and for what it communicated about love in a marriage from the perspective of both men

and women. Some men were also very interested in pregnancy-related issues but unsure of what roles they could play. Divergences between behaviors and attitudes may require strategic thinking about how to adjust a program.

Finding measures that strike a balance between comparability and cultural specificity can be a challenge. Indicators that can be utilized across cultures permit important comparisons and determine the differential effects of similar programmatic strategies. Yet dimensions of gender dynamics most relevant to one culture may not be nearly as relevant to another. Before utilizing measures in one setting that were developed elsewhere, it is important to explore their relevance, through focus groups with members of the community and through reading the literature and holding discussions with knowledgeable informants.

One measure that has been successfully transferred from one culture to another is the Gender-Equitable Men (GEM) Scale. The (GEM) Scale was first developed and tested in Brazil to evaluate the impact of a program to promote gender equitable norms and HIV risk reduction among young men.[144] The GEM Scale was developed with a community-based sample of men aged 15-60 in Rio de Janeiro, Brazil, with particular focus on the subsample of young men aged 15-24 (n = 224). The scale was determined to be reliable and useful for measuring change in the Brazilian context. To assess the scale's usefulness in the very different cultural context of India, research was conducted to examine whether the scale domains and items were relevant and sufficiently sensitive to be applied with young Indian men.[145] Three focus group discussions were conducted with young men aged 18-29 from low-income communities in Mumbai, and the GEM Scale items were administered in a survey to another 65 young men with a similar profile (total n = 86). Focus group results indicate the gender norm "domains" the scale addresses – e.g., roles in sexual relationships, domestic roles, responsibility for reproductive health, partner violence – are relevant to the Indian context. Responses to the GEM Scale items show substantial variability for both young Brazilian and Indian men, indicating that the items are sensitive to responses in both contexts.

Meeting the Sexual Health Needs of Men Who Have Sex with Men in Senegal

Research conducted in many countries has highlighted the vulnerability of men who have sex with men (MSM) to HIV and other STIs. Yet in Africa, they receive little attention in HIV/AIDS programming and service delivery because of widespread denial and stigmatization of homosexual behavior. In Senegal, a diagnostic study conducted by researchers from the National AIDS Control Program (PNLS), Cheikh Anta Diop University, and the Horizons Program has provided valuable information about the needs, behaviors, knowledge, and attitudes of MSM that has important implications for program managers and policymakers working to stem the spread of HIV/AIDS. The researchers used ethnographic and survey methods (n = 250) to elicit information from MSM eighteen years of age or older from several neighborhoods in Dakar.

The study found that the lives of many MSM are characterized by violence and rejection. Forty-three percent of MSM had been raped at least once outside the family home and 37 percent said they had been forced to have sex in the last 12 months. Thirteen percent reported being raped by a policeman. Nearly half of the 250 men interviewed had experienced verbal abuse (including insults and threats) from their family. Many also reported physical abuse (e.g., blows, stone throwing) by family and community members and the police. The study found a good deal of mobility among the men, both voluntary and involuntary; nearly a fourth reported being forced to move in the last 12 months. Numerous MSM emphasized the importance of keeping one's sexual inclinations and relationships a secret because exposure leads to ostracism, stigmatization, and physical or verbal abuse.

The findings from this study were disseminated at a meeting held in April 2001 in Dakar and have catalyzed awareness of the public health importance of developing non-stigmatizing interventions for MSM. As a result, a task force of NGOs and the USAID Mission, under the auspices of the PNLS, has been formed to develop and coordinate services for MSM in Dakar. Potential intervention components include behavior change communication, capacity building of MSM leaders, training of peer educators, identification of service providers sensitive to the health needs of MSM, and creation of spaces that are safe and comfortable where MSM can gather to exchange information.

Source: Niang, Cheikh I., et al. 2002. "Meeting the sexual health needs of men who have sex with men in Senegal," *Horizons Final Report.* Washington, DC: Population Council.

7. CHALLENGES AND RECOMMENDATIONS

This paper has reviewed a wide range of survey and qualitative research, policy documents, and programmatic assessments in an effort to summarize what we know about men's roles in sexual and reproductive health – what they are, what we hope they could be, and how to get there. The compelling evidence presented here for involving men in sexual and reproductive health and the promotion of gender equity would seem irresistible. So why does the case still need to be made a decade after the International Conference on Population and Development in Cairo?

The obstacles to involving men in reproductive health center around a limited vision of both reproductive health and the steps needed to achieve gender equity. People's sexual and reproductive lives are not just about the health sector, nor are reproductive health and gender

equity only women's issues. The failure to appreciate these insights makes working with men the responsibility of clinics alone and social transformation women's affair.

What should we do to involve men more fully?

The strong rhetoric at international conferences and in policy discussions has urged countries to pay more attention to men's roles, but countries have not necessarily followed up in identifying specific activities and allocating budgets. How should the ubiquitous calls for gender equity be realized in concrete programs? How precisely can male involvement be pursued, and through which channels?

International and national agreements and commitments

At the international level, the eight Millennium Development Goals spelled out at the Millennium Summit of the United Nations in September 2000 represent an important strategy for addressing poverty in developing countries. Yet the MDGs miss the opportunity to articulate the contributions men could make to achieving them, *and* largely neglect reproductive health. Given the links between the bleak economic prospects of millions of men in developing countries, the weaknesses of health systems in most developing countries, and men's likelihood of engaging in unsafe behaviors—including unprotected sex – these glaring omissions must be addressed.

Donors can play a key role in moving male involvement forward supporting operationally relevant research, such as studies to clarify linkages between macroeconomic processes, population dynamics and poverty, including the inter-generational transmission of poverty. Donors can also support PRSP preparation directly by organizing dialogues or exchanges on central themes related to reproductive health and gender.[146] The PRSP focus on the maternal mortality MDG, for example, suggests that emphasizing men's roles as parents may be an additional way of linking the PRSP process with concrete national policies and targets.

Money and scale. Countries themselves will need to prioritize male involvement for this work to be sustainable and to achieve an appropriate scale. To date, much if not most male involvement programming in the developing world has been funded by foreign donors. An additional major shortcoming of efforts to involve men in sexual and reproductive health is that they tend to have occurred on a very small scale. Prospects for scaling them up to the national level are slim in most settings, with the exception perhaps of some of the work with the armed forces and police described earlier. Only if governments decide to add and adapt population and sexuality education programs, reproductive health services, and all of the legislation that would support the kind of work we have described here can the sexual and reproductive roles of men be addressed on any scale.

The cross-sectoral collaboration called for repeatedly in recent years really is key.

Men's and women's sexual and reproductive lives are shaped by their economic and social circumstances. The multi-sectoral challenge of promoting reproductive health and more equitable relationships between men and women requires considerable work at the policy level. Policies are needed to coordinate programs across sectors so that addressing men's and women's roles as they play out in sexual and reproductive health does not get relegated to the world's clinics.

The health sector has been slow to take responsibility for promoting gender equity, which it tends to see as beyond its mandate. Health sector officials do not always appreciate the contributions that information and services offered through the health system could make to constructing more equitable relationships. Reinforcing this failure to address gender inequities is the reliance on tried-and-true woman-oriented reproductive health outcomes and measures. The reason seems to be the rigidity imposed by the evaluation systems in place, which are short-term and emphasize clinical objectives and outcomes. The tendency to assess programs by these familiar measures tends to discourage the identification of new outcomes and objectives for reproductive health policies and programs. New measures that capture newer concepts of "social health" are needed, e.g., not just how many men are using contraception, but how couples decide, etc.

In the education sector, the challenges mentioned above are complicated by social and cultural conservatism. Boys and girls, men and women should have access to clear, nonjudgmental information on a wide range of sexual and reproductive health subjects. However, sex education remains a divisive topic in most parts of the world. In many developing countries, there is no sex education in schools; in some countries, sex education starts too late to be helpful. Many young people leave school before receiving it, and some do not attend school at all. Furthermore, the typical school-based curriculum may contain useful information about the differences between male and female reproductive systems, but it usually does not provide the opportunity for young people to learn relationship skills and discuss norms and peer pressure, not to mention ask their burning questions.[147] In contrast with other areas of health programming, there has been very little effort to identify and implement practical ways of helping men understand that safer sex is in their own best interests and that of their families.

The review of data on men's sexual and reproductive lives told us a lot about men, but also identified some important areas in which we should try to learn more. Several important groups of men are particularly neglected in surveys, and these include very young men and boys, older men, men who have sex with men, and men in several important geographic areas, most importantly Asia and the Middle East. What we do know, however, suggests that there is often little communication, even within long-standing relationships.

Male involvement programs

Practical and political obstacles impede efforts to field effective gender-sensitive programs. Uncertainty about how best to involve men lingers, budgetary constraints loom large, and cultural obstacles to a more transformative agenda persist. In the health sector, budgetary, training and logistical challenges pose the main obstacles to involving men. Will increasing the emphasis on programs that involve men weaken already overtaxed services for women? Who are the health care providers and educators who could be tapped to offer the services that men need? Are these professionals sufficient in number, and are they properly trained to undertake necessary activities? If not, how can this training be funded and implemented? What other institutions—nursing and medical schools, regular schools and colleges, private companies, nongovernmental organizations, religious groups—can be enlisted in activities that would lead to increased training in men's service provision?

Addressing gender inequities and unbalanced power relationships requires more than simply working with women or involving men. Every program should begin its work by identifying the gender issues to be addressed in improving people's sexual and reproductive health. Addressing gender inequities requires focusing on *how* services are provided rather than specifying which reproductive health services should be provided and to whom. The promotion of gender equity is often seen as the responsibility of Ministries of Women's Affairs, institutions often unlikely to emphasize recommendations for working with men. Many male involvement programs make the common mistake of believing that they are by definition necessarily addressing gender inequities. True gender-equitable male involvement programs will address gender dynamics and the negative consequences of the unequal balance of power between men and women. The recognition that gender norms have negative implications for men *and* women has yet to translate fully into working with both sexes.

Although the gender socialization of men and boys is often negative, masculinity is an evolving concept and more positive masculinities exist and can be cultivated. Research on male socialization indicates that societies and families around the world emphasize an achievement-oriented masculinity that pushes boys and men to become providers and protectors.[148] Men and boys experience pressures to perform and codes of honor that force them to compete and use violence or take sexual risks to demonstrate their "manliness" and fit in.[149] Prevailing gender norms often overwhelm more positive alternatives, but given opportunities and support, men are interested and motivated to adopt more equitable and healthful alternatives.[150]

Most men want to care for their own health and that of their sexual partners. When they are encouraged and provided with opportunities, many men will seek out reproductive health care. A distinct male reluctance to seek out medical care has been explained variously by low quality of care and poor service promotion, and by the need to protect their reputations as strong and uncomplaining. Having realized the importance of constructive male involvement in reproductive health, clinics that once served women only have started providing facilities focused on men. At many locations, special areas or clinic times are designated just for men. This has helped men feel more comfortable and has encouraged them to seek help.[151] Most men, whether they are partners, other family members, co-workers or neighbors, care deeply about the women in their lives. With a little support, many men are eager to challenge customs and practices that endanger women's health and are willing to participate in supportive reproductive health decision-making.

Men should be encouraged to share their experiences of masculinity with each other – and they are willing to do so. Given that men are socialized in groups – in the schoolyard, in religious institutions, on the playing field – it is important and valuable to offer men alternative group experiences that challenge their traditional notions of manhood. Experiences such as these allow men opportunities to build connections with other men, and to explore more positive dimensions of their masculine identities. Safe and comfortable settings also allow men to express their dissatisfaction with dysfunctional prevailing norms.[152] Improving men's understanding of their own motivations, fears and desires, their ability to broach topics relating to sexuality, and their respect for their partners' wishes is central to improving reproductive health.

Male involvement programs should be designed as part of larger overall reproductive health strategies. As add-ons to existing reproductive health and development programs, male involvement programs are generally vertical in their design and implementation. Instead, constructive male involvement should be viewed as a paradigm that needs to be integrated into the planning and development stage of any reproductive health project.

Addressing critical reproductive health priorities requires expanding program content beyond traditional issues. Most current male involvement programs tend to cover a limited number of "traditional" reproductive health issues: family planning, maternal health, and HIV prevention, and more recently, HIV testing and treatment. Creative attempts must be made to involve men in other critical areas such as gender-based violence, female genital cutting, cervical cancer, and HIV home based care and support.[153]

Male involvement programs should emphasize the broader contextual issues that men face that can negatively affect their reproductive health, including drug and alcohol abuse, unemployment, fatherhood, and male to male violence.[154] These are important issues to address not only for men themselves, but also for the repercussions these can have on the lives of partners and families.

Male involvement efforts of all types must be monitored and evaluated more consistently. The failure to do this results in some instances from a lack of clarity about objectives or an imprecise definition of constructive male involvement. In other situations, it is due to the difficulties of measuring the effects of normative change or because normative change takes so long. Further, very few programs have evolved beyond the 'pilot' stage, even if they can demonstrate success. A number of programs have been successful in devising appropriate tools, and these could serve as models for others.

Strategic multi-sectoral, multi-stakeholder partnerships are key to effective programming. Sectors beyond health such as education, law, and employment are increasingly addressing gender inequities, creating opportunities for linkages between these sectors and the reproductive health field. Opportunities now abound for partnerships with a variety of influential stakeholders at various levels, including political, religious, educational, community, and business leaders. These multi-sectoral, multi-stakeholder partnerships are critical to ensuring that male involvement is addressed and integrated on a large scale into health care delivery and other development activities. When programs build on an existing social capital and relationships with communities they gain access to men where they congregate and interact with one another. Challenging the status quo requires the forging of strategic alliances at the community level.

Creative avenues for outreach to men are critical to achieving meaningful scale and meeting the needs of underserved communities. Though examples of innovative ways to engage men are growing in number, significant scope remains for expanded outreach and greater inclusiveness. Male involvement programs need to continue to innovate in the ways they reach men. This can include recruiting allies such as livelihood and vocational training programs, educational institutions, rites of passage (male circumcision) groups, sports teams, and religious leaders such as imams and Buddhist monks.[155] Instead of seeking or creating new arenas in which to engage men, programmers should utilize the existing key venues where men congregate or can be reached: in workplaces, bars, unions, schools and other locations.[156] Expanding programs is also

easier when working through existing institutions that can reach large numbers of men, such as unions, police, the military, and industries such as mining or transportation.[157]

Social crises may also create opportunities for dialogue or paradigm shifts in gender relations. The viewpoints of programmers, researchers and society in general regarding gender norms have been changed by social or health crises. The HIV epidemic has created an important opening for involving men in helping implement equitable steps to stem the epidemic in their communities.[158] High levels of violence in many countries have prompted interest in creating more positive role models for young men. Societal crisis can also lead to a renewed emphasis on social justice and human rights. The rights-oriented male involvement movement shares several goals with other social justice movements. Given their commitment to principles of equity and liberation, men involved in these other movements might be natural supporters of constructive male involvement.[159]

Appropriate staff training in gender analysis and working with men greatly increases the effectiveness of outreach efforts and program activities. A study examining the possibility of offering services to men in Bolivia, Colombia and Paraguay found that in all three countries, providers acknowledged the importance of these services, but felt unable to provide them because of their "scant technical capacity and knowledge about the emotional and cultural aspects of male sexual behavior."[160] The confidence and effectiveness of program staff can be greatly increased through appropriate experiences and training. Providers' comfort with their own sexuality and understanding of gender directly condition how they interact with male clients (as individuals or as members of couples).[161] To ensure that key decision makers and managers support constructive male involvement and understand the linkages between gender equity and reproductive health, programs need to include focused time with senior management and key staff within partner institutions. Eventually, concern with gender equity should permeate all aspects of organizational culture, influencing recruitment of appropriate staff and contributing to the establishment of a gender balance within organizations, especially in positions of decision-making.

Concluding comments

The critical perspective that has led to calls for greater male involvement in sexual and reproductive health has often described men in rather negative terms. This "deficit model" of male roles does not effectively motivate people to take action of any sort. A close correlate of this observation is, as one researcher and advocate has put it, that "Policies designed to encourage male involvement and responsibility would probably be more successful if they were conceived of as rights."[162] Clarifying the negative effects of gender norms on *men's* health and well-being and not just women's could facilitate the development and implementation of more visionary policies and more innovative implementation. Men's potential roles in relation to their children tend to be articulated as obligations rather than rights. Yet proposing them as a right might provide a rather different opportunity for men, and could lead policy-makers to think differently about the conditions that would make it possible for men to commit more fully to their children.[163] An emphasis on responsibility tends to focus on punitive measures to ensure that "irresponsible" men pay child support, rather than *also* helping to create the circumstances that would support men in positive fathering roles.

Over time, the field has come to recognize that gender roles interfere with men's health as well as women's, and that dominant masculinity poses risks to men's health: from drinking to violence to sexual risk-taking, there are many aspects of what it means to be a man that can be bad news for men's health. No one now believes that the earlier emphasis on women's reproductive roles separate from their sexual and emotional lives and the fuller context of their relationships with men made any sense. Nor has such a cramped vision done justice to men and their needs and rights. We were short-sighted and wrong then, and we should not continue to perpetuate and compound the error now.

Thus the main objective of this paper has been to communicate that all policies and programs, information and services need to reflect the social realities of how men and women relate, and how this affects their health. It is a simple message, but it is one of the major contributions of the Cairo Programme of Action. This thinking shifts the focus of our analysis of health away from simply biomedical, clinical, or technical responses to the social relationships that shape health outcomes. Increasingly, the common denominator of successful programs is that they pay attention to the relational components of sexual and reproductive health. There is an obvious clinical rationale for providing services to both men and women. But the more clearly we understand health outcomes as resulting from social and economic relationships, the more *all* of our program responses can address these first causes rather than just the clinical "symptoms" of poor sexual and reproductive health.

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