Involving Men in Reproductive Health: Implications for Health and Rights

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Who and Why

That men figure in a list of the “hardly reached” in reproductive health (RH) testifies to the complex history and politics of this field. It is true that RH services have tended to overlook men and concentrate their efforts on women. Yet family planning (FP) services were often delivered in an expedient manner, not to serve women’s needs, but to reduce population growth. The field’s traditional focus on women as the means through which population policy could most effectively be implemented left little room for men, since the assumptions that underlay services for women neglected sex and relationships. Men were seen as peripheral at best and problematic at worst (Greene and Biddlecom 2000).

Critiques of this woman-focused model gathered momentum and led to the rights-oriented 1994 International Conference on Population and Development (ICPD) Programme of Action. A broader understanding of constraints to RH gained acceptance, one that acknowledges the cultural and economic contexts in which people make choices about their health as well as the need for clinical services. Gender relations are important contextual constraints to both women’s and men’s RH. Addressing these constraints is crucial to the development of RH programs. In addressing the needs of the “hardly reached,” programs must deal with gender inequities as rights violations that inhibit good health.

Conventional human rights concepts do not consistently include the social constraints of gender relations on reproductive rights and health, however. Common statements on reproductive rights focus on the right to determine without coercion whether, when, with whom, and how to have children, and how many to have. This is seen as a responsibility of governments toward their people. Reproductive health advocates have attempted to expand this definition of reproductive rights in two ways, arguing:

- that social and cultural constraints, including gender inequity, curtail the reproductive rights outlined above and need to be addressed; and
that individuals also have the right to RH services. This second point is seen by some as less ethically compelling as it varies according to available resources and is thus relative rather than an absolute human right (Li 1993).

Men’s roles in RH provide us with a special case that inherently involves both of these types of rights. On the one hand, men and the roles they play in relation to women have constrained women’s health and rights. On the other, men’s own RH needs have been overlooked. This article explores the implications of these two central ways in which men are implicated in any discussion of RH and rights.

Obstacles to Reaching Men
Reproductive morbidity and mortality are far more widespread among women than men as a result of their reproductive physiology, and no one would argue that these problems are adequately addressed by existing health systems. In an age of health sector reform and other changes that seek to cut costs and increase the efficiency of the health sector, many worry that involving men in RH will simply subtract from the finite pie of resources available for women’s health. This concern for finite resources clearly implies an additive approach to working with men, which is not always accurate. There are many benefits for women that stem from involving men in RH (Greene 1999).

As the fathers, brothers and husbands of women, men are uniquely positioned to contribute to women’s health in many ways. Yet relatively few FP/RH programs have tried to reach men in order to challenge and transform the gender norms that most often subjugate women. By focusing on demographic goals, programs that involve men have attempted primarily to overcome men’s objections to women’s contraceptive use.

Providing services for men themselves requires overcoming several constraints: gender relations, men’s own reluctance to seek out services, financial constraints, unprepared health workers, and assumptions about men’s interest in or resistance to various aspects of RH. Around the world, concepts of masculinity include greater risk-taking, and the tendency not to seek out medical services in general (Barker 2000). Both men and women are less likely for reasons of embarrassment to address their own RH ailments than they are to seek treatment for other health problems. In India, men are often more likely to seek out the help of untrained “quacks” than they are to go to a medical clinic, for reasons of proximity and confidentiality, among others (The Evaluation Project 1997).

In addition to the factors above, the often accurate perception that clinics do not welcome men, makes it unlikely that men will step foot in most conventional RH clinics. Although services focused on women and children may reflect local cultural realities of women’s centrality in child-rearing, they also institutionalize clinics as places for women only. Thus
maternal and child health clinics potentially reinforce a peripheral role for fathers. Information-sharing about RH has also occurred along gender lines. 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” (Skibiak 1993), many programs have marginalized men and minimized male participation. It is little wonder then that men see RH clinics as unwelcoming.

Similar assumptions about men’s roles in the family have also shaped the sorts of services that are offered. Treatments for sexually transmitted infections (STIs) predominate in the range of services available to men. This is because men are seen as important transmitters, more likely to be symptomatic and to seek treatment for STIs than are women. Men’s sexual performance may also be more overtly affected by an infection. The relative weight given to male sexuality in many FP/RH programs that involve men is evident. For example, in India the overwhelming emphasis is on female sterilization by tubal ligation. Vasectomy, which is quicker, cheaper, safer and less invasive, is often viewed in the minds of both providers and clients as a threat to male sexuality, as well as to men’s strength and ability to do hard work.

Appropriate Approaches
Social factors relating to gender inequity cannot be neglected by RH programs attempting to improve women’s and men’s health. Thus all RH programs, and especially efforts to involve men, need to be measured not only for their capacity to increase contraceptive use and clinical treatments, but by their ability to contribute to the gradual eradication of gender inequity. The ICPD’s emphasis on gender equity has expanded the context for health beyond clinic walls by acknowledging the linkages between clinical conditions and sex, gender, sexuality, and reproduction. The awareness of gender inequity can and should be incorporated into programs at every level. Involving men is not only about recruiting a new constituency to family planning services, but also about qualitatively changing the way that services and the messages they convey about gender relations are delivered. However, RH programs, as listed in the box at right, can actually reinforce gender inequities.

The relatively new expectations regarding the social content of RH programs are difficult to describe, and an example of a problematic approach may be useful. A male motivation campaign in Zimbabwe was strongly guided by a desire to increase contraceptive use by reducing men’s objections to women’s use. The program increased knowledge of and com-

Potential Pitfalls of Male Involvement
- Reinforcing men’s dominance in reproductive and sexual decision-making
- Reinforcing managerial hierarchies favoring men
- Shifting resources away from programs for women
- Overemphasis on men’s entitlement to specific services and neglect of gender equity objective
- Reinforcing a limited role for men in child-rearing
munication about FP methods, but men exposed to the campaign were much more likely to say that the husband alone should decide whether to practice family planning (Kuseka 1990; Piotrow et al. 1992). Despite this experience, a second, similar campaign was launched with much the same result: many men interpreted the message to mean that they alone should make FP decisions (Kim et al. 1996). Had the campaigns focused centrally on joint decision-making as well as increases in contraceptive use, they might not have undermined women’s say in contraceptive decision-making.

A common weakness of most programs involving men is their tendency to over-emphasize the strictly clinical aspects of RH, and to sideline the important social implications of how RH is affected by gender issues. The ways that men are integrated into RH programs have everything to do with reinforcing perceptions of “right” relations between the sexes. Having recognized the underlying social constraints to RH, we then need to develop programs that address these constraints. Program evaluations and impact assessments need to reflect an orientation not only to health but also to the underlying social conditions that limit it. In other words, the promotion of gender equity needs to underlie program objectives.

For a start, are men’s and women’s needs given similar consideration? The widespread tendency to accentuate men’s sexuality, especially as women’s sexuality continues to be neglected, suggests they are not (IPPF/WHR and AVSC 1998). An emphasis on men’s perceived rights to services has led to the development of parallel services for men, but with a difference: services for men often focus on STIs and sexual performance (Collumbien 1999; Kaza 1998).

A research program to involve men in maternal care (Frontiers in Reproductive Health 2000) contains several key gender-sensitive ingredients. Acknowledging that simply participating in the study may expose women to physical, emotional or sexual abuse, each project site will practice care and discretion in discussing sensitive issues with men and women, establish systems for training staff to recognize the signs of abuse, and will refer women to services dealing with violence. The study’s research questions look at men’s willingness to accompany their female partners to several counseling sessions during their prenatal and postpartum care, the impact of their participation on contraceptive use and STI preven-
tion six months later, and any changes in gender relations attributable to the intervention. The expectation of the study is that “men and women in the experimental group will have more frequent and positive interaction regarding RH issues as well as other mutual support, compared to men and women in the control group.” Results from this intervention study are expected in three years.

**Examples of Successful Interventions**

What we know of program “successes” in male involvement is limited. Relatively few RH programs have expanded their sights to address both clinical health and gender inequities. Those few that have attempted to broaden their focus face enormous challenges to measuring their impact, as the effects of RH interventions on people’s ways of interacting and thinking about gender relations are diffuse and not readily captured by typical FP measures such as “couple-years of protection” (CYP). Experimental measures have been developed and implemented, but have not consistently been adopted. “Social impact” or “gender” indicators are still regarded as inadequate by many funders whose interests shape and support interventions and their evaluation.

One outstanding project is the visionary *Stepping Stones*, that produced a manual and series of workshops to address the spread of HIV and responses to the disease. The carefully sequenced activities for peer groups help participants evaluate their own relationships critically, and impart skills for negotiation. One exercise, for example, asks people to consider the following questions in light of local traditions:

> Are there traditions which we have in our community which involve sex, which could help the spread of HIV or other STIs? What are these traditions and why are they risky? Could there be a way in which everyone could agree to these traditions being changed, to reduce the threat of the spread of HIV? (Welbourn 1998)

The tradition that a widow marry her dead husband’s brother is one example presented in Uganda where *Stepping Stones* was originally developed. Having chosen a tradition to examine, the group then discusses how and why it could contribute to the spread of disease, and considers how some of these traditions could be modified to reduce the threat of HIV and other STIs. The manual notes how difficult it is for individuals to break with these traditions, while it provides specific guidance on ways that groups can:

> adapt or even break with tradition and permit people to behave differently, because of the threat of HIV. In this way, the local chiefs have altered the tradition to cope with modern circumstances. For instance, in one area in Zambia, widows can now jump over the legs of their dead husband’s relative, instead of having sex with him. (Welbourn 1998)
In order to keep people from feeling that their culture is under threat, the exercise specifically points out that each society has good and bad traditions, an observation that releases people to look at their own ways with a critical eye. Some of the settings where the Stepping Stones workshops have been run have witnessed decreases in domestic violence (Welbourn 2000).

Another promising example of male involvement is the work of the Society for Integrated Development in the Himalayas (SIDH). This nongovernmental organization (NGO) in northern India took on the gender-related expectations that threaten women's health during pregnancy and just after giving birth. SIDH conducted qualitative research on traditional attitudes and practices, and learned that both men and women believed hard work and the avoidance of certain (nutritious) foods were normal during pregnancy, and that women were given low priority in obtaining health care. As a result of these findings, SIDH developed a four-day workshop for young men and women aged 14 to 22, in which, as in Stepping Stones, role-playing and other techniques are used to challenge prevailing gender stereotypes. Ongoing evaluation of SIDH's gender training project will focus on how the work affects women's health. Participants report a far greater understanding of RH issues and the links between RH and gender roles (www.path.org, 1 February 2000).

Implications and Recommendations for Involving Men in RH

Involving men in RH programs traditionally focusing on women is complicated by its implications for the rights of both men and women. On the one hand, male involvement offers the possibility of making explicit steps toward social change. On the other hand, male involvement can be interpreted simply as an opportunity to provide remedial services for men long overlooked by RH systems. Men are not only individuals needing services, but they may potentially compete with women for RH resources. Men may interfere with or support women in obtaining the services women need. Men, just like women, are central to the health of their families. In the process of involving them in such programs, therefore, they must be reached on behalf of others as well as themselves.

Several crucial characteristics distinguish particularly good RH programs involving men. First, these programs all explicitly state their desire to address gender inequities as hindrances to women's and men's health. In other words, their intention to influence gender relations is incorporated into program design, and because it is explicit, it is reflected in program measures of success and impact.

Second, these programs involve the active participation of men and women they seek to serve. Rather than simply delivering new clinical services, they engage people in a consideration of the relationships and stereotypes that shape their lives and often limit their health. This
leads us to the third commonality among good programs: their work reflects an understanding of the relationships between men and women, and how these relationships determine the practices and roles that influence health. This relational approach influences how services are delivered as much or more than which services are selected. These programs coordinate outreach and clinical activities in ways that contribute to gender equity.

The hallmark of an equity-oriented male involvement program is its overt advocacy of reproductive rights through the transformation of gender relations. Deference to patriarchal and other power hierarchies is sometimes portrayed as an indicator of respect for culture. But if the RH field stands back and accepts cultural values that curtail the human rights of women, it accepts men’s power and women’s subordination. Policymakers and program designers must examine whose interests are best served by an uncritical acceptance of gender-based cultural values (Rao 1995), and then decide what is the best for the promotion of health and rights. By not involving men in policies and programs, the imbalance of power in reproductive and sexual decision-making remains unaddressed.

References & Resources


Resources

USAID’s Interagency Gender Working Group
http://www.measureprogram.org/asp_scripts/igwg.asp

The Men and Reproductive Health Subcommittee has produced a number of materials including a CD-ROM on male involvement (Johns Hopkins Center for Communication Programs, 1999. “An Essential Library of Readings on Men and Reproductive Health,” CD-ROM compiled and edited by Megan Drennan, Margaret E. Greene and Diane Rubino). For more information, contact The Subcommittee has also developed a Website on men’s participation in RH as part of PATH’s Reproductive Health Outlook Website: www.rho.org/.

EngenderHealth’s Men As Partners (MAP) Program
http://www.engenderhealth.org/ia/www/wwm.html
EngenderHealth’s Men as Partners Program aims “to help increase men’s awareness of key issues in RH and to enable men to share more equally in responsibility for FP and the prevention of sexually transmitted diseases”. In May 1997 MAP arranged an international workshop in Mombasa, Kenya on the theme: Men as Partners, Ideas from Four Continents. (http://www.engenderhealth.org/ia/www/emmb.html)

Case studies were presented from Colombia, Pakistan, Uganda and the U.S. with programs aimed at increasing men’s awareness and responsibility for the RH of the family. (http://www.engenderhealth.org/pubs/avscnews/sp97/691-map.html)

Population Council’s Toward a New Partnership, U.S.
http://www.popcouncil.org/gfd/partnership2.html (s)

In its Gender, Family, and Development Program, the Population Council publishes a newsletter on the Internet: “Toward a New Partnership: Encouraging the Positive Involvement of Men as Supportive Partners in Reproductive Health.”

The Program for Appropriate Technology in Health (PATH) Programs for Men

Men play a crucial role in their own RH as well as that of women. As husbands, boyfriends, or patrons of sex workers, men can put themselves and women at risk of disease by their sexual choices and behaviors. For these reasons, men are an important audience for RH initiatives. It is essential that RH programs shift from the traditional focus on women alone toward a concept of shared responsibility that involves men in improving their own as well as women’s RH.

Programa de Apoio ao Pai (Program for support to fathers)
http://www.ufpe.br/papai

This Brazilian Website (in Portuguese) deals with male participation in sexuality and reproduction. The project, PAPAI, links intervention, research and teaching, and is being developed in Recife, Brazil, at the Federal University of Pernambuco in partnership with the Psychological Clinic and the Laboratory of Human Social Interaction. It has as its general objective to raise the importance of youth male participation in the sexual and reproductive sphere.

The Men’s Bibliography
http://online.anu.edu.au/~e900392/mensbiblio/mensbibliomenu.html/
The Men’s Bibliography is a comprehensive list of writing on men, masculinities, and sexualities. It is free and links to other Websites.

The Men’s Rape Prevention Project, Washington, D.C., U.S.
http://www.mrpp.org

Monthly email newsletter includes late-breaking Project events and news about men’s efforts around the globe to join with women in preventing violence and rape.
PANOS publications on Men and HIV in Zambia, Swaziland, Malawi and Zimbabwe

As part of its official partnership with UNAIDS for the World AIDS Campaign on AIDS and Men, PANOS has produced four, 20-page documents on Men and HIV in Zambia, Malawi, Zimbabwe and Swaziland. These documents were developed through consultation with a diverse range of stakeholders in each of the countries, including epidemiologists, social scientists, people living with HIV, and representatives of men’s groups. They are intended as an overview for those with little or no scientific knowledge of HIV and AIDS issues.

These documents are accessible from Panos’ Website. http://www.panos.org.uk

Resource-poor organizations in Southern Africa can order the booklets free of charge.

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