

Issue paper on

Men, Sexuality and Reproductive Health

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SWEDISH INTERNATIONAL DEVELOPMENT
COOPERATION AGENCY

Department for Democracy and
Social Development
Health Division

Sida's Health Division has during the period 1996–97 elaborated three policy documents.

These include;

- A Position Paper on Population, Development and Cooperation
- A Policy for The Health Sector
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It was during this process that Sida commissioned a series of Swedish experts to formulate Issue Papers on specific areas as a basis for policy discussions. Considering that these papers are of interest to a wider audience the Health Division has now decided to publish some of them.

The views and interpretations expressed in this document are the authors, and do not necessarily reflect those of the Swedish International Development Cooperation Agency, Sida.

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The challenge

The field of population and family planning has long centred its attention on women in efforts to reduce high fertility rates. Services have been directed mainly to women, delivered through maternal and child health programmes and using largely female contraceptive technology. Men have thus been effectively excluded from reproductive health programmes and from associated research. In the now more inclusive field of sexual and reproductive health, as articulated in the international conferences in Cairo 1994 and in Beijing 1995, the individual needs, choices and rights feature more centrally. The inclusive of men's reproductive health and rights concerns and their roles and responsibilities vis-à-vis their partners/wives' sexual and reproductive health is now increasingly recognised as a central issue.

In the new emphasis on the need to "involve" men in sexual and reproductive health, it is important to look at the issue in an historical and socio-cultural context. Throughout history, every society has developed mechanisms to regulate sexuality and fertility, through institutional arrangements such as initiation, marriage rules, rules for sexual abstinence outside marriage and post-partum, and other systems for social control. The demographic transition in industrialised countries, from large to small families, took place well before the development and the diffusion of modern contraceptive technology. Periodic abstinence and withdrawal, both requiring a high degree of male collaboration, were probably the two most common methods employed by couples before modern contraceptives became widely available.

Decades of "family planning" efforts, motivated by demographic targets more than by concern with the reproductive health and rights of women and men, have taught us that we can no longer disregard the underlying social dynamics of fertility and reproduction. We now have considerable evidence to show that men's attitudes and behaviour and the inequality between men and women in sexual and social relations, profoundly affect women's ability to exercise choices and to attain good health. In this paper we discuss some of these issues, and consider the strategies needed to address men as responsible partners in sexual and reproductive health.

During the past decade, gender roles have undergone a process of transformation in many cultures and countries. The migration and urbanisation processes in many parts of the world have altered traditional ways of life and relationships between men and women.

In many societies in Africa, for instance, the lack of access to land and income is increasingly making men incapable of fulfilling the social expectation of being the "provider" and supporting the family financially. Traditional institutions are breaking up, cohabitation is replacing marriage, and political, economic and social activities once crucial for male prestige are disappearing. Men are left with a patriarchal ideology bereft of its legitimising activities—and faced with unemployment (Silberschmidt, 1995). In many cases, men have withdrawn from their earlier responsibilities, leaving the women to manage the home and care for the children. This seems to have strengthened women's identity and self-esteem, while men are often reduced to being "figureheads" of households, a form of marginalization. Their authority has come under threat

and so has their identity and self-esteem. In such development processes, the relations between men and women become tense, antagonistic and sometimes violent. Other consequences of urbanisation and uprootedness are poverty and prostitution.

In Southeast Asia, rapid economic development and urbanisation in recent decades have changed the living conditions of many people. This has occurred in a context of strongly patriarchal cultures where male dominance has been unquestioned, son preference is strong, and premarital sexual relations for women are strongly condemned while men are encouraged to get sexually experienced before marriage. Yet, old family structures and support systems have been weakened. The vulnerability of Asian women in this process is well documented, e.g. in the dramatic increase in commercialisation of sex and in domestic violence. Women's reproductive dilemma in fulfilling the family's expectations for a son to carry on the kinship line while limiting fertility to the official one- or two-child norms, is a striking feature in for example Vietnam and China where population policies are coercive. Less well known is how socio-economic transformations influence men's role, identity and their sexual behaviour. How do men experience the dramatic demographic transition which is now occurring in many South East Asian countries, where family size in some countries has gone down from 6 to 2 in a few decades? What does it mean to men to not get a son?

In this global context of rapid social transformation, instability and conflicting norms and values, male control over women's reproduction and sexuality seems to have become increasingly important to male identity in many societies. Male identity seems on the whole to have become linked to sexuality in a more profound way. Sexual activity with many partners gives prestige. Men, including husbands, have wide **sexual networks**. Geographic mobility by choice or force may contribute greatly to sexual mobility and a broader base for establishing a network of partners. Evidence from HIV/AIDS research suggests that, a wife is not in a position to refuse her husband sexual services or to ask him to use condoms even when she suspects him of being infected. As a result, women are exposed to considerable risk of contracting STDs including AIDS from their husbands.

Sexual abuse of youngsters also occurs increasingly in contemporary societies. In Eastern and Southern Africa, men have developed a preference for young girls, "spring chickens," said to be "cheaper" as well as free of HIV. Particularly in urban contexts where social control is diminished, the "sugar daddy" phenomenon has become widespread. In many countries in Asia, young girls and boys are recruited into the sex industry for economic reasons.

The meaning and purpose of sexuality

Male sexuality is varied in its forms and expression. The sexual life of men tends to be longer than that of women, often starting younger, involving more partners, and lasting longer. However, there are big gaps in our knowledge of male sexuality, particularly in the developing countries. One way of understanding male sexuality and sexual and reproductive health is to analyse the forms of relationships that men are involved in during different stages of their lives (Orobaton and Guyer 1994). These differ in meaning and purpose and satisfy different needs.

The boy child goes through a **socialisation process** to become a man. Peers and elders are important in this process as well as “idols” with whom one can identify. In many societies, young boys pass through special **rites of initiation** into adulthood at puberty where they are taught central values and initiated into sexual activity. In Kenya, among the Kikuyu people, boys are circumcised around the age of 10–16 and are nowadays pressured by peers into having sexual intercourse soon thereafter. They are even instructed on how to negotiate for sex with women (Ahlberg 1997). But some of the rituals are also changing with far-reaching implications for the sexual and reproductive health of women and men.

Whatever the content of socialisation, it entails an institutionalised form of transmission of knowledge and symbols, which facilitates the process of transformation from childhood to adulthood. Today, socialisation patterns have increasingly become distorted. Young boys are left to cope with their sexuality within a paradoxical environment of prohibitive attitudes, romantic love, and yet apparent sexual freedom for men. In some cultures in the Far East, e.g. Thailand, Vietnam and Burma, young men are often encouraged to visit prostitutes to gain their first sexual experience. Most societies encourage men to experiment sexually before marriage while the same behaviour is discouraged in young women. The dilemmas which arise in the relationships of young people as a consequence of this double standard are considerable. More significantly, these socialisation processes shape the male sexual role and identity in his expected domination of the female.

Unmarried men are looked down upon and are consequently pressured to marry by relatives and friends. They are also expected to reproduce. Due to this, some men marry for no other reason than to demonstrate their sexual potency and fertility. Appreciation of conceptions of potency, fertility and the regeneration of life contributes to an understanding of male sexual behaviour. The meaning of semen is also significant in this context. In many cultures it is considered a life-giving force. In some African societies, for instance, it is believed that semen is meant to flow freely into the female body. This has been found to have implications in the prevention of STD/HIV. To hamper this process by the use of a condom, which also reduces semen to flow, is considered a waste (Talle 1995). Many young women believe semen is a necessary ingredient they need for their physical and mental development and that of their babies.

Procreation and **fatherhood** are central to male identity. The desire to have a son is fundamental to men in many cultures as a means of continuing the line of kinship. Having many children is perceived of as an advantage. Men (as well as women) still expect to be taken care of by their children during old age. In contemporary societies this insurance is most guaranteed when the children have been adequately educated. Taking **responsibility** for one's offspring is central everywhere. However, there is variation in what people in different cultures consider to be responsible male behaviour vis-à-vis their children and in different types of relationships. The social organisation of labour, household, and family often determines patterns of social support. In many societies today, men's participation in child care and birthing is seen as fundamental to good bonding and responsibility-taking. In some countries, such as Sweden, national legislation has been used to encourage this. In other societies it is not considered manly to participate in birthing nor to have responsibility for child care or domestic activities.

Another central aspect of sexuality, and a strong motivating factor for men (and women), is **sex for pleasure**, a dimension which is seldom addressed in the sexual and reproductive health (SRH) context. Expression of men's sexuality entails the involvement of **peers** who provide feedback, reinforcement, and sometimes even logistic support and cover to carry out sexual activity without hindrance. However, the **pressures** that men and boys place on each other with respect to sexual and reproductive behaviour are considerable and important to understand. Boys in many cultures face the pressure to have early sexual experience to prove that they are men.

Homosexuality and **bisexuality** occur in all societies, more or less accepted or hidden. In most societies, homosexuality is forbidden in both customary and other forms of law and it is practised in secrecy. In societies with muslim influence, including the coastal cultures of Africa, male homosexuality is tolerated as a sexual variation. However, men marry, beget children and obtain a social position in their community (Fuglesang 1994). Homosexuality is known to develop in single-sex settings such as boarding-schools, prisons, the military, and increasingly in sex-tourism. However, the practice is more an expression of sexual variation than of sexual identity, as it tends to be in contemporary western societies. Most people will enter into heterosexual relations and reproduce if they are fertile, because they are expected to do so.

Focusing on men

In the context of changing gender roles and male sexuality discussed above, the need to take men on board in SRH is urgent. The need is even greater when one examines the output of major SRH programmes including fertility regulation and STD/HIV control.

Why has the need to focus on men increased?

In demographic terms "family planning", which has dominated the SRH field since the 1950s, has not performed according to expectations. The neglect of men has been described by the International Planned Parenthood Federation (IPPF) as the major impediment to the success of family planning in sub-Saharan Africa. Moreover, with the emergence of HIV/AIDS, it has become apparent just how little knowledge we have about male sexuality. At the same time, the dominant role of men in the transmission of STD/HIV has become clear.

Female reproductive and sexual behaviour cannot be separated from that of men. The most consistent research findings from different parts of the world suggest that in most societies men play the dominant role in reproductive **decision making**. A woman's male partner influences not only whether she will use a contraceptive but also how well she will use the chosen method. In Zimbabwe, a survey showed that nearly half of the married women believed that men alone should be responsible for family planning decisions (Kuseka, 1990). In many places this tends to be the opinion of men as well. A partner may also influence a woman's decision to undergo an abortion. In Vietnam a study among married women who had had abortions showed that men were almost always involved in the abortion decision. Men's arguments for an abortion showed concerns about family economy and the health of their wives, while those who were against abortion had ethical doubts or hoped for a son (Johansson 1997).

The present situation of STD/HIV shows a similar pattern. Due to their powerlessness, women have little possibility to refuse sexual intercourse even when they may suspect their husbands of being infected. They also delay seeking care.

Although women are in control of certain spheres of their lives, they are still **subservient to men** when it comes to sexual and reproductive health. The division of labour between partners often allots a larger share of the burden to women. They are often expected to behave submissively towards their husbands who have the recognised right in many cultures to discipline their wives through various means such as wife beating. In many societies, marriage often involves little companionship between spouses. Interspousal communication and joint decision-making with respect to sexual and reproductive matters tend to be quite limited. Abuse is still widespread, even in contexts of love and strong conjugal bonds.

The **empowerment of women** in spheres of sexuality and reproduction entails the ability for women to decide freely about their fertility, to enjoy their own sexuality and to have the means to protect themselves from diseases. The separation between sexuality and reproduction which is facilitated by modern contraceptive technology, has in some respects given women greater control over their sexuality, and, consequently, reduced the control of men. Such shifts in the life situation of women require the collaboration of men; the men in their personal lives and the men in positions of institutional power. Although men may be open to learning about fertility regulation and have knowledge about the form and function of contraceptives, there is a wide gap between contraceptive knowledge and actual use. We know less about why and how men act in ways that are incompatible with fertility regulation and sexual health. Some studies indicate that, among other things, men fear, probably rightly so, that changes in the rights of women will change the power balance between men and women.

The challenge of deeply rooted gender roles and authority patterns naturally leads to insecurity and even resistance. Consequently, the dilemmas men experience as lovers, spouses, fathers, and sometimes also partners in homosexual relations, are many in today's changing society. Men need knowledge and support to deal with regulation of sexuality and fertility in this context. In most places, men are still lacking the information, services, resources and the sense of dignity that comes from the capacity to participate.

To be successful in reaching men, we need to take a perspective that acknowledges both the dominance of men over women as well as the **needs and rights of men** themselves. Men, like women, have their own sexual and reproductive needs and problems, even in the present situation of gender inequality. For example, they often do not have adequate access to counselling and health services for contraception and STDs.

Recently, the issue of male SRH has started appearing on the agenda of many international and national organisations. New attention has been given to male contraceptive methods, including vasectomy and condoms, the latter being also instrumental for the prevention of disease. There has also been increasing attention directed to understanding male sexuality, and the socio-cultural, economic and political factors that shape it. This new perspective is also a consequence of the debate about the need to promote the rights of women everywhere, which has largely been promoted by women's health groups and increasingly by policy makers and programme planners. This has led to a greater awareness of **gender**

relations, that is, inequalities and the ways these are expressed and can be changed. Policies and programme declarations addressing male SRH are being formulated. Both the Cairo and the Beijing plans of action have provisions for male involvement. Research has received new impetus, and pilot projects are being initiated. It is important to tackle the issue at different levels, but much of this initiative is still rhetorical. In the following section we shall, however, explore some attempts to get practical activities off the ground.

Strategies for reaching men with information and service

During the last decade, many organisations have launched pilot programmes to try to involve men in different aspects of SRH. Principally, this has been done by “family planning” associations as an attempt to increase the acceptability and use of contraception. HIV/AIDS prevention work, through government as well as NGOs, focusing on changing sexual behaviour and increasing condom use has contributed to some extent. With the emergence of AIDS and the knowledge of the link between conventional STDs and AIDS, integrating fertility regulation and STD control has emerged as a strategy. In this context, men are increasingly in focus. Experience has shown that attitudes are easier to change than behaviour and there is a great need to address the specific information and service needs of men. What is needed is **creative initiative** that can challenge the conventional view of men as obstacles in SRH. Existing resources and channels of communication in local communities need to be used in an optimal and yet sensitive way. In the following, some examples are given of attempts to increase contraceptive use through male involvement (see FHI, 1992).

In Zimbabwe, the National Family Planning Council (ZNFPC) launched an ambitious nation-wide **male motivation** project in 1988, addressing men exclusively. This education project was the first of its kind in sub-Saharan Africa. The project was designed to increase knowledge of family planning, to promote more favourable attitudes among men, to increase contraceptive use, and to promote joint decision making. It relied heavily on popular radio, serial drama, motivational talks, and family planning leaflets to promote the messages. The radio drama was by far the most effective method, reaching about two out of every five men surveyed, covering both urban and rural areas. Men in rural Zimbabwe have radios so the serial drama reached them and influenced their thinking. Between 1988 and 1990 the proportion of men reporting that family planning is a joint decision increased from 25% to 35%.

Community and **peer counselling** has been used in Pakistan. In a pilot project run by the Urban Community Development Council (funded by USAID), male educators visit families to talk specifically to men about fertility regulation. In rural areas the programme is reported to be very successful. In four years the contraceptive prevalence rate among married couples increased from 9% to 21%. In urban areas, however, the “city mentality” proved to be an obstacle. However, community-based distribution programmes which seek out men in their homes or in their workplaces have proven to be successful in encouraging men to use contraceptives. The use of “peer counsellors” is a model that is popular and cost-effective. It is also used increasingly in youth outreach programmes (such as UMATI in Tanzania) where boys and girls are recruited to counsel their peers.

Quite a few family planning associations in Africa have initiated **employment-based** programmes. Discussions are held with the management of companies, factories and industrial plants, and these are encouraged to include “family planning” services and counselling at their company clinics. The private sector Family Planning Programme in Kenya is similarly organised. In 1988, 50 companies and plantations were involved. This is perhaps one of the most successful programmes in the country measured in terms of contraceptive acceptance. In 1987, the Planned Parenthood Association of Zambia launched a motivational campaign for male industrial workers providing counselling and information about a whole range of contraceptives. It is considered to be quite successful.

Some HIV/AIDS prevention programmes are also often **employment based**, such as the truck drivers’ programme run by AMREF in Eastern Africa. Condom distribution and peer counselling along the highways where the drivers stop have been central here. Some organisations have also set up employment-based programmes in collaboration with state institutions. UMATI in Tanzania, for instance, has activities targeting men in the military, the police and even in the prisons for contraceptive use. Uganda’s AIDS control program was one of the first in Africa to use this kind of initiative. In Asia, Thailand has extensive experience with male motivation programmes through the private sector as well as with community-based distribution.

Another service delivery model targeting men is the exclusive **male clinic**. In Colombia, Profamilia, one of the largest family planning associations in the world, opened its first clinic for men in 1985 in Bogota. (Today 8 of the 50 clinics are all-male clinics.) These clinics usually have a separate entrance and waiting room for men but are connected to female clinics to increase cost-effectiveness. Men get special attention at the clinic, and the staff are mostly men. This helps visitors feel at ease and ensures them of privacy. The clinic offers a wide range of integrated SRH services, e.g. counselling on sexuality, information and instructions for contraceptives such as condoms, STD treatment and vasectomies. The clinic is self-sustaining, as it charges for some services. They have become very popular and successful in attracting men. Individualised care, a wide range of services, Saturday hours, and a very attractive facility are said to be the most important criteria for success.

An increasing number of family planning associations in Africa are setting up **male clinics** today. However, these are not very broad in their service delivery, focusing mainly on vasectomy promotion. In Africa and in many Asian countries, there is considerable resistance against this method, from both men and women. Myths and misconceptions are many. The practice scares men, who associate it with castration and impotency. Even women are sceptical, as they too believe that it affects men’s potency and maleness. In Vietnam, where the male/female sterilisation ratio is 1:14, many women prefer to get sterilised themselves rather than having a sterilised husband. (Johansson 1995).

Social marketing of condoms has done much to catch the attention of men, who are the users and primary buyers of condoms. Resistance towards condom use, based on both social and technical grounds, has been common. Many men are of the opinion that it reduces the sensitivity. Young adolescent men experience technical problems. Often the condoms are too big for them as they are not fully grown. As men tend to wear condoms with ‘temporary’ partners outside mar-

riage, women associate condom use with prostitution and are sceptical to usage. This attitude is slowly changing, but condoms are still seldom used within marriage due to the association with promiscuity and the fact that spouses seldom talk about sexual issues.

In Sweden, projects for men have mostly concentrated on raising men's awareness of gender roles, strengthening male identity, and discussing felt needs and problems. Projects have stressed the importance of male self-esteem and men's rights to sexual and reproductive counselling and services. Quite a lot of work has also been done to train adult men to counsel boys about sexuality and intimate relations in "men to men" talks, the rationale being that boys need good role models as well as contact and dialogue with adult men (Centervall 1995).

In summary, the approaches to enhance male participation and responsibility in SRH are many and varied, but so far both research and actual programmes are limited. There seems to be little consensus on the best way to provide services and education/information to men. Realities of limited resources make separate services for men less economically feasible on a large scale. Most effective and sustainable may be those programmes and community-based services that are acceptable and appropriate both to men and women. Ideally, the long-term objective of all SRH programmes must be to encourage partnership and joint decision making between men and women in matters of sexuality and reproduction. However, prevailing male dominance and cultural rules for gender segregation may in some settings necessitate separate solutions for men and women, at least in the beginning. The key to any intervention is that services are of a high quality, offered in a respectful way and sensitive to culture, gender and age.

Although it is necessary to initiate programmes for men, some people will protest. Some women's activist groups that have struggled for the recognition of women's needs and rights in recent decades tend to be sceptical of this development. They fear that directing attention and resources to men's SRH needs and rights will jeopardise the benefits gained so far by women. While this may be true, and caution is needed, others, especially feminists involved in social work where they deal with men and violence, have started advocating working with men as part of the feminist agenda. They argue that women's liberation is not feasible by working with women alone (Cavanagh, 1996). This, then, points to the essence of the challenge of "involving men" in SRH.

Conclusions

- Locally specific, qualitative research is needed to explore the context and meaning of male sexuality and reproduction as well as men's problems and concerns to manage their sexual and reproductive health and to support that of their partners/wives.
- Operational research is needed to implement, monitor and evaluate interventions for male involvement in SRH programmes, taken in the broad sense of the word.
- Programmes for male involvement in SRH should be the joint undertaking of governments, international and bilateral organisations and NGOs.

- Governments should take responsibility to develop sustainable and multi sectorial SRH services and education addressing men, integrated in regular services wherever feasible and appropriate.
- Training of trainers and health workers to address these issues is a vital task.
- NGOs, which are usually more flexible and can act at grass-root levels, should be supported to develop and test innovative approaches to male SRH programmes in close partnership with local groups.
- International and bilateral organisations have an important role not only as founders of research and interventions, but to help facilitate exchange of research and programme experiences between and within countries and programmes.
- Programmes which are already supported, such as those on gender awareness, must be encouraged to start addressing male issues in a more consistent way.

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