



## MEN AS PARTNERS IN REPRODUCTIVE HEALTH

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**Abstract:** *If men are to exercise their reproductive rights and responsibilities, they, as much as women, need access to information, counselling and services. For too long men's role has been seen as marginal to women's health. Yet in the Asia Pacific region as well as many other countries, men are the main policy makers, household heads, and religious and community leaders. Thus when men are involved in matters of sexual and reproductive health, such programs are more likely to be effective.*

### **Introduction:**

Since the International Conference on Population and Development (ICPD) in 1994 in Cairo, there has been a paradigm shift away from programs focusing solely on women's health and family planning towards sexual and reproductive health more generally. For too long, men's sexual and reproductive health needs were overlooked. And yet significant numbers of men, particularly in poorer countries, still engage in unprotected sex. Men want and need reliable and accessible information and services that can help them lead healthy sexual lives, but often they do not get them, especially in developing countries (Gutmacher 2002).

Many maternal and child health programs in the Pacific, for instance, simply do not cater enough to the needs of men and adolescents (White 2000). And around the world, even where the sexual and reproductive health needs of married men might get some attention, those of young men are neglected (Rivers et al, 2002).

While men have specific and often neglected needs, their roles and responsibilities also impact on the health and well-being of women and children (Power et al 2005). Thus, in those cultures – notably the Pacific - where men are the main decision makers in the family and community, if men are supportive of the goals of reproductive health programs then it might reasonably be expected that the programs are more likely to achieve success.

### **International recognition of men's role in reproductive health**

The International Conference on Population and Development (ICPD) was one of the first international conferences to recognise the male role in reproductive health (ICPD 1994). Its Programme of Action (POA) stated:

*Innovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescent and adult men. Such programmes must both educate and enable men to share more equally in family planning and in domestic and child rearing responsibilities and to accept the major responsibility for prevention of sexually transmitted diseases...*

As the POA also notes, given that men play a significant role in women's sexual and reproductive health outcomes, it 'adds value' to women's health to engage men as partners in programs.

The same message was reinforced at the 1995 World Conference on Women in Beijing

*"Shared responsibility between men and women in matters related to reproductive and sexual behavior is essential to improving women's health." (RHO 2006)*

## **Barriers to involving men in sexual and reproductive health programs**

In designing programs that involve men, there is often lack of information about men's perspectives that might help. In addition, because reproductive health services were directed solely at women for so long, many men feel out of place or unwelcome at reproductive health clinics. As we know in our own culture, men are hesitant to seek medical care and in particular, sexual and reproductive health care. Men can be viewed as irresponsible or not appropriate clientele at some reproductive health services. Sometimes there are unfavorable policies, such as prohibitions on condom advertising which exacerbates the problem that there is not the same range of contraceptives available for men. Or there may be logistic constraints, such as lack of trained male staff, male-friendly clinics, convenient hours, or separate waiting and service areas for men (RHO 2006).

## **Designing programs that involve men**

Tending to men's needs may include a number of strategies such as adding services for men to existing clinic-based services, as in Bangladesh (Al-Sabir et al 2004) or establishing separate services. Men can be reached through the workplace, the military, or men's groups with information and services. Condoms can be distributed using male field workers or through social marketing. There may be outreach programs to male youth through popular sporting events or mass media educational campaigns (RHO 2006).

Some of these strategies were used in a broader family planning program in Zimbabwe (Kim et al). Despite a relatively successful family planning program in that country that had achieved 36 per cent contraceptive prevalence by 1988, average family size still remained high with 5.5 children per woman. The program had largely been directed at women and most of the contraceptive use was short-term (the pill). Recognising that men, however, exerted great influence on family size and family planning decisions, the Zimbabwe National Family Planning Council pioneered a successful male motivation campaign in 1988-89 and another in 1993.

*The second round included radio dramas—in two vernacular languages as well as the lingua franca, English—radio and television spots, posters, newspaper and magazine advertisements, pamphlets, a football tournament with giant puppet shows at half-time, other puppet shows, motivational talks, family festivals, and live dramas. Planners also used messages and images designed to appeal to men, such as language borrowed from competitive sports and pictures of local football heroes. (Kim et al 1996)*

Probably as a result of higher contraceptive and primary health care costs, contraceptive use had been declining prior to the campaign. The trend reversed, however, with the onset of the campaign and demand for long-term contraception e.g. IUDs, and permanent methods e.g. vasectomies, began to rise. Most encouragingly, couples exposed to the campaign discussed family planning more and men involved themselves more in decisions on contraceptive methods. The method of choice in many of our partner countries is actually vasectomy but we rarely see information and education about this method being promoted, perhaps because in the past it was not carried out very well. It is now time to re-visit that issue.

## **Concerns about involving men in broader SRH programs**

Despite the overall success of involving men in programs such as this, there have been genuine fears that involving men in family planning education and services could further erode women's control over reproductive health decisions (RHO 2004). Reproductive health services have allowed many women a degree of autonomy over their own lives. Many fear that, without genuine gender equity, involving men will perpetuate existing gender inequalities. One unexpected result of involving men in the otherwise successful family planning campaign in Zimbabwe (above) which encouraged men to play a greater role in family planning decisions was an increase in the percentage of men who thought that they should have *sole* control over contraceptive decision-making. It is also feared by some that involving men in decisions over abortion could have similar negative consequences.

## **Competition for funds**

The question also arises as to whether programs involving men as partners will compete for funds with programs designed for women's health where resources are limited and needs abundant. In many countries, where women still carry the burden of sexual and reproductive ill health, it is imperative that funding for women's health services not have resources taken away from them. One researcher, de Schooter, argues that while there are still gaps in the research regarding the benefits of involving men in reproductive health programs and even data on proven successful strategies with men, it is difficult to commit fully to men's health where there are limited financial and human resources (de Schutter 1999).

## **Women's attitude to men's involvement**

Nevertheless, women generally express interest in man's participation in sexual and reproductive health. In a Kenya study, 90 per cent of women said they desired men's participation in antenatal care, post-partum visits, and family planning visits. Fewer women, however, wanted husbands present during physical examinations (67%) or in the labour ward (63%) or during delivery (50%). Young mothers in Istanbul, Turkey, expected their husbands to be involved in family planning and child care. In Cochabamba, Bolivia, 90 per cent said that men should support their partner's decision to practice contraception. On the other hand, women in Mexico wanted to be counselled separately from their partners on the issue of sexually transmitted infections (Blanc 2001).

## **Gap between men's desire to help and action**

In a number of studies, men's desire to help does not necessarily translate into action. In Baroda district, India, for instance, men indicated an interest in accompanying their wives to ante- and postnatal checkups yet only half were aware whether their wife had had such care during her last pregnancy. In Kenya, most men felt positive about men's involvement in reproductive health services, yet only two-thirds of women said their partners were aware of their visits. In Turkey, husbands wanted a closer relationship with their children in the post-partum period than their fathers had had with them, yet said they did not know how to help. Husbands of adolescent wives in Maharashtra State in India advised them to lighten their loads during pregnancy but rarely took over the domestic chores themselves (Blanc 2001).

## **The need for gender equity**

Gender inequality has a strong influence on reproductive health status. It would appear self evident, therefore, that involving men effectively in sexual and reproductive health programs has to incorporate means to reduce such inequality. It is important to take into account, when designing such programs, the interplay between men's and women's roles rather than focusing on either alone. All care must be taken to avoid implementing programs that worsen existing male dominance (Helzner 1996).

## Conclusion

Men's sexual and reproductive needs had been overlooked for a long time until the ICPD in Cairo in 1994 where it was agreed that information, counselling and services must be made available for men. At the Women's Conference in 1995 in Beijing, it was argued that shared responsibility between men and women on these matters would improve women's health. With men as the main decision makers, particularly in the Pacific, it would seem obvious that involving men would indeed enhance women's health. There are certainly success stories of men's involvement, such as that in Zimbabwe. On the other hand, women in developing countries are still at an enormous disadvantage health-wise and in terms of equity, and there is the danger that involving men may take resources away from badly needed resources for women, or take away the autonomy they had acquired through women's only programs. Nevertheless, assuming programs can be developed that work actively to decrease gender inequality, it should be possible to provide for the sexual and reproductive needs of both men and women, without disadvantage to either.

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