

Part III.J
Male Involvement
in Reproductive
Health Programs

- Number of visits to male-focused services, by type of service
- Percent of men (husbands) who are supportive of their partner's reproductive health practices
- Percent of contraceptive method use requiring male cooperation
- Percent of men and women who discuss reproductive health issues with their spouse or sexual partner

MALE INVOLVEMENT IN RH PROGRAMS

Reproductive health programs have traditionally focused on women. However, since the ICPD Conference of 1994, programs have paid increasing attention to male involvement in reproductive health services. The Cairo Plan of Action highlighted the need to “promote gender equality in all spheres of life... and to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles” (United Nations, 1994). In recent years, family planning and other reproductive health programs have increased their efforts to involve men in their programs, because they recognize that men have an important influence on women’s and children’s health, as well as distinct health needs of their own. Many advocates for involving men in reproductive health programs believe that involving men can lead to greater gender equity.

Gender is often misunderstood as a synonym for women’s issues, but gender refers to the socio-cultural roles of both women and men. Men as well as women face gender-related barriers to reproductive health. Gender-sensitive programs recognize that gender inequalities between women and men significantly influence the sexual health of both men and women. Programs that aim to improve the status of women must also recognize that men influence the status of women’s health.

Gender norms that act as barriers to women’s involvement in reproductive health programs also act as barriers for men. Men are frequently described as the forgotten clients, particularly for family planning services. Men face both socio-cultural barriers and institutional barriers to involvement.

Socio-cultural definitions of masculinity may make it difficult for men to seek reproductive health information or services. Men who wish to limit their family size often face gender norms that equate number of children with virility and that discourage men from using reproductive health services of any kind. Some societies encourage men to take sexual risks, such as frequenting sex workers. Some have suggested that risk-taking be-

havior also extends to having sex without condoms (Foreman, 1999). Some cultures equate masculinity with exercising power over women. Men’s fears of losing power (often triggered by women becoming primary decision-makers about family planning) can lead to gender-based violence.¹

Men who do wish to use available services also encounter gender barriers. Men’s involvement in the health system often stops at the door to the clinic. When they accompany their partners to a facility, men may find an absence of programs that encourage or allow them to participate. Men are concerned about preventing and treating sexually transmitted infections (STIs), yet often they do not know where treatment is available. Men also worry about impotency and infertility; they are more likely than women to work in areas with environmental or occupational hazards that can lead to reproductive health problems. However, clinics and programs, especially in remote and rural areas, focus on women’s health.

Approaches and Objectives of Male Involvement Initiatives

Greene (1999) describes the evolution in initiatives aimed at increasing male involvement in reproductive health – specifically, she outlines four approaches to male involvement:

The traditional family planning approach: This approach, which dominated the field prior to Cairo ICPD in 1994, predominantly focuses on providing contraceptive methods to women for the purpose of reducing fertility.

The men and family planning framework: This approach assumes that men can prevent women’s contraceptive use and that they themselves are an untapped group of potential contraceptors. It treats males primarily as a means of increasing contraceptive prevalence.

¹ See Part III.K for more discussion on violence.

The male equality framework: This approach is characterized by programs designed to serve men as RH clients in much the same fashion as programs have served women, consistent with the Cairo Programme of Action that called for increased attention to the individual needs of women, men, and adolescents.

The gender equity framework: This approach addresses the relationship between women and men and the sharing of responsibility and action. It focuses on men as supportive partners of women, and thus reflects the spirit of the ICPD document and the transformation of social roles that constrain reproductive health and rights. It emphasizes the ways services are provided and the opportunities to deliver and reinforce messages supportive of gender equity rather than specifying which RH services should be provided and to whom.

RH initiatives directed toward women generally have clearly defined behavioral objectives: to increase contraceptive prevalence, to increase the use of a skilled birth attendant at delivery, to increase the use of condoms for STI/HIV prevention, to increase the prevalence of breastfeeding, and so forth. In contrast, no single common behavioral objective underlies male involvement programs, and in some cases, they have no discernable behavioral objective. Rather, such programs view participation of males as an end in itself.

To the extent that male initiatives have had specific behavioral objectives, they have evolved over time, consistent with the four approaches outlined above. Under the first two (traditional and men and family planning), the primary objective tended to be the same as for women's programs: to increase contraceptive prevalence. However, programs that have adopted the third approach (male equity) seek to increase utilization of male-oriented RH services, the first of the objectives described below. Programs with a gender equity focus often have one or more of the remaining objectives listed below: to increase couple communication, to increase support for women's RH practice, and to change societal gender norms that harm women's health.

With the expansion of reproductive health beyond family planning to a broader range of subjects, the potential for male involvement also increases. For example, males often play the dominant role in sexual decision-making, directly related to prevention behaviors for HIV/AIDS. Men play a crucial role in providing financial and logistic support for women in need of emergency obstetrical

care, as well as postabortion care. Adolescent programs seek to reach males as well as females, not only with information and services to protect themselves and their partners, but also with messages regarding gender equity. Males are also part of the intended audiences for initiatives to eliminate FGC. Whereas family planning programs tended to focus largely on women, the expanded range of RH interventions calls for an expanded role for men. In short, where the objectives of male initiatives extend beyond simply increasing contraceptive use, they tend to include one or more of the following objectives.

(1) To increase utilization of male-oriented RH services

Men's reproductive health needs include a wide range of services: family planning, treatment and prevention of STI/HIV/AIDS, infertility, sexual problems (impotency), and others. They also need clinics and doctors that provide confidential and non-judgmental care. Program staff should be aware that, like women, men are not a homogenous group. The needs of adolescent males, married men, older men, men with HIV/AIDS, and homosexual men differ. However, reaching men is more difficult than reaching women, for whom maternal and child health services have been designed. Traditionally, men are much less likely to have used a health clinic than women are.

Male-oriented services take several forms. Some countries have established male-only clinics. Others have established special hours (or evenings) for men at facilities oriented to women or to the general public. Others have publicized existing services more widely (e.g., STI treatment or vasectomy) to reach a larger number of men, or they have added services to increase options for males and to improve existing services (e.g., no-scalpel vasectomies).

(2) To increase couple communication

Research to date in the area of family planning shows that couples who make contraceptive decisions together tend to have higher rates of contraceptive use (Huezo and Malhotra, 1993). Women may have perceptions about their partner's ideal family size or desire for more children that prove false when the couple actually discusses the subject. Similarly, couple communication is essential for negotiating condom use or use of natural family planning.

While increasing couple communication is a desirable objective, we mention several caveats. Increasing couple communication does not necessarily improve communication. Nor does it ensure that women will have an equitable role in decision-making. Programs must ensure that they do not inadvertently undermine women's ability to make RH decisions by involving men. For example, one campaign in Zimbabwe used athletes to encourage men to play a greater role in family planning decision-making but actually increased the percentage of men who thought they should have sole control over contraceptive decision-making (Piotrow et al., 1992).

(3) To increase partner support for women's RH practice

In addition to addressing men's own reproductive health concerns, involving men may improve women's health. Women generally do not make decisions about their own reproductive health in a vacuum. Rather, their husbands as well as other family members influence them. Men are instrumental in providing the necessary physical, financial, and emotional support to give women access to reproductive healthcare, or conversely represent obstacles for many women who wish to protect their reproductive health. Some programs seeking to better women's health encourage men to:

- Ensure that their partners have adequate nutrition during pregnancy;
- Ensure that their partners seek prenatal care;
- Ensure that their partners seek emergency obstetrical care, if needed;
- Prevent the spread of STI/HIV; and
- Provide support for families by encouraging education for both boys and girls, adequate nutrition, and healthcare for all.

However, not all women want their partners "involved." Some use contraceptives against their husbands' wishes or without their husbands' knowledge. Others are afraid to raise the subject of family planning or condom use for fear of violence. In short, programs need to ensure that the female clients **want** their partners involved before programs proceed to involve them.

(4) To change societal gender norms that harm women's health.

Although changing social norms may seem an impossible task, over the past 30 years, we have witnessed a dramatic change in the norms governing the acceptability of family planning. The concept that having a large number of male children is a sign of masculinity has changed in many countries around the world. Some programs have begun to focus on men with the objective of influencing social norms related to promiscuity, forced sexual intercourse, and violence. In Nicaragua, for example, a UNFPA program "Apoyo a los Servicios y Acciones de IEC del Ejército de Nicaragua en Derechos y Salud Sexual Reproductiva" (Support for Sexual and Reproductive Health Services and IEC Initiatives in the Nicaraguan Army) worked to sensitize soldiers in the National Army to issues of sexuality, in particular STI prevention and gender-based violence (UNFPA, 2000).

Other programs have promoted specific behaviors that reduce risk to both men and women: encouraging abstinence or delay of sexual initiation, reducing the number of sexual partners, and consistently using condoms for sexual relations, especially with non-regular partners.

Programs dealing with larger cultural issues, such as female genital cutting and the early marriage of females, have also begun to include men in their programming with the objective of changing their attitudes on these deeply entrenched practices.

Methodological Challenges of Evaluating Male Involvement Initiatives

Despite the recent surge of interest in this area, relatively few organizations have evaluated effectiveness of these programs. Most projects have been small in scale, and few have been subjected to rigorous evaluation. Even though male involvement initiatives are still in their infancy, several challenges for evaluating these programs are already evident.

- **Many male involvement initiatives lack clear behavioral objectives.**

The purpose of program evaluation is to determine whether the program has achieved its objectives. In al-

most all other areas of RH, intermediate objectives refer to expected changes in knowledge, attitudes, and behaviors that, over time, lead to improved health outcomes (e.g., decreases in fertility, mortality, and morbidity). Many male involvement initiatives to date have focused on male participation in activities seemingly as an end in itself, not as a means to meaningful behavioral change. Others share the objectives of programs designed to reach women (e.g., increase contraceptive use), but lack the means to isolate the role of male involvement in the process. Programs generally work on certain underlying assumptions regarding the benefits of male participation, but few programs have designed interventions based on a clear conceptual framework – illustrating the pathways by which male participation will improve RH behaviors and outcomes – that provides the basis for systematic evaluation.

- **Because of the historic focus of the RH field on women, relatively little data exist on men.**

The 1980s saw growing recognition of the role men play in family planning decision-making; consequently, the DHS began to collect a limited amount of data on males, as a complement to the conventional DHS-data collection for women. With the spread of the AIDS epidemic, males have assumed a higher profile in RH interventions: as a result, the DHS and the RHS surveys have collected more data on men. However, routine service statistics often capture conventional service utilization, which focuses on women and children, not on men. In short, data on men are less available than data on women are.

- **Quantitative measures (from the DHS/RHS or service statistics) do not capture the complex issues involved in gender dynamics.**

Despite the traditional reliance on quantitative indicators, these indicators will not be sufficient to guide the development and refinement of male involvement programs. To complement the quantitative indicators (such as those listed in this *Compendium*), programs will want to use a variety of qualitative techniques to assist them in designing and evaluating programs in the future.

The indicators presented in this *Compendium* are by no means exhaustive. Rather, they represent illustrative indicators corresponding to the four common behavioral objectives of male involvement interventions, outlined above.

As mentioned above, the evaluation of most male involvement initiatives focuses on process measures of male participation in activities. Few to date have actually measured these interventions in terms of outcomes (e.g., knowledge, attitudes, behavior). The indicators that follow illustrate the types of measures that evaluators can apply to male involvement activities in the future, depending on the actual objectives of each intervention. In addition to the indicators presented in this section, male involvement programs can also use a number of the indicators presented for Behavior Change Communication Programs. (See Part II.F.)

Indicator

NUMBER OF VISITS TO MALE-FOCUSED SERVICES, BY TYPE OF SERVICE

Definition

The number of “visits” – each occasion on which an individual seeks assistance from a given facility (or male-focused service within a larger facility)

The number of visits will be the same or greater than the number of persons using the service (reflecting some repeat visits to the service).

Data Requirement

Number of visits, by type of visit

Data Source(s)

Program service statistics

Purpose and Issues

The indicator reflects the volume of service provided to men for RH problems, as well as the nature of the problems treated. It is useful in justifying the continuation of this type of service if demand remains high. Also, it allows program managers to adjust staffing patterns based on the services most in demand.

An alternative indicator is the number of individuals seeking information and/or services. This indicator raises the question of possible repeat visitors, which is not an issue with “number of visits.”

This indicator represents a minimum of information needed to track male use of RH facilities. The studies determining client satisfaction with the services will further enhance the monitoring process.

Indicator

PERCENT OF MEN (HUSBANDS) WHO ARE SUPPORTIVE OF THEIR PARTNERS' REPRODUCTIVE HEALTH PRACTICES

Definition

The percent of males who support their partners' reproductive health practices

This indicator is calculated as:

$$\frac{\text{\# of males who support their partners' reproductive health practices}}{\text{Total \# of men surveyed}} \times 100$$

“Supportive” can be operationally defined in several different ways, including attitudes toward specific behaviors (e.g., contraceptive use), responses to hypothetical situations, and reported actions/behaviors.

“Reproductive health practices” refer to the behaviors that reproductive health programs promote (e.g., often the objective of the program): contraceptive use, breastfeeding, delivery in the presence of a skilled birth attendant, and so forth.

Data Requirements

Responses to structured or in-depth interviews

Data Source(s)

Surveys among the male clientele at health facilities or other men's reproductive health sites (program-based) or among the men in the general public (population-based). Alternative sources are surveys among the wives of participants in male-focused programs.

Purpose and Issues

One way a man can become “involved” in RH is by supporting his wife/partner in her practice of desirable health behaviors. Although some argue that this type of involvement does not go “far enough,” in societies where males have withheld such support, this involvement can represent an important step forward.

Evaluators can assess men's level of support for women's RH practices using three types of questions: attitudes, responses to hypothetical situations, and reported actions. Illustrative questions of each type are presented in Box III.J.1. One expects that these responses will become more favorable as a result of interventions directed toward male involvement.

The answers to this set of questions are subject to bias, especially if men are aware that their attitudes or behaviors deviate from socially accepted responses. The best solution to this problem is for the interviewers to ask these questions in a matter-of-fact way. An alternative approach is to interview women about their husbands' attitudes and behaviors vis-à-vis family planning, safe pregnancy, delivery, STI/HIV risk, and other prevention behaviors. However, such accounts may be biased if the wives know that their husbands participate in the male-focused activities and thus “anticipate” changes in their behavior.

Box III.J.1 Illustrative Items for Measuring Men's Support of Their Wife's/Partner's RH Practices

Attitudes:

Do you approve or disapprove of your wife's/partner's:

- (a) Using a contraceptive method to prevent pregnancy?
- (b) Receiving antenatal care during pregnancy?
- (c) Having a trained birth attendant present at delivery?
- (d) Breastfeeding your baby?

Hypothetical situations:

- 1) If your wife/partner went into labor and experienced complications but you were away on a trip, should she seek health care on her own or wait for your return?
- 2) Suppose a woman suspected that her husband/partner was having sexual relations with several other women. Is she justified or not to suggest using condoms when she and her husband/partner have sex?

Actual behaviors:

- 1) Have you ever told (or otherwise let your wife/partner know) that you approve or disapprove of her using contraception?
- 2) During your wife's/partner's last pregnancy, did you have a plan to get her to a hospital or health center if she had complications? (If so, explain).

Indicator

PERCENT OF CONTRACEPTIVE METHOD USE REQUIRING MALE COOPERATION

Definition

“Contraceptive method use” refers to the number of individuals in a population, clients in a program, or respondents on a survey who report using some type of contraceptive method (female or male). Methods requiring male cooperation include vasectomy, condoms, withdrawal, and periodic abstinence (e.g., rhythm).

This indicator is calculated as:

$$\frac{\text{\# of users reporting use of condom, vasectomy, periodic abstinence, or withdrawal}}{\text{Total \# of contraceptive users}} \times 100$$

Alternatively, this indicator may also be calculated for new adopters of contraceptives:

$$\frac{\text{\# of new adopters who opt for condoms, vasectomy, or periodic abstinence}}{\text{Total \# of new adopters}} \times 100$$

Data Requirements

Population-based responses (among married women of reproductive age); program-based on new adopters during a reference period (e.g., one year)

Data Source(s)

DHS, RHS, or other representative survey; service statistics

Purpose and Issues

This indicator measures the extent to which men take responsibility for contraception within their own marriage or other sexual union. Family planning programs have traditionally focused on women, and the large majority of contraceptive use consists of female-controlled methods (oral pill, IUD, injectables, implants, female sterilization).

One advantage of this indicator is that the data are readily available through routinely collected service statistics or through DHS or RHS surveys. The shortcomings are two-fold. First, male involvement interventions usually target a limited geographical area, in which case these large-scale surveys lack appropriate data for evaluation (although a representative survey of the area will). Second, program-based service statistics are readily available. However, they fail to capture contraceptive use outside the government or NGO facilities that provide family planning (e.g., pharmacies, which are a major source of supply of condoms).

Not all male involvement initiatives are designed to increase male responsibility for contraceptive use. Thus, this indicator is appropriate only when the intervention has this specific objective.

Indicator

PERCENT OF MEN AND WOMEN WHO DISCUSS REPRODUCTIVE HEALTH ISSUES WITH THEIR SPOUSE OR SEXUAL PARTNER

Definition

The extent to which couples discuss RH issues

“Reproductive health issues” are operationally defined in relation to the local context (see illustrative questions below).

Data Requirements

Responses to interviews

Data Source(s)

DHS-type survey; special survey; and survey among clients

Purpose and Issues

Many societies prohibit men and women (even husbands and wives) from discussing RH issues, such as contraceptive use, condom use for STI prevention, women’s nutritional needs during pregnancy, and so forth. Male involvement interventions often are designed to increase male awareness of RH issues and to increase partner communication on these topics. This indicator measures the extent to which husbands and wives or other sexual partners discuss specific RH topics. The concept of inter-partner communication is somewhat open-ended. Questions on partner communication need to be clear and concrete to foster valid responses. Illustrative questions include the following:

“In the past month, did you and your spouse/partner discuss:

- Using or continuing to use contraception to prevent pregnancy?
- Using condoms to prevent sexually transmitted infections, including HIV?

- The need for a skilled birth attendant at delivery (if pregnant)?
- The need for your partner to get adequate nutrition and rest (if pregnant)?
- Whether or not to circumcise your daughter (if appropriate)?”

A one-time measure of communication between partners is useful for diagnostic purposes, but not as an indicator for monitoring or evaluating a program. Rather, the evaluator must use some type of study design that shows the effects of the intervention on increased inter-partner communication.

Evaluators can design studies to:

- Compare the percentage of clients who report inter-partner communication on specific topics before and after counseling or other BCC intervention (note: this approach requires interviewing the client on two separate occasions); and
- Compare the percentage of clients in experimental versus control groups who report inter-partner communication on specific topics (i.e., in the former group, the male partners participated in the counseling session, in the latter group they did not).²

² This design requires random assignment of subjects to the experimental vs. control group, as well as a before/after measurement.

