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Conference on Men's Participation in Reproductive Health

Harare, Zimbabwe: December 2-6, 1996

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Table of Contents

Background	1
Specific Objectives of the Conference	1
Proceedings	1
Results of the advocacy workshop	4
Evaluation of the advocacy session	4
Suggestions for Improvement	5
Conclusions/Recommendations for HHRAA/SARA	5

Appendix A: Conference Agenda

Appendix B: Dr. Touré's Comments

Appendix C: Workgroup

Appendix D: Field Trip Sites

Appendix E: Advocacy Day Agenda

Appendix F: Possible Advocacy Objectives

Appendix G: Workgroup Worksheets

Appendix H: Harare Declaration

Background

From December 2 to 6, 1996, SARA Population and Reproductive Health Advisor, Dr. Lalla Touré, SARA Infectious Diseases Advisor, Dr. May Post, and AED Public Policy Advisor, Ritu Sharma, attended a regional conference on “Men’s Participation in Reproductive Health” in Harare, Zimbabwe.

This five-day conference was cofunded by AED/SARA-IPPF-JHU/PCS in conjunction with the Zimbabwe National Family Planning Council (ZNFPC). A team of high level decision makers and program managers in the field of reproductive health came together to discuss and discover new approaches and solutions to the communication, service, and policy challenges to increasing men’s participation in reproductive health (RH), including STDs/HIV/AIDS. This conference was meant to be a strong and positive step toward instituting more appropriate and effective men’s involvement in family planning programs in the Africa region.

The purpose of SARA’s participation was to conduct a session to introduce policy advocacy to the participants and to illustrate how policy advocacy can assist in increasing male involvement in RH.

Specific Objectives of the Conference

- ◆ Produce a concise, comprehensive “plan of action” report on the findings of the workshop.
- ◆ Critically examine lessons learned from on-going and completed projects to involve men throughout Africa and the developing world.
- ◆ Discuss and clarify the relation of men’s involvement to policy advocacy, communication, and service delivery.
- ◆ Identify gaps between existing programs and perceived needs with the aim of finding workable solutions.
- ◆ Share IEC materials from successful men’s involvement programs.

Proceedings

The conference brought together 60 participants from 13 Anglophone African countries: Botswana, Cameroon, Ethiopia, Gambia, Ghana, Kenya, Malawi, Nigeria, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe. Representatives of some donor agencies/CAs were there: AVSC International, the Population Council, USAID, and World Bank. The opening and closing ceremonies were chaired by the Minister of Education and the Minister of Health respectively.

Proceedings

The conference focused on three key topics of policy advocacy, communication, and service delivery related to men's involvement in RH, and used plenary sessions and workgroup sessions during the first four days; the fifth day was all plenary. A detailed report on the conference proceedings and results will be made available by JHU/PCS; therefore, this report is only a brief overview. (See Appendix A for the Agenda.)

On the first day, conference objectives and expectations were defined, and presentations were made on lessons learned from the literature on men's involvement, on youth, on HIV/AIDS, and on challenges related to each of them, followed by a film presentation. (See Appendix B for Dr. Touré's opening comments.) Then, several case studies were presented, including the Zimbabwe male motivation project, the Kenya vasectomy promotion project, and the Ghana Okyeame approach.

The afternoon was devoted to workgroup sessions around five topics:

- ◆ sustaining men's participation,
- ◆ cultural barriers to men's participation,
- ◆ men as different audiences,
- ◆ young men and reproductive health, and
- ◆ integrating IEC into men's reproductive health.

(See Appendix C on workgroups.)

The second day was focused on communication within the context of service delivery. Reports were made on the results of the working group sessions, and an overview was made on counseling for men, clinic/worksite/CBD services, social marketing and the private sector. Then several case studies were presented, including:

- ◆ integrating modern contraceptive practice into traditional medicine in Nigeria,
- ◆ Ghana's "Daddies Club,"
- ◆ condom promotion,
- ◆ formation of literacy groups to discuss reproductive health,

- ◆ vocational health center activities, and
- ◆ the Kenya mystery client study.

The afternoon was devoted to the same five break-out sessions as the day before, with emphasis on service delivery.

On the third day, all participants went on a field trip to three sites to benefit from ZNFPC's experience in male involvement programs. (See Appendix D for site descriptions.)

On the fourth day, Lalla Touré and Ritu Sharma facilitated a full-day session on policy advocacy for participants. (See Appendix E, Advocacy Day Agenda.)

The goals for the day workshop were to:

- ◆ introduce policy advocacy to the participants;
- ◆ illustrate how policy advocacy can assist in increasing male involvement in reproductive health;
- ◆ develop a set of advocacy objectives or recommendations for men's participation in RH from the local level to the national level; and,
- ◆ by the end of the day, have selected a realistic advocacy objective and have solid start on an advocacy action plan.

Ritu Sharma greeted the participants and began with a discussion on **What is Advocacy?** She then presented an overview of the policy process and the essential elements of advocacy. Nick Danforth, PCS consultant, gave a brief history on men's reproductive health policy issues from the Cairo population conference and Beijing women's conference. Lalla Toure then presented a series of possible advocacy objectives based on the previous discussions at the conference. (See Appendix F for a list of these objectives.)

Participants then reconvened in their five thematic workgroups (young men and RH, men as diverse audiences, sustainability of men's participation, integration of IEC into men's RH, cultural barriers to men's participation) and altered and augmented the list of possible advocacy objectives.

Ritu Sharma started the workgroup sessions by introducing the two exercises with sample case studies for the Policy Process Map. The first break-out session focused on choosing an advocacy objective. Participants selected one or two advocacy objectives from the list of possible objectives and compared them using a set of criteria.

Results of the advocacy workshop

After a lunch break, the second workgroup session focused on understanding the decision-making process. Participants selected one advocacy objective, identified the institution with the responsibility for that objective and outlined the first few stages in the decision-making process at that institution. The small groups also brainstormed on actions they could take to influence the decision-making process. The day closed with reports from workgroups and open discussion. (See Appendix G for workgroup worksheets.)

On the fifth day, the conference closed with presentations by the Minister of Health, USAID and the World Bank. Workshop participants presented “pledges” on behalf of their countries outlining what specific actions they will take as a result of the conference. A full description of the pledges will be available in the JHU/PCS report. JHU/PCS also announced their “Challenge Cup” Program in which they are soliciting small grant proposals for men’s reproductive health initiatives. The Harare Declaration was made by all participants, which acknowledged that the challenge to men’s participation be addressed at the individual level, the community level, the institutional level, and the policy level; and identified areas of action in communication, service delivery, and policy advocacy. (See Appendix H for the Harare Declaration.)

Results of the advocacy workshop

It was clear that one day is insufficient to transfer the process of advocacy adequately. Nonetheless, many of the workshop participants noted in their pledges that they would use the advocacy skills they gained when they return to their countries. In particular, participants from Kenya, South Africa, Tanzania, Uganda, Senegal, Ghana and Mauritius stated that the Introduction to Advocacy Guide would assist them in developing an advocacy strategy. Representatives of the Mauritius Family Planning Association, Planned Parenthood Federation of Kenya and the Agency for the Development of Women and Children (ADWAC) of Gambia expressed their desire to receive a longer training course in advocacy.

Evaluation of the advocacy session

Although the workshop participants completed the exercises, and the goals for the one-day session on advocacy were met, several factors combined to reduce the overall effectiveness of the session. Many evaluation forms noted that the time allotted to covering advocacy was too short and the workgroup sessions were too rushed and structured. The emphasis on following the exercise format did not allow enough time for free-flowing discussion and exchange. In addition, the inclusion of real case studies with time for analysis would have been beneficial.

Suggestions for Improvement

- ◆ Include one or two real-life case studies of advocacy with discussion questions.
- ◆ Allow ample time for free-flowing discussion among participants, either in small groups or in plenary.
- ◆ Extend the time allotted for a one-day session from 6 hours to 8 hours.
- ◆ Train advocacy specialists in adult education/workshop training techniques.

Conclusions/Recommendations for HHRAA/SARA

Since this was a successful conference that gave the opportunity to share experiences in communication and service delivery, and given the fact that the advocacy session created a lot of interest and enthusiasm, we would recommend that AED/SARA consider a replication in Francophone Africa. The Population Council, AVSC, and the REDSO/WCA SFPS project in Abidjan, have all manifested interest in being co-sponsors, in addition to SARA, PCS, and IPPF, if the Francophone conference were agreed upon. The Reproductive Health Research Network could lead the organization of such conference.

The advocacy guide has stimulated a lot of interest. Given the fact that it is frequently difficult to find the three to five days necessary for a more complete training in the advocacy process, it would be useful to design a one-day introduction to advocacy.

Appendix A: Conference Agenda

*AFRICA REGIONAL CONFERENCE ON MEN'S PARTICIPATION IN
REPRODUCTIVE HEALTH*

AGENDA

Sheraton Hotel, Harare
December 1 - 6, 1996

SUNDAY

1 December

4:00 - 6:00 PM
6:00 - 8:00 PM

Faculty
REGISTRATION, Jacaranda Room
RECEPTION, Jacaranda Room

TUESDAY

3 December

- 8:30 - 10:30 PRESENTATION and OPEN DISCUSSION of Key Findings from Break-Out Groups
- 10:30 - 11:00 TEA/COFFEE BREAK
- 11:00 - 11:15 Break-Out Topics Identified (Plenary Room)
- 11:15 - 1:00 COMMUNICATION WITHIN THE CONTEXT OF SERVICE DELIVERY (IPPF)
Overview: Counseling for Men; Clinic/worksite/CBD services; Social Marketing and the Private Sector
Case Study I: Nigeria - Integrating modern contraceptive practice into traditional medicine (PPFN)
Case Study II: Ghana - Daddies Clubs; Condom promotion; (PPRG) Formation of literacy groups to discuss Reproductive Health; Vocational Center health activities.
Case Study III: Swaziland-Industry based programs; Promotion of "Swazi-Male" (FLAS)
Case Study IV: Kenya - Mystery Client Study (AVSC)
- 1:00 - 2:00 LUNCH
- 2:00 - 2:15 Break-Out Topics Identified (Plenary Room)
- 2:15 - 3:45 BREAK - OUT SESSIONS
- 3:45 - 4:00 TEA/COFFEE BREAK
- 4:00 - 5:30 BREAK - OUT SESSIONS continue

As of: December 1, 1996

WEDNESDAY

4 December

8:30 - 10:30

PRESENTATION and OPEN DISCUSSION of Key Findings from Break-Out Groups

10:30- 11:30

TRAVEL to ZNFPC identified Site

11:30 - 1:30

SITE VISIT

1:30 - 2:30

TRAVEL back to Hotel

2:30 - 3:30

LUNCH

3:30 - 4:30

DISCUSS HIGHLIGHTS/LESSONS LEARNED from the Field Trip

7:30

DINNER! DANCING! With Oliver Mutukudzi, ZACT Theatre

jacaranda trees

As of: December 1, 1996

THURSDAY

5 December

8:30 - 9:30

POLICY/ADVOCACY (SARA)

Overview: What is advocacy?; Essential elements of advocacy; Current policy environment; Q & A

9:30 - 11:00

Brainstorming session on advocacy objectives/recommendations from the local to the national level/from the micro to the macro level.

11:00 - 11:30

TEA/COFFEE BREAK

Recommendation = 15 min. How to select an objective

11:30 - 1:00

BREAK-OUT SESSIONS - Choosing an advocacy objective

1:00 - 2:00

LUNCH

Recommendation = 15 min

2:00 - 3:30

BREAK-OUT SESSIONS - Understanding the Decision Making Process

3:30 - 4:00²

PRESENTATION and OPEN DISCUSSION of Key Findings from Break-Out Groups

² Note: Plenary room must be vacated by 4:00 on this day.

FRIDAY
6 December

- 8:30 - 9:30 **Plenary Session Presentation: Recommendations for Men's Participation visa-vi Opening Challenges**
- 9:30 - 10:30 **"Pledges"** — *Very interesting*
Very interesting
- 10:30 -11:00 **TEA/COFFEE BREAK**
- 11:00 - 12:00 **"Pledges" continue**
- 12:00 - 12:30 **Donors' Reaction**
- 12:30 - 1:00 **LAUNCH of the Men's Reproductive Health & Sports Initiative**
- 1:00 - 1:30 **CEREMONIAL CLOSURE: Minister of Health, the Hon. Dr. T. Stamps**
- 1:30 - 2:30 **LUNCH**

As of: December 1, 1996

Appendix B: Dr. Touré's Comments

**AFRICA REGIONAL CONFERENCE
ON
MEN'S PARTICIPATION IN REPRODUCTIVE HEALTH
HARARE SHERATON DECEMBER 1-6, 1996**

Let me start by thanking all of you: ~~the Honorable~~ The Honourable, Mrs Mujuru for accepting to officially open this workshop; The USAID mission Director for his presence; The ZNFPC representative; JHU/PCS and IPPF people for having taken the initiative to organize this important workshop and to the ZNFPC staff to make it happen; representatives of other organizations and CAs; and all the participants who came from all over Africa to assist and contribute to this workshop.

What is SARA? Support for Analysis and Research in Africa. It is a USAID funded Project awarded to the Academy for Educational Development to support the USAID Africa Bureau's HHRAA initiative (Health & Human Resources Analysis in Africa).

SARA's mandate is to identify social-sector issues of regional concern in Africa and participate in research analysis and dissemination activities related to these issues. SARA aims to improve the link between policy makers and researchers, by promoting the use of research findings in policy and program development, and by identifying policy information needs for research attention. This is done in collaboration with African institutions.

2/.....

SARA has experience working with regional networks of researchers and decision makers, and regional institutions on key reproductive health issues, including men's participation. SARA has broken new ground in the area of policy formulation and programmatic decision making with focused dissemination mechanisms and the development of advocacy tools for use in Africa.

After these words on SARA let me tell you how delighted ^{I am} to be here this morning, to participate in what I consider to be a highly important workshop given its topic "Men's Participation in Reproductive Health".

We all know that involving men and obtaining their support and commitment to reproductive health is of crucial importance in Africa.

As an illustration, let me give you some tearful testimonies from African women during interviews :

1. The first one is a cry from a woman on her sorrow to an interviewer in Burkina Faso:
"I am interested in FP, I know a lot of women who also are interested, but what to do? Tell me what to do to space my children. I lost a child

because he was too young when I became pregnant of this one I am carrying. Lack of breast milk and food, and fatigue, all contributed to his death, because I could not take care of him. We need to be helped to ~~save~~^{take care of our} children and not to look at them dying like that (stop, cry and tears). We women, want FP, but how do we deal with our husbands? You need to talk to them, so they can accept.”

The second one is :-

2. From a young adolescent in Nigeria :-

“It may not be the fault of our mothers but of our fathers. If our mothers say they do not want children, our fathers will object, force them as long as fathers are heads of household, our mothers will have to agree with them. I give you an example, one woman had 6 children, her husband still worried her, she went to the doctor for FP. Even though she made love with her husband she was not pregnant. The husband was surprised, and went to make a report to her parents. She was forced to have children.

The last Testimony

3. This from a Cameroonian woman during a workshop conducted by a male doctor:

“We are glad it is a man who is trying to show how important FP is, thank you. There are men in this room who believe and behave as if having children is the affair of a woman alone. She is not just a breeder, but a person who should enjoy sex, relax and have children when she wants, especially for her health. Men should also go to FP with their wives. They should know about the methods and the need for good nutrition and healthy children.

These are quotes from interviews focused on family planning. I am sure we could get the same touching testimonies concerning STDs/AIDS. The STD/AIDS tragedy we are experiencing now in Africa, would not have that magnitude, had we involved men into reproductive health from the beginning.

But, as we like to say in French “Mieux vaut tard que jamais”, means “Better late than never.”

Let me hope that during these 5 days, each of us will give the maximum of him or herself during the experience sharing, in identifying challenges, gaps and addressing issues and problems, and come up with realistic solutions to be considered back home, be it in communication, service delivery or policy advocacy.

Thank you!

DR LALLA TOURE
POPULATION & REPRODUCTIVE HEALTH ADVISOR
SARA Project

Appendix C: Workgroup

WORKGROUP

THEME: INTEGRATING IEC IN MEN'S REPRODUCTIVE HEALTH (HIV/AIDS/STDs/FP) SERVICES AT THE DISTRICT LEVEL.

Information, Education and Communication is an important element in the integration of reproductive health services - STDs/HIV/AIDS/FP- at the district health level. Innovative strategies needed to maximise reach to more men and their partners, especially with IEC and service delivery, is a dire need in most reproductive health programmes. IEC is a strong driving force in reaching men with more reproductive services at the district or community levels if integrated in the essential package of services. Taking into consideration the challenges in reaching men as an audience, analyse the following approaches and make recommendations vis-a-vis men's reproductive health programmes in the African region.

1. Integrating and decentralising IEC/HIV/AIDS/STDs/FP programmes to district health level.
2. Including Family Planning counseling with HIV/AIDS risk assessment in district health services.
3. Promoting the dual benefits of condom use - family planning and prevention of STDs.
4. HIV/AIDS Counseling with Syndromic approach for STDs diagnosis and treatment of men and their partners.
5. Instituting collaboration between tuberculosis and HIV/AIDS programmes at both central and community levels to change attitudes about infections and reduce stigma in the community.
6. Improving quality of service delivery by:
 - a) enhancing interpersonal communication and counseling skills of providers at all levels on FP/HIV/AIDS/STDs;
 - b) fostering the rights of men and their partners to quality and satisfactory service in FP/HIV/AIDS/STDs.

YOUNG MEN AS AN AUDIENCE

(Day 1)

How do we:

- ▶ Redefine their sexual expectations?
- ▶ Change their behaviour early?
- ▶ Delay sexual activity until they are willing to be more responsible?

How do we teach young men:

- ▶ Better social communication skills?
- ▶ How to deal with peer pressure?
- ▶ How to communicate with young women?

What channels do we use to reach youth?

(Day 2)

How do we:

- ▶ Make contraceptive and counseling services available to youth?
- ▶ Enhance the image among young men of contraceptives and services?
- ▶ Train providers to reach and counsel young men?
- ▶ Choose appropriate providers?

(Day 3) *How do we:*

- ▶ Advocate for better services for youth?
- ▶ Sustain services for young men?
- ▶ Initiate or promote policies that encourage responsible behaviour among young men?

Appendix D: Field Trip Sites

ZIMBABWE NATIONAL FAMILY PLANNING COUNCIL

MASHONALAND EAST PROVINCE

SYNOPSIS OF MALE MOTIVATION COMMUNICATION STRATEGY FOR THE PIG INDUSTRY BOARD FARM

The Pig Industry Board farm is a commercial farm 30 km out of Harare. Approximately 500 people live on the farm of which 65 are employees on the farm.

Infrastructure on the farm is limited. There are inadequate sanitation facilities. The farm has no school and children have to attend the school on the next farm. The nearest clinic is approximately 10 km away. The farm is however, well serviced by a mobile outreach team and a CBD.

The major social and health problems identified were:

- early marriages
- early sexual activity
- drug and alcohol abuse
- sexually transmitted infections

Most of these problems were attributed to men seducing youths and problems tended to increase during planting and harvest season when there is an influx of casual labourers. Most men have Family Planning knowledge although they admit there is a lot of non use. This non use is attributed to a lot of myth and misconceptions about family planning. Those who do not use family planning are mostly using short term methods. The communication strategy designed will address the following problems among men:

- Myths and misconceptions about Family Planning
- Increase knowledge on the following:-
 - Sexually Transmitted Infection -
 - Long term and permanent methods
 - Problems associated with having sex with minors

The male motivation talk will consist of lecture, drama, followed by discussion and distribution of reading materials.

ZIMBABWE NATIONAL FAMILY PLANNING COUNCIL

MASHONALAND GROUP

**SYNOPSIS OF THE MALE MOTIVATION COMMUNICATION STRATEGY FOR
CHITUNGWIZA CITY**

Chitungwiza is a large urban settlement with a city status 25 km from Harare. The city has a total population of 264 912 as at 1992 census. Of these, males in the 20 - 25 age group were 66 154, while females 15 - 49 years (which is the reproductive age) were 77 209.

The town does not have a strong industrial base with most of the big companies having folded. Many bread winners have been affected negatively by this. The town is serviced by 1 referral hospital, 4 polyclinics, private surgeries and clinics, and community health workers and CBDS. These facilities are, however, inadequate because of the influx of people from rural areas.

The problems identified from the community analysis were unemployment, lack of accommodation, prostitution and high mortality. There is also a problem of large families attributed to rampant polygamous marriages based on permissive and religious beliefs. There are also myths and misconceptions about Family Planning and methods such as long term and permanent methods.

The male motivation communication strategy will seek to address the problems of:

- Lack of knowledge on long term and permanent methods.
- Large families and polygamy.

This will be done through a talk and group discussion and a video will be used to reinforce the talk. Reading material will also be distributed.

ZIMBABWE NATIONAL FAMILY PLANNING COUNCIL

MASHONALAND GROUP

SYNOPSIS OF MALE MOTIVATION COMMUNICATION STRATEGY FOR DOMBOSHAWA COMMUNITY

Murape Ward is part of Domboshawa Communal Lands situated approximately 60 km from Harare. The Ward has a population of 11 170 with 2225 households and an average family size of 5.

The people in this area depend largely on market gardening and vending.

The Ward is serviced by one health centre, IEHT and CBD. There are 3 primary schools and 1 secondary school and the area is well serviced with shops, water and sanitation programmes.

The main problems identified were transport, unemployment, thieving, unwanted pregnancies drug and alcohol abuse, school drop outs due to pregnancies and prostitution. Sexually transmitted infections were also reported as a problem.

Most people listen to radios between 6 a.m. 9 a.m. and then 6 p.m. to p.m. Most enjoy soccer and talk shows on radio. Drama is also appreciated.

Knowledge on family planning, has been disseminated through the clinic and CBD. There are however a lot of myths and misconceptions about Family Planning. People believe use of Family Planning methods leads to infertility and also leads to prostitution. Most men confessed their lack of knowledge on long term and permanent methods.

The communication strategy will address the problems of:

- myths and misconceptions about Family Planning
- inadequate knowledge on long term and permanent methods of Family Planning
- unwanted pregnancies
- sexually transmitted infections

The male motivation talk will include lecture and discussion, drama and quiz. Reading materials will also be distributed.

Appendix E: Advocacy Day Agenda

Advocacy Day Agenda, Thursday, December 5, 1996

- 8:30 - 9:30 am Overview of Advocacy
- ⇒ What is Advocacy?
 - ⇒ Essential Elements of Advocacy
 - ⇒ Current policy environment for men's participation in RH
 - ⇒ Questions and Answers
- 9:30 - 9:45 am Presentation of possible advocacy objectives to increase men's participation in reproductive health. These objectives were drawn from discussions which took place during the previous three days of the workshop. *(The full set of these policy advocacy objectives is presented below.)*
- 9:45 - 11:00 am Participants reconvened in their thematic discussion groups (youth, men as diverse audiences, sustainability, integration of IEC, cultural barriers) and altered and augmented the list of possible advocacy objectives.
- 11:00 - 11:30 am TEA/COFFEE BREAK
- 11:30 - 11:45 am Introduction to break-out session exercises with sample case study for the Policy Process Map.
- 12:00 - 1:00 pm Break-out session: Choosing an advocacy objective
Participants selected one or two advocacy objectives from the list of possible objectives and compared them using a set of criteria.
- 1:00 - 2:00 pm LUNCH
- 2:00 - 3:30 pm Break-out session: Understanding the decision-making process.
Participants selected one advocacy objective, identified the institution with the responsibility for that objective and outlined the first few stages in the decision-making process at that institution. The small groups also brain stormed on actions they could take to influence the decision-making process.
- 3:30 - 4:00 pm Reports from break-out groups and open discussion.

Revised Agenda for a One-Day Conference Presentation for Policy Advocacy

A common format to provide an introduction to advocacy will likely be the one-day conference presentation. The following is a revised agenda based on discussions with participants and the evaluations.

- I. What is Advocacy?
 - A. Brainstorming exercise and open discussion

- II. The Dynamic Advocacy Process
 - A. Presentation of the model
 - B. Questions and open discussion.

- III. Basic Elements of Advocacy: Case Study
 - A. Presentation of the basic elements
 - B. Presentation of the case study
 - C. Analysis and discussion
 - Questions to guide discussion:
 1. What were the key elements of the advocacy strategy presented?
 2. Was the effort successful? Why or why not?
 3. What could have been improved or added?

- IV. Break-out sessions by thematic group
 - Questions to guide discussions:
 - A. What policy actions relating to your theme would enhance men's participation in RH? List as many as possible.
 - B. Are one or two of these actions a priority (provide advocacy objective selection criteria for reference)? Which ones and why?
 - C. For one priority action, what strategies could you use to influence the decision-making process?

- V. Report to Plenary
 - A. Report from break-out sessions
 - B. Evaluation

Appendix F: Possible Advocacy Objectives

Possible Advocacy Objectives

These examples illustrate the types of policy recommendations which could increase men's participation in reproductive health. Each objective is followed by an estimate of the time frame for completion.

Integration of Information, Communication and Education

1. Ministries of health, education, family/social affairs, information, labor and agriculture should coordinate to promote men's participation in family planning and reproductive health (2 years).
2. National legislature should pass laws to allow family planning and reproductive health information/messages to be broadcast on mass media (1 year).
3. National governments should expand access to radio and television in remote areas (5 years).
4. Gain the active support of mass media "gatekeepers" in carrying family planning/RH messages (2 years).
5. Family planning program managers should train or orient all staff, rather than just providers, in men's reproductive health and family planning needs (2 years).
6. Public and private district health structures should provide integrated, comprehensive, and high quality reproductive health services to men. These services should include IEC and counseling (2 years).
7. Community and religious leaders should vocally support the integration of IEC programmes targeted toward male involvement in existing family planning and reproductive health programs (1 year).

Sustaining Men's Reproductive Health Programs

1. Existing training programs for men (e.g. agricultural extension) should include reproductive health and family planning information wherever possible (2 years).
2. National leaders (president, vice president, minister of health, etc.) should commit financial resources to integrating men's reproductive health into existing family planning programs (2 years).
3. Donors, national ministries and NGOs should coordinate FP/RH activities for men (2 years).

4. National family planning organizations should actively involve communities in the design, planning and implementation of men's RH/FP activities (2 years).
5. Community and religious leaders should actively encourage men to use family planning (1 year).
6. National family planning organizations should encourage private sector involvement in men's programs (1 year).
7. Communities should provide the initial capital for men's RH/FP programs. Advocacy should focus on community endorsement of cost sharing/fee for services (2 years).

Cultural Barriers

1. National government should outlaw polygamy (5-10 years).
2. National legislature should pass equitable maternity and paternity laws in order to encourage men to be more involved with child care (3 years).
3. National legislature should change child benefit laws to discourage large families (e.g. cap child benefits at four children) (5 years).
4. National legislature should pass mandatory child support laws (3-5 years).
5. National government/Ministry of Education should increase resources to expand access to basic education for men and women (3 years).
6. Government should ban destructive cultural practices such as wife inheritance, wife sharing and female genital mutilation (5 years).
7. Community and religious leaders should vocally support women's rights and discourage harmful cultural practices (5 years).
8. Community and religious leaders should actively encourage men to use family planning (1 year).
9. Health district teams should appoint or hire a community outreach coordinator to involve the community in person-to-person and small group discussions on men's participation in reproductive health (2 years).
10. Ministry of Health and/or Ministry of Social Affairs should fund IEC programs to sensitize men about the importance of mutual decision-making, partner communication, the consequences of gender preference for children and the socio-economic impacts of large families (3 years).

11. Ministry of Health or Ministry of Social Affairs should fund an education campaign discouraging multiple partners and promoting condom use among men (2 years).

Men as Diverse Audiences

1. The Ministry of Social Affairs should allocate resources to conducting an IEC campaign to reduce men's preferences for large families (1 year).
2. The Ministry of Health should encourage employers and universities to provide RH/FP information to men (2 years).
3. National governments should lower taxes on contraceptive devices and/or provide subsidies for contraceptives (5 years).
4. National government/Ministry of Health should increase budgets for research into male contraceptive methods and utilization (3 years).
5. Family planning organizations should conduct special training for all staff on men's reproductive health and family planning needs (2 years).
6. Family planning organizations should provide programs for men which increase access and protect privacy (e.g. special hours/location for men) (2 years).
7. Community and religious leaders should actively encourage men to use family planning (1 year).
8. Legislatures should make laws on spousal consent equitable; consent should be required by both husband and wife or neither partner (2 years).
9. STD clinics should provide additional education and sensitization to men with STDs so that these men will be less likely to transmit their STD to their wife/partner(s) (2 years).
10. Ministry of Social Affairs should allocate resources to an IEC campaign toward men to reduce violence against women (2 years).
11. The Ministry of Justice should ask the president to sign a decree declaring that violence against women is unacceptable and will be punished (1 year).
12. Family planning organizations should focus their IEC messages on male responsibility (2 years).

Youth

1. Pass national laws to allow boys and girls to receive basic education about reproductive health and responsible sexual behavior in schools or other relevant fora (3 years).

2. Pass national laws/regulations to legalize the distribution of contraceptive devices to adolescents (5-10 years).
3. Government should set minimum age of marriage at 18 and enforce these laws (3 years).
4. School regulations which expel pregnant students and/or their partners should be amended to allow youth to complete their schooling. Alternative methods to encourage sexual responsibility should be implemented (e.g. these students should participate in a special family life/parenting course) (2 years).
5. Service organizations should provide programs for youth which increase access to family planning and protect privacy (e.g. special hours or locations for young people) (1 year).
6. Service organizations should provide special training for all staff on adolescent reproductive health, family planning and sexuality issues in order to present a positive attitude toward youth (2 years).
7. Community and opinion leaders should actively encourage parents to learn about and discuss reproductive health issues with their children (5 years).
8. Community leaders should vocally support the delay of marriage (3-5 years).
9. Reproductive health clinics should provide post-abortion care for adolescents (3 years).

Several participants noted that while governments could certainly do many things to support and enhance men's participation in reproductive health, governments cannot and should not do everything. Much can be done at the local community and district levels without major new national initiatives. It was suggested that many of the above recommendations could be recast to focus on the community level.

Appendix G: Workgroup Worksheets

Checklist for Choosing an Advocacy Objective: Objective Analysis

Criteria	Objective 1	Objective 2
<input checked="" type="checkbox"/> Do qualitative or quantitative data exist which show that reaching the objective will result in real improvements in the situation?	Yes: DHS Studies.	
<input checked="" type="checkbox"/> Is the objective achievable? Even with opposition?	Yes; But church, parents opposition	
<input checked="" type="checkbox"/> Will many people support the objective? Do people care about the objective deeply enough to take action?	Yes. Parents, Educational Institutions, Youth Assoc, Policy makers (Health Educ) Health Service providers ACP, AIC, UAC,	
<input checked="" type="checkbox"/> Will you be able to raise money or other resources to support your work on the objective?	Yes: creative reallocation of funds	
<input checked="" type="checkbox"/> Can you clearly identify the target decision-makers? What are their names and positions?	Yes. Programme Managers - Name stops.	

Checklist for Choosing an Advocacy Objective: Objective Analysis

Criteria	Objective 1	Objective 2
<input checked="" type="checkbox"/> Does the objective have a clear time frame that is realistic?	Yes 1 year	
<input checked="" type="checkbox"/> Do you have the alliances with key individuals or organizations needed to reach your objective? Will the objective help build alliances with other sectors, NGOs, leaders, or stakeholders? Which ones?	Youth, NGOs eg ACP, AIC, UAC	
<input checked="" type="checkbox"/> Is the objective easy to understand?	Yes	
<input checked="" type="checkbox"/> Will working on the objective provide people with opportunities to learn more about and become involved with the decision-making process?	Yes. - Youth groups AIDS grps etc.	
<input checked="" type="checkbox"/>		

55

Checklist for Choosing an Advocacy Objective: Objective Analysis

12-1
2-3
Selecting advocacy objectives
Process map

deduct

1
2
3
4
5

Commitment

Criteria	Objective 1	Objective 2
1 <input checked="" type="checkbox"/> Do qualitative or quantitative data exist which show that reaching the objective will result in real improvements in the situation?	Yes DHS • Data shows	
2 <input checked="" type="checkbox"/> Is the objective achievable? Even with opposition?	Yes. Possible obstructions Youth in school, religion - 2mb (not below 16 yrs) - Age restrict, provider attitudes (internal opposition)	
3 <input checked="" type="checkbox"/> Will many people support the objective? Do people care about the objective deeply enough to take action?	Yes. General community, Youth, Instit when directors, health people, Policy makers in Health/Educ, AIDS care, NGOs, AIDS COP, AIDS related groups, (service organizations)	
4 <input checked="" type="checkbox"/> Will you be able to raise money or other resources to support your work on the objective? for the advocacy.	Yes → Free up some of the time of a person • Fuel • Materials • Re-allocate already existing resources	
5 <input checked="" type="checkbox"/> Can you clearly identify the target decision-makers? What are their names and positions?	• Directors of program • Program Managers • USAIDS • Service delivery managers	

etc

Checklist for Choosing an Advocacy Objective: Objective Analysis

Criteria	Objective 1	Objective 2
6 <input checked="" type="checkbox"/> Does the objective have a clear time frame that is realistic?	1 year	
7 <input checked="" type="checkbox"/> Do you have the alliances with key individuals or organizations needed to reach your objective? Will the objective help build alliances with other sectors, NGOs, leaders, or stakeholders? Which ones?	Youth groups, NGOs, ^{print} media	
8 <input checked="" type="checkbox"/> Is the objective easy to understand?	yes	
9 <input checked="" type="checkbox"/> Will working on the objective provide people with opportunities to learn more about and become involved with the decision-making process?	yes, Youth groups, AIDS groups	
10 <input checked="" type="checkbox"/>		

51

Checklist for Choosing an Advocacy Objective: Objective Analysis

Criteria	Objective 1	Objective 2
<input checked="" type="checkbox"/> Do qualitative or quantitative data exist which show that reaching the objective will result in real improvements in the situation?	<ul style="list-style-type: none"> - DHS - Synchroic Management - Pop Council CBID 	
<input checked="" type="checkbox"/> Is the objective achievable? Even with opposition?	<ul style="list-style-type: none"> - The opp-situation is the Health Association - But can be achieved 	
<input checked="" type="checkbox"/> Will many people support the objective? Do people care about the objective deeply enough to take action?	<ul style="list-style-type: none"> - Yes 	
<input checked="" type="checkbox"/> Will you be able to raise money or other resources to support your work on the objective?	<ul style="list-style-type: none"> - Yes - CBID already exists and can be used - Cost - retraining - CIA 	
<input checked="" type="checkbox"/> Can you clearly identify the target decision-makers? What are their names and positions?	<ul style="list-style-type: none"> - Ministry of Health - Health Councils/Associations - DHS - Program Managers (CBID) 	

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22

Checklist for Choosing an Advocacy Objective: Objective Analysis

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Criteria	Objective 1	Objective 2
<input checked="" type="checkbox"/> Does the objective have a clear time frame that is realistic?	Yes	
<input checked="" type="checkbox"/> Do you have the alliances with key individuals or organizations needed to reach your objective? Will the objective help build alliances with other sectors, NGOs, leaders, or stakeholders? Which ones?	Yes • Project Manager • Debra • Bimbe Initiative	
<input checked="" type="checkbox"/> Is the objective easy to understand?	Yes	
<input checked="" type="checkbox"/> Will working on the objective provide people with opportunities to learn more about and become involved with the decision-making process?	Yes • Will learn elements • contracts • Listening / Transfer of Skills	
<input checked="" type="checkbox"/>		

bc

Checklist for Choosing an Advocacy Objective: Objective Analysis

Criteria	Objective 1	Objective 2
<input checked="" type="checkbox"/> Do qualitative or quantitative data exist which show that reaching the objective will result in real improvements in the situation?	- Material (Morbidity) / HIV/AIDS/STI DATA SURVEYS - NDHS, NISH, Monthly Reports, Annual reports.	Speeches from local leaders.
<input checked="" type="checkbox"/> Is the objective achievable? Even with opposition?	The objective is achievable. There are some current funding from NABH but it should be increased.	Integration of male ^{AH} services into existing health services.
<input checked="" type="checkbox"/> Will many people support the objective? Do people care about the objective deeply enough to take action?	Many will support the objective. Because it has a health/life-saving strategy. It also has economic benefits. Human rights & F.P.	
<input checked="" type="checkbox"/> Will you be able to raise money or other resources to support your work on the objective?	It has to be marketed to draw finance/funding due to donor interest in Men R.H. Issue. Inter-sectoral collaboration networking to achieve success.	
<input checked="" type="checkbox"/> Can you clearly identify the target decision-makers? What are their names and positions?	Head of State and Wives, Ministers (Finance, Industries, Health etc), State Government, local govt leaders, Women lobby groups.	

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40

Checklist for Choosing an Advocacy Objective: Objective Analysis

Criteria	Objective 1	Objective 2
<input checked="" type="checkbox"/> Does the objective have a clear time frame that is realistic?	(3 years) 5% ^{p2} increase 1998 - 2000. <i>achievable</i>	
<input checked="" type="checkbox"/> Do you have the alliances with key individuals or organizations needed to reach your objective? Will the objective help build alliances with other sectors, NGOs, leaders, or stakeholders? Which ones?	Alliances already exist - Women ^{pressure} groups, Donors, NGOs, Women and ^{and} rest ^{rest} groups, Ministry of Health, Education, Social Welfare.	
<input checked="" type="checkbox"/> Is the objective easy to understand?	Yes, it is easy to understand Life-saving, better quality of life and economic benefits.	
<input checked="" type="checkbox"/> Will working on the objective provide people with opportunities to learn more about and become involved with the decision-making process?	Marketing the benefits to be accrued from the project. Benefits are directed to individuals, and families, and	
<input checked="" type="checkbox"/>	Communities and nations would be attracted to the project.	

4

Checklist for Choosing an Advocacy Objective: Objective Analysis

Criteria	Objective 1	Objective 2
<input checked="" type="checkbox"/> Do qualitative or quantitative data exist which show that reaching the objective will result in real improvements in the situation?	<ul style="list-style-type: none"> - DHS - Synchonic Management - Pop Council CBD 	
<input checked="" type="checkbox"/> Is the objective achievable? Even with opposition?	<ul style="list-style-type: none"> - The oppositio. is the Medical Associations - But can be achieved. 	
<input checked="" type="checkbox"/> Will many people support the objective? Do people care about the objective deeply enough to take action?	<ul style="list-style-type: none"> • Yes. 	
<input checked="" type="checkbox"/> Will you be able to raise money or other resources to support your work on the objective?	<ul style="list-style-type: none"> • Yes • CBD already exists and can be used • Cost - retraining • TA 	
<input checked="" type="checkbox"/> Can you clearly identify the target decision-makers? What are their names and positions?	<ul style="list-style-type: none"> • Minister of Health • Med. Councils/Associations • Dms • Program Managers (CBD) 	

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48

Checklist for Choosing an Advocacy Objective: Objective Analysis

Criteria	Objective 1	Objective 2
<input checked="" type="checkbox"/> Does the objective have a clear time frame that is realistic?	Yes	
<input checked="" type="checkbox"/> Do you have the alliances with key individuals or organizations needed to reach your objective? Will the objective help build alliances with other sectors, NGOs, leaders, or stakeholders? Which ones?	<ul style="list-style-type: none"> • Yes - Programme Managers • Donors • Bamako Initiatives 	
<input checked="" type="checkbox"/> Is the objective easy to understand?	• Yes.	
<input checked="" type="checkbox"/> Will working on the objective provide people with opportunities to learn more about and become involved with the decision-making process?	<ul style="list-style-type: none"> • Yes. • Will learn channels & protocols • Lobbying / Transfer of Skills 	
<input checked="" type="checkbox"/>		

Checklist for Choosing an Advocacy Objective: Objective Analysis

Criteria	Objective 1	Objective 2
<input checked="" type="checkbox"/> Do qualitative or quantitative data exist which show that reaching the objective will result in real improvements in the situation?	- Maternal / Morbidity / HIV / AIDS / STI / DATA SURVEYS - SDHS / NISH Monthly Reports / Annual reports / Speeches from local leaders.	
<input checked="" type="checkbox"/> Is the objective achievable? Even with opposition?	The objective is achievable. There are some current funding from National govt but it should be increased.	Integration of Male ^{AH} services into existing health services.
<input checked="" type="checkbox"/> Will many people support the objective? Do people care about the objective deeply enough to take action?	Many will support the objective because it has a health / life-saving strategy. It also has economic benefits. Human rights of P.P.	
<input checked="" type="checkbox"/> Will you be able to raise money or other resources to support your work on the objective?	It has to be marketed to draw finance / funding due to donor interest in Men R.H. issue. Inter-sectoral collaboration / Networking to achieve success.	
<input checked="" type="checkbox"/> Can you clearly identify the target decision-makers? What are their names and positions?	Head of state and Wives Ministers (Finance, Industries, Health etc), State Govt. officials, Wives, local govt leaders, Women lobby groups.	

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Checklist for Choosing an Advocacy Objective: Objective Analysis

Criteria	Objective 1	Objective 2
<input checked="" type="checkbox"/> Does the objective have a clear time frame that is realistic?	(3 years) 5% ^{per} increase 1998 - 2000. <i>achievable</i>	
<input checked="" type="checkbox"/> Do you have the alliances with key individuals or organizations needed to reach your objective? Will the objective help build alliances with other sectors, NGOs, leaders, or stakeholders? Which ones?	Alliances already exist! Women ^{pressure} groups, Donors, NGOs, Women in ⁱⁿ the ^{the} groups ^{groups} , Ministers of Health, Education, Social Welfare.	
<input checked="" type="checkbox"/> Is the objective easy to understand?	Yes, it is easy to understand. Life-saving, better quality of life and economic benefits .	
<input checked="" type="checkbox"/> Will working on the objective provide people with opportunities to learn more about and become involved with the decision-making process?	Marketing the benefits to be accepted from the project. Benefits are directed to individuals and families, and	
<input checked="" type="checkbox"/>	Communities and nations would be attracted to the project.	

45

Ministry of Health to broaden
 the range of services offered
 by CBDS to include single
 dose treatment of STDS.
Policy Process Map: Stage One

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Proposal Formation	
Institution/Organization	(National FP org) or CAs
Formal Process	Proposal initiated (by Program managers in family planning units) and submitted to the Director of Medical Services
Informal Process	Informal discussion, opinion leaders, CAs, Medical Associations, donors
Decision-Makers Involved	Program Managers, Colleagues, CBI supervisors, Divisional Chiefs, District Chiefs
Approximate Date of Action	January - Feb 1997
How we can influence the process at this stage.	<ul style="list-style-type: none"> • Hold meeting, set agenda & outline for proposal • Present good data to highlight magnitude • Concept paper • Meet key individuals, institutions

1/6

Policy Process Map: Stage Two

Proposal Introduction	
Institution/Organization: National FP org.	
Formal Process	<ul style="list-style-type: none"> • FP unit submits proposal to DMS the minister via the DMS • Formal presentation by the CEO of the org.
Informal Process	Program proposer has got in-house 'green light'
Decision-Makers Involved	Program Minister, DMS, Ex. Director of Organization.
Approximate Date of Action	4 weeks (March)
How we can influence the process at this stage	<ul style="list-style-type: none"> • Notify stakeholders that proposal is with the Minister • Follow up - (pin-in-the-neck) • Exploit all informal opportunities

Policy Process Map: Stage Three

Policy Deliberation	
Institution/Organization:	FP organization
Formal Process	<ul style="list-style-type: none"> Ensure representation at all stages and defend the proposal.
Informal Process	<ul style="list-style-type: none"> Continue exploring informal opportunities Lobby those who have the ministers ears
Decision-Makers Involved	<ul style="list-style-type: none"> Minister and advisors
Approximate Date of Action	4 weeks (April)
How we can influence the process at this stage	<ul style="list-style-type: none"> Build support with Minister & advisors eg. through formal / informal organize full visit to CBD prog. Have media coverage for ministers Have media highlight (B) potential Keep Continue dialogue with medical associations Get parliamentarians to raise the issue in parliament

28

Policy Process Map: Stage Four

Approval or Rejection	
Institution/Organization:	FP organization
Formal Process	
Informal Process	
Decision-Makers Involved	
Approximate Date of Action	4 weeks (May)
How we can influence the process at this stage	<ul style="list-style-type: none"> • Push Continue pushing our agenda in the media. eg. documentaries, letters to the editors

49

Policy Process Map: Stage Five

Advancement to the Next Level	
Institution/Organization:	M of Health
Formal Process -	<ul style="list-style-type: none"> Minister has communicates to the proposer and to other ministries Gazettement of decision.
Informal Process	
Decision-Makers Involved	Minister, DMS, Chief Executives, Program Manager, Admin
Approximate Date of Action	May - December
How we can influence the process at this stage	<ul style="list-style-type: none"> Hold dissemination workshops Plan training and re-training of CBDs at different levels

Program Manager P for implementation

50

Policy Process Map: Stage One

Proposal Formation	
Institution/Organization:	National Fp. organization (ZNFPC).
Formal Process	Asst Director + Asst. Director ^{IEC} service delivery to produce proposal on the need to provide special services for youth.
Informal Process	The two ^{assistants} directors would discuss with staff in their departments + other related departments
Decision-Makers Involved	Director of Technical Services.
Approximate Date of Action	Jan 97.
How we can influence the process at this stage.	<ul style="list-style-type: none"> • Provide Asst. Directors with background information/data/research findings. • Invite interested/concerned groups to give presentations to ZNFPC • Hold consultative meetings with youth associations. • Meet with opposing groups to understand & address their concerns

51

Policy Process Map: Stage Two

Proposal Introduction	
Institution/Organization: ZNFPC	
Formal Process	Proposal finalized by Assistant Directors + presented to the Executive Director.
Informal Process	2 Assistant Directors talk with Director of Technical Services + solicit his support + commitment.
Decision-Makers Involved	Executive Director + Director of Technical Services.
Approximate Date of Action	March '97.
How we can influence the process at this stage	<ul style="list-style-type: none"> • Informal conversations with Secretary of Health, Board Members, close friends of Director. • Contact donor agencies and solicit their support. • Contact youth associations.

52

Policy Process Map: Stage Three

Policy Deliberation	
Institution/Organization: ZNFPC.	
Formal Process	Executive Director considers the proposal and discussed implications, suggests changes in cooperation with Tech. Director and
Informal Process	Exec. Director informally talks to dancers, other f.p. agencies, youth organizations, MCH, program managers, board.
Decision-Makers Involved	Executive Director + Technical Director
Approximate Date of Action	April '97.
How we can influence the process at this stage	• Continue to hold conversations with youth associations, dancers, board members etc.

Policy Process Map: Stage Four

Approval or Rejection	
Institution/Organization:	ZNFPC.
Formal Process	Executive Director approves proposal (or rejects).
Informal Process	Continue to talk informally with Executive + Technical Directors + find out if need for more information or support.
Decision-Makers Involved	Executive Director.
Approximate Date of Action	April '97 (or later if more information needed)
How we can influence the process at this stage	<ul style="list-style-type: none"> • Continue to meet with interested groups. • Collect further information if needed • Collaborate with personal assistant to Director to ensure file is on top of priority list / assess need of Director.

Policy Process Map: Stage Five

Advancement to the Next Level

Institution/Organization: ZNFPC.	
Formal Process	Executive Director do announces approval ^{at staff meeting.} & briefs Technical Director + delegates implementation to Asst. Directors
Informal Process	Informal meetings with staff to begin looking at implications.
Decision-Makers Involved	Technical Director + Two Assistant Directors
Approximate Date of Action	June '97.
How we can influence the process at this stage	<ul style="list-style-type: none"> • and Acknowledge Executive Directors decision & announce your commitment to the policy change.

55

Obj.

A. To integrate men's RH issues into the existing

progrms: STDs

HIV/AIDS

TB

FP

IEC

↳ Policy Process Map / Stage 1

Insti: National AIDS Committee

Formal Add men's RH's issue to the
Informal Process: Next committee
meet. agenda

Informal discussions / ^{from} party
Informal doc.
Friends

Date: Dec 1996 / Jan 1997

How to influence:

Establish working rapport
Executive Director / Chairman
of AIDS Committee.

C. Stage 2

Formal Process: Submit a refined
document on men's RT
issues to the National
Board on AIDS

Men's Participation Programmes: Challenges

COMMUNICATION	CAMEROON	EGYPT	GAMBIA	GHANA	KENYA	MAURITIUS	S AFRICA	S LEONE	TANZANIA	UGANDA	ZAMBIA	ZIMBABWE
1. Strong Pronatalist Beliefs	●											
2. Unclear roles for men	●					●	●					
3. Unclear Roles for Providers	●											
4. Ineffective Management	●	●										
5. Little Involvement of C.O.L.	●											
6. Conflicting Religious Beliefs	●		●									
7. Misconception/Rumors	●		●	●		●						
8. Fears-Infidelity, "Power" Loss	●			●			●					
9. Inadequately Trained Providers	●				●							
10. Inability Demand to Match Services	●											
11. FP/RH issues are women's issues	●					●		●	●		●	
12. Messages not focused on Target Group	●	●										
13. Socio-cultural Beliefs or Stereotypes	●				●		●	●	●	●	●	●
14. Religious Beliefs	●		●		●		●					
15. Inadequate Community Out-Reach	●				●		●	●				
16. High Illiteracy among men	●						●	●				
17. Low priority to Gender issues	●									●		

Men's Participation Programmes: Challenges

<u>THEME</u>	<u>CHALLENGES</u>	C A M E R O O N	E G Y P T	G A M B I A	G H A N A	K E N Y A	M A U R I T I U S	S A F R I C A	S L E O N E	T A N Z A N I A	U G A N D A	Z A M B I A	Z I M B A B W E
POLICY/ ADVOCACY	1. Pronatalist Policies	●											
	2. Not integrated Service Policies & Guidelines	●											
	3. Over Centralized Implementation	●	●										
	4. No Political Commitment	●	●										
	5. Limited Access to National Media	●		●					●				
	6. Fear-Political/Public backlash	●											
	7. Poor Implementation of Services	●											
	8. Inappropriate Training Curricula	●											
	9. Cost of Men's Contraceptives	●											
	10. Restrictions to Vasectomy	●											

Men's Participation Programmes: Challenges

THEME	CHALLENGES	CAMEROON	EGYPT	GAMBIA	GHANA	KENYA	MAURITIUS	S AFRICA	S LEONE	TANZANIA	UGANDA	ZAMBIA	ZIMBABWE
SERVICE DELIVERY	1. Limited Contraceptive Options	●			●								
	2. Poor Program Management	●	●			●							
	3. Unknown Reprod. Goals/Hx	●				●							
	4. Men's Priorities Different -B11 Information vs. FP Method	●				●							
	5. Poor Implementation of SDP	●							●				
	6. Difficulties to Follow-up	●				●							
	7. Difficulties to match services to demand created	●				●							
	8. Inaccessible Geographic areas	●							●				
	9. Low Utilization of Health Units for Treatment										●		

Appendix H: Harare Declaration

**HARARE DECLARATION ON MEN'S PARTICIPATION
IN REPRODUCTIVE HEALTH IN AFRICA**

December 1-6, 1996

I. PREAMBLE

We, the 66 participants at the Africa Regional Conference on Men's Participation in Reproductive Health, representing 17 nations of sub-Saharan Africa and donor agencies, having met to discuss and discover new approaches and solutions to communication, service, and policy challenges to increasing men's participation in reproductive health, hereby declare that we fully commit ourselves to efforts to build upon the important work of many African governments and NGOs as well as donor agencies to promote men's responsible and equitable role in reproductive and sexual health of women and children.

II. CHALLENGES TO MEN'S PARTICIPATION

We face serious challenges in increasing men's participation at the:

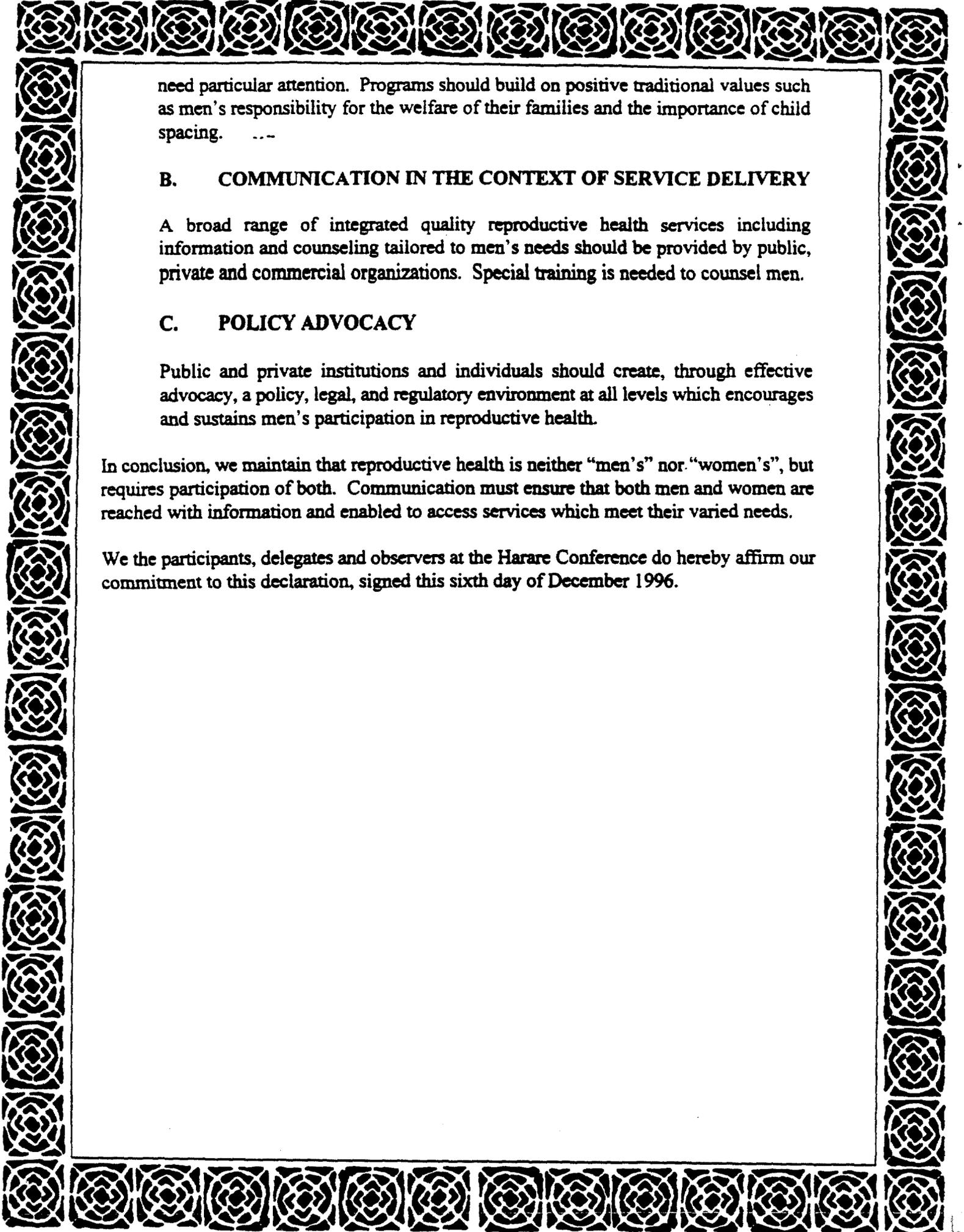
- A. **Individual level**, where many African men lack information about reproductive health, and couples are often unable to discuss and reach shared decisions about sexuality and contraception;
- B. **Community level**, where some religious and traditional values favor men having large families, and where changing social structures contribute to increased STD/HIV transmission, unwanted pregnancies, and other reproductive health problems.
- C. **Institutional level**, where men's access to quality reproductive health information and services is hindered by existing structures which do not meet their needs.
- D. **Policy level**, where some laws and regulations constrain men's access to reproductive health information and services.

III. AREAS FOR ACTION

We believe these challenges must be addressed to build effective participation of men as responsible, caring, and understanding partners.

A. COMMUNICATION TO INCREASE MEN'S PARTICIPATION

Strategic communication programs should effectively address the information needs of diverse groups of men and change social norms to provide an enabling environment for partner communication and shared decision-making. Young men



need particular attention. Programs should build on positive traditional values such as men's responsibility for the welfare of their families and the importance of child spacing. ---

B. COMMUNICATION IN THE CONTEXT OF SERVICE DELIVERY

A broad range of integrated quality reproductive health services including information and counseling tailored to men's needs should be provided by public, private and commercial organizations. Special training is needed to counsel men.

C. POLICY ADVOCACY

Public and private institutions and individuals should create, through effective advocacy, a policy, legal, and regulatory environment at all levels which encourages and sustains men's participation in reproductive health.

In conclusion, we maintain that reproductive health is neither "men's" nor "women's", but requires participation of both. Communication must ensure that both men and women are reached with information and enabled to access services which meet their varied needs.

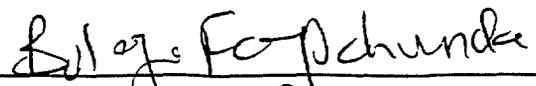
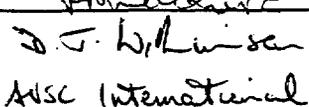
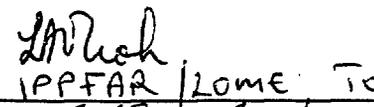
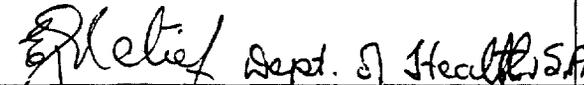
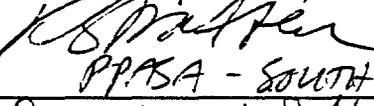
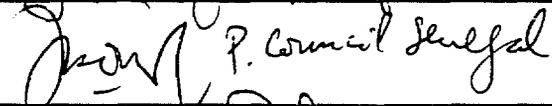
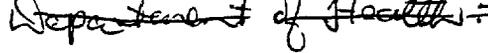
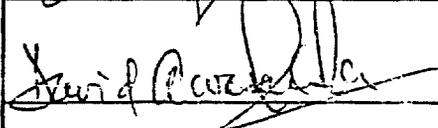
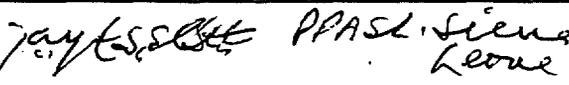
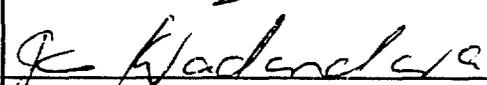
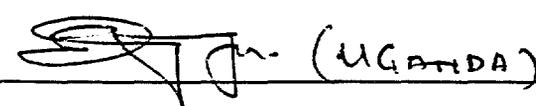
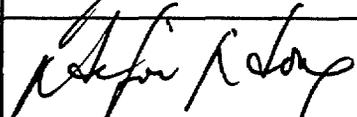
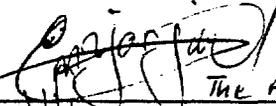
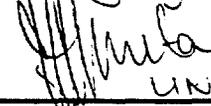
We the participants, delegates and observers at the Harare Conference do hereby affirm our commitment to this declaration, signed this sixth day of December 1996.

**AFRICA REGIONAL CONFERENCE ON MEN'S PARTICIPATION
IN REPRODUCTIVE HEALTH
HARARE , DECEMBER 1 - 6, 1996**

DECLARATION SIGNATURES

<i>Blakely</i>	<i>W. P. C. (Cameroon)</i>
<i>M. M. M.</i>	<i>J. M. M. (ZAMBIA)</i>
<i>L. Botsh.</i>	<i>B. M. M. (Zambia)</i>
<i>A. Ngulube.</i>	<i>[Signature]</i>
<i>[Signature] (Mauritius)</i>	<i>[Signature]</i>
<i>[Signature]</i>	<i>[Signature] (Uganda)</i>
<i>N. J. A. C. (GHANA)</i>	<i>[Signature] (Uganda)</i>
<i>[Signature]</i>	<i>[Signature] (Uganda)</i>
<i>[Signature]</i>	<i>[Signature] (Tanzania)</i>
<i>[Signature] ZAMBIA</i>	<i>[Signature] (TANZANIA)</i>
<i>[Signature] Ethiopia</i>	<i>[Signature] KENYA.</i>
<i>[Signature] South</i>	<i>[Signature] KENYA.</i>

BEST AVAILABLE COPY

 Zimbabwe	 PPFN NIGERIA.
 Bilge Fopchunde	 INTRAH Kenya/ESA
 A.A. Ado IPPFAR / NAROSI KENYA	 J. Wilkin AVSC International
May Post SARA Project / AED U.S.A.	 IPPFAR / LOME, TOGO.
 Chief Dept. of Health SA	 PPSA - SOUTH AFRICA.
 P. Council Legal	 Department of Health =
 David ...	 PPASL, Sierra Leone
 Khadem ...	 STJ (UGANDA)
 Kwame ...	WHO: Zimbabwe. NATIONAL POPULATION COUNCIL SECRETARIAT. GHANA.
 Kotei	Health Education Unit, Min of Health, Accra, Ghana
 Tom ...	JHU/PCS, Baltimore
 Kofi ...	AVSC International
 ASWAC The Agency for the Development of Women & Children.	
 UNFPA, ZIMBABWE.	LINE

