



# Challenges and Opportunities for Male Involvement in Reproductive Health in Cambodia

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## Executive Summary

Increasingly, recognition is growing on a global scale that the involvement of men in reproductive health (RH) policy and service delivery offers both men and women important benefits. Cambodia has acknowledged these benefits and is one of the first nations to promote male involvement at the policy and service implementation levels.

Involving men in reproductive healthcare could help Cambodia achieve some major development goals, such as a decreased maternal mortality rate and an increased contraceptive prevalence rate. Involving men could also help reduce the overall prevalence of HIV/AIDS—an outcome possible only if men are involved not just as clients of RH care but also as partners, service providers, policymakers, teachers, and project managers.

Until today, male involvement in RH in Cambodia has been relatively underdeveloped. Despite the availability of a few contraceptive methods for men, maternal and child health (MCH) programs provide most RH care, strategic plans and services lack indicators for men, and most service providers are not equipped or trained to accommodate male clients. RH facilities tend to be female-oriented; as a result, men are often reluctant to avail themselves of services. Men's reluctance to access RH care can also mean that barriers to accessing health, such as distance and cost, which affect both men and women, are even more influential in preventing men from seeking RH counseling or treatment or even seeking services as partners.

Gender differences in Cambodian society appear to have a profound effect on male involvement in reproductive health, which is usually assumed to be a woman's concern—at the household, service provision, and policy levels. Cultural expectations also make it difficult for women to discuss RH issues with men.

With little opposition to involving men in reproductive healthcare, Cambodia evidences clear support for male involvement in RH. The national agenda recognizes the importance of gender issues, but usually only with respect to promoting the rights and situation of women. There is some concern, however, that a narrow focus on gender could impede efforts to promote and expand services for men. Several government policies and strategies mention men, and others offer strong opportunities for male involvement. The most important of these opportunities is the new five-year National Reproductive Health Strategic Plan, scheduled for a 2006 launch.

Although the political climate is conducive to including the involvement of men on the reproductive health policy agenda, involving men at the implementation level poses challenges. Services directed at men usually cater to groups of men perceived to be at high risk, such as migrant workers or members of the military. Targeting the general male population is not yet a priority for most health services. If men are going to seek reproductive healthcare, Cambodia must change the environment in which that care is offered, address the cultural traditions associated with seeking health care, and alter the approach to many aspects of sexual and reproductive health.

This is not to say that health facilities and agencies do not provide services for men. While most services operate an “open-door” policy for men, the number of more specific initiatives directed at men is limited. Moreover, in the private health sector, many practitioners are men who, if properly trained and equipped, could be an important resource in encouraging men to use RH care.

To expand and strengthen male involvement in reproductive health in Cambodia, this report offers the following recommendations:

- A set of guidelines to mainstream male involvement need to be developed and distributed.
- Agencies interested in implementing male involvement in reproductive health must plan for a long-term commitment.
- Campaigns need to be implemented that educate seemingly “low-risk” social and demographic groups.
- Current education campaigns need to be reviewed in the context of male involvement and should not, for example, reinforce gender inequities or the notion that condom use is restricted only to high-risk situations.
- Existing services should be made more “male-friendly,” with service providers undergoing additional training and engaging in effective outreach activities.
- The private health sector should be directly involved in efforts that foster male involvement.

## Abbreviations

AIDS	Acquired immune deficiency syndrome
BCC	Behavior change communication
CAPPD	Cambodian Association of Parliamentarians on Population and Development
CHEMS	Cambodia Health Education Media Services
CMN	Cambodian Men's Network
FHI	Family Health International
GAD/C	Gender and Development/Cambodia
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
IUD	Intrauterine device
KHANA	Khmer HIV/AIDS NGO Alliance
MCH	Maternal and child health
MoEYS	Ministry of Education, Youth and Sports
MoH	Ministry of Health
MoP	Ministry of Planning
MoWA	Ministry of Women's Affairs
NAA	National AIDS Authority
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NGO	Nongovernmental organization
NIS	National Institute of Statistics
NMCHC	National Maternal and Child Health Centre
PMTCT	Prevention of mother-to-child transmission
PPAP	Person-to-Person Advocacy with Parliamentarians
RACHA	Reproductive and Child Health Alliance
RH	Reproductive health
RHAC	Reproductive Health Association of Cambodia
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
VCCT	Voluntary confidential counseling and testing
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women



# 1. Introduction

The last 15 years have witnessed increasing global recognition of the importance of men's involvement in sexual and reproductive health (SRH). Issues such as the AIDS epidemic have reinforced the urgency of encouraging men to take responsibility for their own sexual and reproductive health and that of their partners (Salem, 2004). Despite global recognition at the level of international agreements, many countries have not developed large-scale programs that reach out to men. As a result, many men are not aware of why they need to be involved in SRH, how they can be involved, and what services are available for them and their partners.

Involving men is particularly challenging in countries whose culturally defined gender roles may hinder men's participation. For example, in countries where communication between couples is limited and manifestations of masculinity often involve violence against women and alcohol consumption, high-risk sexual behavior is commonplace. Involving men in SRH in such settings is complicated and demands a long-term commitment. Yet, the rewards could be profound. The potential benefits of men's involvement include expanded rights for women, improved family health, better communication between partners, and joint and informed decisionmaking within households. Cambodia is a nation that would benefit enormously from involving men in addressing SRH issues.

The methodology for this research consisted of a literature review of documents referring to male involvement in reproductive health programs in general and in Cambodia in particular. The literature review was combined with interviews conducted by either members of the Reproductive Health Promotion Working Group or the consultant. Interviewees were representatives of SRH implementing agencies, government departments responsible for RH activities, or civil society and government-based lobbying groups. The list of interviewees and their organizations follows:

<b>Name of Interviewee</b>	<b>Organization</b>
Mr. Chhay Kim Sore	Gender and Development/Cambodia (GAD/C)
Dr. Sok Sokun and Ms. Sam Sochea	United Nations Population Fund (UNFPA)
Dr. Var Chivorn	Reproductive Health Association of Cambodia (RHAC)
Ph. Hou Nirmita	Health Department, Ministry of Women's Affairs (MoWA)
Dr. Tung Rathavy	National Reproductive Health Program, Ministry of Health (MoH)
Dr. Khieu Serey Vuthea	Reproductive and Child Health Alliance (RACHA)
Dr. Nith Sophea	Family Health International (FHI)
Mr. Sor Sontheary	BBC World Service Trust
Dr. Tith Khimuy	Khmer HIV/AIDS Alliance (KHANA)
Mr. Lim Leang	CARE
Mrs. Kim Sokuntheary	Cambodian Health Education Media Services (CHEMS)
Dr. Srey Daro	Cambodian Association of Parliamentarians on Population and Development/Person-to-Person Advocacy with Parliamentarians (CAPPD/PPAP)

Annex 1 provides a copy of the questionnaire.

## **2. The Challenges of Male Involvement in Cambodia**

At 437 per 100,000 live births, Cambodia's maternal mortality rate is one of the highest in the world (NIS and ORC Macro, 2001). The country's contraceptive prevalence rate is relatively low, at 19 percent for modern methods, while the number of births remains higher than the desired number of children (NIS and ORC Macro, 2001).

Cambodia has one of the highest HIV/AIDS prevalence rates in Asia, at 1.9 percent in 2003 (National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), 2004a), with transmission occurring primarily through heterosexual sex. The epidemic has evolved from one largely limited to high-risk groups, including sex workers, the military, injection drug users, and migrant populations, to a crisis affecting the entire population. The transition can partially be explained by the natural progression of the epidemic, the reversal in trends within high-risk groups, and the AIDS-related deaths that have already occurred within those groups. However, the practice of sex with several partners and the extremely low rates of condom use between married and regular partners have probably accelerated the disease's progression into the general populace. In 2002, 42 percent of new HIV infections were reported to have occurred from husband to wife (NCHADS, 2002).

These factors indicate a clear role for men in sexual and reproductive health. However, while many aspects of RH care in Cambodia have improved, male involvement in RH is still underdeveloped. Compared with women, Cambodia has developed only a few indicators for male involvement. Statistics collected on male clients show far lower attendance rates at reproductive health facilities; relatively few methods of available male contraceptives; and the provision of most RH services through maternal and child health (MCH) programs (particularly in rural areas). The curriculum for MCH training does not currently cover male involvement, and the strategic plans of government departments and nongovernmental organizations (NGOs) do not ordinarily include indicators for men, such as partner referrals and male clients of sexually transmitted infection (STI) services.

Recently, male involvement has become part of the agenda of some of Cambodia's SRH implementing agencies. However, the agencies report that traditional gender differences in Cambodian society tend to impede the benefits of male involvement in reproductive health. Some interviewees noted that, in Cambodia as elsewhere, reproductive health is usually considered a woman's concern both within households and at the policy level, where strategies and legislation rarely specify male involvement as a core component of RH interventions. Focusing RH programs exclusively on women leads to low levels of understanding, not just on the part of men, who have little notion of their role in reproductive health, but also on the part of service providers, who are not technically equipped, properly trained, or indeed inclined to meet the needs of male clients.

## **3. Potential Benefits of Working with Men in Cambodia**

Cambodia is a predominantly patriarchal society, although recent demographic changes suggest that women head at least one-quarter of all households (UNIFEM et al., 2004). Furthermore, women earn a significant proportion of family income; yet, men have held onto their traditional place in society as stronger, more educated, more "worldly," and more able to earn an income and thus more deserving of a greater share of household resources. Men also hold most of the positions of authority in the government and civil service and are managers in both the public and private health sectors. Involving men in RH is therefore essential in order to draw attention to women's rights and improve the health status of both men and women. Targeting men as beneficiaries of RH care and as supportive partners could address Cambodia's high rates of maternal and infant mortality and reduce the overall total fertility rate by

increasing contraceptive prevalence, choice,<sup>1</sup> and access to appropriate services and trained personnel. Targeting men as service providers will improve and expand the services offered by the private and public health services. Targeting men as policymakers will facilitate progress toward Cambodia's national development goals and help mainstream gender equity in legislation and service implementation.

Traditional perceptions of femininity also make it difficult for women to talk about reproductive health and sex with their male partners (Beaufils, 2000). Many RH care organizations that work with women note that their clients want men to be more knowledgeable, communicative, and receptive to joint decisionmaking (Walston, 2005a), particularly with respect to birth spacing. Often, however, men assume that birth spacing is entirely a women's responsibility, thus limiting the potential for dual-protection use and long-term contraceptive methods. According to the RH organizations, women also recognize the benefits of increased male knowledge about fertility cycles, childbirth, and the prevention of HIV and other STIs. Couples will be more likely to avoid unwanted pregnancy, ensure safe ante- and postnatal periods, and prevent STI transmission. Research by KHANA (Khmer HIV/AIDS NGO Alliance) indicates that when men participate in group discussions with their wives and in all-male groups, women find it much easier to raise sensitive subjects at home, such as the use of condoms for marital sex (KHANA, 2000). However, while efforts continue to increase the use of condoms outside of marriage to help prevent infection, public health services do not consistently promote condoms as a dual-protection method (Walston, 2005b).

More than half of Cambodia's population is under age 20 (NIS and ORC Marco, 2001). The National Youth Risk Behaviour Survey 2003–2004<sup>2</sup> found that, although only 2 percent of the sample was sexually active, one-third of the sexually active youth never used condoms, yet more than 40 percent had multiple partners. The survey also found that nearly one-quarter of all youth are not aware of STIs and that 25 percent had experienced or witnessed recent domestic violence in their own household (MoEYS, 2004). These statistics indicate the importance and urgency of, first, educating young people of both sexes *before* many of them become sexually active and, second, providing services to help reduce STI prevalence and unplanned pregnancies in what is a dominant demographic group.

#### **4. Policy Support for Male Involvement**

Currently, political support for male involvement is manifested by a lack of opposition to it rather than by any specific support. Many respondents said that, with the possible exception of the draft law on domestic violence, which in its present form reinforces the traditional perception of a man's role within marriage, they were unaware of laws and policies that either help or hinder efforts to involve men in reproductive health. Currently, the draft law does not recognize marital rape as a crime. One agency interviewed for this report explained that members of Cambodia's National Assembly, the majority of whose members are men, are concerned that viewing marital rape as anything other than a man's right would be seen as too threatening to Cambodian cultural values. Gender-based violence, including marital rape, is common in Cambodia. In tandem with women's limited powers of negotiation, many of the agencies interviewed see marital rape as a significant influence on reproductive health, particularly with regard to condom use within marriage.

In recent years, gender issues have found their way onto Cambodia's national agenda. However, concern with gender inequity in Cambodia almost always takes the form of policies and programs that exclusively promote the role, rights, and situation of women. Interviewees noted that such an approach can lead

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<sup>1</sup> The cost of contraception can be a decisive factor in choosing a contraceptive method (KHANA, 2000), even if that method is unsuitable. By limiting women's control of financial resources and not taking part in decisions regarding contraceptives, men can reduce the effectiveness or safety of contraceptive methods.

<sup>2</sup> The Ministry of Education, Youth and Sports (MoEYS) conducted the survey in cooperation with UNICEF and UNESCO.

donors to neglect male involvement in reproductive health while implementing agencies maintain a sole focus on women.

One intervention that could help policymakers address gender issues and male involvement in reproductive health is the establishment of the Cambodian Association of Parliamentarians on Population and Development (CAPPD). The CAPPD launched its Person-to-Person Advocacy with Parliamentarians Project in 2002, promoting RH care issues among Parliamentarians and commune council members in accordance with the principles of the ICPD (International Conference on Population and Development) Plan of Action. The project's first phase lobbied 131 lawmakers (the overwhelming majority of whom are men) on issues such as birth spacing, safe motherhood, and HIV transmission, covering three-quarters of the National Assembly and two-thirds of the Senate. The CAPPD has now extended the project to target the new members of the National Assembly and commune councils who won their seats in the 2003 elections.

At present, while a limited number of government strategies and policies make reference to men, implementing agencies do not necessarily translate words into practice. One way to ensure that policy implementation contributes to the full and effective involvement of men in RH issues is to develop clear male involvement guidelines. The policies that would benefit from these guidelines are as follows:

- i. The National Population Policy, which includes the objective *“To support couples and individuals to decide freely and responsibly on the number and spacing of their children, and to have access to the information, education, services and means to do so.”* It also outlines a strategy to *“Promote male responsibility and partnership in RH at the household and community levels”* (Ministry of Planning (MoP), 2003a).
- ii. The Policy on Women, the Girl Child, and STI/HIV/AIDS, which states, *“The Ministry. . . recognizes that this is a gender-based pandemic and that the spread of HIV/AIDS among women and girls can be slowed only if concrete changes are brought about in the sexual behavior of men. Gender and HIV mainstreaming efforts at the national, provincial and local levels are hampered by negative attitudes towards discussing sex, sexuality and reproductive rights. Accordingly, MWVA places prevention, care, support and protection of women and the girl child plus the need to change the behavior of men on the agenda for policy-makers and service-providers through the Policy. . . ”* (Ministry of Women's and Veterans' Affairs, 2003).
- iii. The new five-year National Reproductive Health Strategy to be launched by the Ministry of Health in 2006. The strategy will include six emphases: the expansion of RH care services; the strengthening of service provider capacity; the strengthening of MoH managerial capacity; effective information, education, and communication (IEC); research; and the development of political support (including multisectoral and civil society support). All of these areas of emphasis offer strong opportunities for integrating components of male involvement.
- iv. The Socio-Economic Development Plan II (SEDPII), which intends to promote maternal health by providing ante- and postnatal care and promoting birth spacing for high-fertility groups (MoP, 2002).
- v. The Health Sector Strategic Plan 2003–2007, which has identified the provision of maternal health services, including birth spacing, ante- and postnatal care, safe deliveries and emergency obstetric care, safe abortions, and postabortion counseling as priority areas (MoH, 2002).
- vi. The National Strategic Plan for a Comprehensive and Multi-Sectoral Response to HIV/AIDS, 2001–2005, which focuses on *“empowering the individual, the family and community in preventing HIV and dealing with the consequences of HIV/AIDS through the promotion of a social, cultural and*

*economic environment that is conducive to the prevention, care, and mitigation of HIV/AIDS.” In particular, the plan aims to “lessen the vulnerability of women and girls to HIV/AIDS and to increase their status by seeking to offset prevailing discriminatory attitudes in society especially among men” (National AIDS Authority, 2001).*

vii. The Birth Spacing Policy for Cambodia, which states in its general principle that “*Cambodia will take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care. . . . Couples and individuals have the right to decide freely and responsibly on the number and spacing of their children and to have the education and means to do so*” (MoH, 1995).

viii. The Safe Motherhood Policy, which includes the policy directives to “*Increase the awareness of families, men and women about the importance of safe motherhood. . .*” and to “*review pre-service nursing and midwifery training programs to assure a cadre of personnel capable of carrying out quality midwifery care. . . including a review of the distribution of male/female admissions to nursing training*” (MoH, 1997).

The lack of financial and technical resources in Cambodia means that, in the near future, the nation is unlikely to provide additional RH care services specifically targeted to male needs. Instead, Cambodia is working toward integration of RH initiatives with HIV/AIDS programs, for which donor support remains strong (Walston, 2005b). Nonetheless, the current fiscal climate might present an opportunity for male involvement. That is, for the integration of RH care and HIV/AIDS services to be effective, the integrated services must focus on issues such as STI referral, treatment, and counseling; the use of condoms as a dual-protection method; and birth spacing for high-risk couples.

## **5. Opposition and Challenges to Male Involvement**

Most health-related policies do not specifically refer to male involvement and fail to offer suggestions for how to involve men in program implementation. Gender-related policies tend to overlook the concept of equality and the role of men in promoting women’s access to services and development opportunities. Implementing agencies that choose to involve men actively in their services receive little technical or financial support from the government. In general, programs lack clarity as to how male involvement should be promoted and thus implement their services with the unspoken assumption that services are equally accessible to both sexes.

Opposition to male involvement often comes from men themselves. Respondents point to men’s reluctance to change their practices regarding reproductive health, their feelings of embarrassment,<sup>3</sup> and a belief that reproductive health, particularly birth spacing, should remain the concern of women. Evidence also suggests that men’s perception of risk limits their involvement in reproductive health. “[T]he motivation for men to use condoms is not to prevent transmission but to protect themselves from infection” (MoH, 2000). Another indicator of men’s perception of risk is the low rate of HIV testing, even among high-risk groups. Research by NCHADS concluded that 71 percent of the military and 81 percent of “motodop” drivers had never undergone an HIV test (NCHADS, 2001). It seems that men are either unclear about or refuse to acknowledge their own vulnerability and the danger to which they expose their partners.

Social, economic, and cultural challenges also pose barriers to involving men in RH matters. Barriers include the following:

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<sup>3</sup> Unlike in the case of a visit to a pharmacy or traditional healer, Cambodians fear that visits to doctors will involve invasive physical examinations. Such fear is often reported as a barrier to accessing health services (KHANA, 2000).

i. Addressing men as a target group

Several interviewees considered men to be beneficiaries of their programs because men were simply eligible for the services available. However, men were not specifically targeted in these programs. Other programs focus on specific target groups selected on the basis of their occupation (e.g., soldiers, police officers, construction workers, and garment factory workers) and the perceived risks associated with the various occupations. Focusing on specific target groups tends to overlook married men who live at home and have stable family lives but who also occasionally exhibit high-risk sexual behavior and, as a consequence, put themselves and their wives at risk for STIs and unwanted pregnancy. Targeting the general male population as husbands, boyfriends, and individuals in need of improved and expanded health services is not yet a priority for RH agencies.

ii. Engaging men in reproductive health

Respondents found that men were “uninterested” by RH, viewing it as not their concern. In particular, men believe that women should assume primary responsibility for birth spacing. However, decisions regarding sex ultimately rest with the man. Therefore, counseling for birth spacing must address cultural challenges. If contraceptive methods besides condoms are the method of choice, women will still have to bear the responsibility for birth spacing,<sup>4</sup> causing men to perceive that they can engage in sex without condoms. Some sole-method choices for birth spacing, such as the pill, IUD, or injection, could help maintain men’s passive participation in family planning. Alternatively, promoting condoms as a dual method, such as in Population Services International’s efforts with its OK Condom brand, will help foster husband-wife sharing of responsibility for birth spacing and protect both from infection. As one respondent noted, although it is not always possible to change traditional values and men may always want to make decisions within the family unit, it is possible to change men’s perceptions. Men may therefore make choices that are good for themselves and their family.

iii. Addressing the perception of male and female roles in Cambodian society

Cambodian society’s expectations for male and female sexual roles are markedly different. Men’s needs for sexual variety and quantity are perceived as a priority while women are expected to be monogamous and uninformed. Traditionally, women look after the household; they are responsible for domestic labor and care of the family. They give birth and make decisions about their reproductive health. Men are the breadwinners; their needs generally come first, and they tend to monopolize scarce household resources. These realities ensure that few financial resources are available for any member of the household in need of RH care (NIS and ORC Macro, 2001; UNIFEM et al., 2004). Moreover, respondents noted that a man who patronizes a specialized facility offering RH care is likely to feel ill at ease. It is women who predominantly staff such facilities, which typically offer few distractions or IEC initiatives designed for a male audience.

iv. Changing the environment in which RH care services are offered

Some respondents argued that the women-oriented environment for RH services—with its predominance of female clients and service providers—is a reflection of donor influence and emphasis on women’s concerns. It is undeniable that, in a country such as Cambodia whose maternal and infant mortality rates are high, women are in urgent need of specific services. Donors have responded to that need, helping expand services that promote safe deliveries, ante- and postnatal care, safe motherhood, contraceptive availability, maternal and child nutrition, and immunization. A subsequent risk, however, is that, without careful planning, the exclusive focus on women will militate against the involvement of men in RH. Such a possibility warrants further research and appropriate responses by donors and agencies involved in providing RH services.

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<sup>4</sup> The exceptions would be male sterilization, although it too would have little effect in promoting condom use.

v. Changing approaches to sexual and reproductive health

Approaches to SRH can themselves be barriers to involving men. The 100 Percent Condom Program, for example, focused on the use of condoms in commercial sex establishments. While highly successful in promoting condom use in commercial sex relationships, the program nonetheless helped stigmatize condom use and did not attempt to change men's behaviors and attitudes outside commercial relationships. Instead, the program placed sex workers squarely in the spotlight as a high-risk group, helping eliminate the expectation that men would assume responsibility for any of their sexual relationships.

vi. The cultural traditions of seeking health care

The challenge of involving men in RH interventions is not simply a matter of overcoming feelings of shame and embarrassment but must also address the cultural traditions associated with seeking health care. First, men are less likely than women to seek treatment, testing, or counseling for a STI by a trained health provider or to obtain such services if requested to do so by their regular partners (NCHADS, 2001; NCHADS, 2004b). Second, Cambodians are more likely to seek the services of private rather than public sources of health care, including traditional healers (MoP, 1997; CARE, July 2000; Greenwood and Francis, 2001). It is assumed that the private sector more easily guarantees confidentiality, distributes medication in satisfactory quantities (which, in Cambodia, is more highly valued than advice) (MEDiCAM, 1999), and involves shorter waiting times (KHANA, 2000). Moreover, the private health sector is often more accessible. However, visits to private pharmacies and traditional healers can result in high levels of self-medication and incorrect diagnosis and treatment (RACHA, 1998), which can have significant implications for STI prevalence and drug compliance (including contraceptives).

The public health system suffers from limited staff and poor capacity. Many health centers, particularly in rural areas, are understaffed and underequipped and operate at inconvenient hours. Implementing male involvement directed at the public health system may place an additional strain on scarce resources without addressing a major problem of the public health system—underutilization.

vii. Limited access to formal health services

Financial constraints, loss of income through lost work time, or the inability to arrange transport are all factors that prevent men from either accompanying their wives to RH appointments or keeping their own RH appointments. For example, vasectomies and female sterilization require two round trips to the provincial hospital (for many, a prohibitively expensive journey) for two people; both procedures require the written consent of both partners but cannot be performed on the same day consent is granted.

## 6. Current Efforts to Involve Men in Reproductive Health

Male involvement in RH initiatives and services in Cambodia is in its earliest stages and therefore limited. Some agencies, such as Marie Stopes International (MSI), operate an “open-door” policy for men, whereby men can patronize clinics as clients in their own right whenever they want. Other projects recognize the role that men play in reproductive health. For example, RHAC's STI partner program encourages women to return to the clinic with their male partner so that both can receive treatment and counseling. Currently, 80 percent of women who visit RHAC for an STI consultation return to the clinic with their partner for treatment.

Other examples of male involvement include CARE Cambodia's *Couples in the Know* initiative, launched in May 2000. The project aimed to increase the safety of sexual encounters among men and women by improving their negotiation skills and increasing their understanding of sexual health. Based on a peer facilitation approach, the project selected couples on the basis of their positive couple behavior (such as fidelity) to lead participatory discussions on sexual and reproductive health topics. These peer

educators then held discussion sessions with other couples, covering topics such as HIV transmission, dual condom use, domestic violence, and the perceived roles of men and women. An evaluation of the pilot project indicated that, while educating women in sexual health and condom use might increase their knowledge, it did not significantly increase their ability to negotiate safer sex with their husbands. However, once husbands were exposed to the same education as their wives, women felt far more confident about initiating conversations on sex and condom use (CARE, 2004). Anecdotal evidence also suggests that condom use within marriage is increasing and that levels of domestic violence have dropped.

Several organizations have identified specific groups in terms of their vulnerability, particularly to HIV/AIDS, and now target services and education initiatives to those groups. One such example is the Reproductive Health Association of Cambodia's (RHAC) behavior change communication (BCC) activities on HIV/AIDS and reproductive health for young fishermen. The project focuses on a residential and mooring location for 4,555 fishermen and their families in Sihanoukville, Cambodia's main fishing port. Using peer educators, group education sessions, quiz shows, and other IEC methods, the project promotes safer sex, the utilization of clinical and referral services, and positive behavior change. Since the project began, it has distributed more than 410,000 condoms, nearly 4,000 fishermen have participated in education sessions, and nearly 2,000 have been referred to VCCT centers and RHAC clinics (RHAC, 2004). RHAC also promotes male-friendly services through separate waiting areas, male service providers, and separate examination rooms.

Other examples of projects focusing on vulnerable groups include the Reproductive and Child Health Alliance's (RACHA) program for migrant couples, Family Health International's (FHI) pilot projects for sweethearts and uniformed personnel and their wives, and the work of Cambodian Health Education Media Services (CHEMS) and CARE Cambodia with garment factory workers.

Adolescent health is one of the greatest challenges facing Cambodia's government and civil society. The United Nations Population Fund (UNFPA), RHAC, CHEMS, Maryknoll Cambodia, and CARE Cambodia are all examples of organizations that target adolescents of both sexes in clinical and education programs addressing SRH and the prevention of HIV/AIDS. CHEMS broadcasts a radio phone-in show and soap opera aimed at Cambodian men and women under the age of 26. The broadcasts, which feature several topics such as menstruation, first sexual experiences, STIs, pregnancy, and contraception, air on two of the most popular stations in Cambodia and are distributed on tape to other NGOs working in the sector. Calling or writing to a radio show has been shown to be an effective means of obtaining information about topics that many young people feel uncomfortable discussing with their families, teachers, or local health worker.

Maryknoll Cambodia has approached male involvement by using a "holistic approach to sexuality" in its *Karol and Setha* program. The program aims to help young people think about and reflect on the relationships between men and women and, in so doing, take more responsibility for their sexual activities. The program hopes to increase responsible sexual behavior by helping young people to develop critical thinking skills, training mobile teams in the holistic approach to sexuality, and raising awareness about RH, HIV prevention, and domestic violence. Activities with adolescents and children discuss anatomy, puberty, and the psychological differences between boys and girls. Discussions also address gender, mutual understanding, and how to listen and express feelings. Besides conducting activities with adolescents and children, Maryknoll conducts training sessions with NGOs that work with youth.

While not working specifically in the health sector, Gender and Development Cambodia (GAD/C) advocates gender equality, which closely affects reproductive health. GAD/C is skilled at producing gender-sensitive IEC materials and training other organizations to integrate gender issues into their services. In 2001, GAD/C created the Cambodian Men's Network (CMN) in response to the escalation of

domestic violence within Cambodian households. Through training, advocacy, and the involvement of youth, the network supports its members and NGOs in helping to reduce and eventually eliminate violence against women in Cambodia.

The media, particularly radio and television, commonly disseminate RH information in Cambodia. The BBC World Service Trust developed and broadcasts a weekly hour-long national radio show entitled *Real Man* presented by men to a target audience of men. The program advocates increased understanding and involvement of men in household concerns, including domestic labor, child care, and SRH. Radio is accessible to almost all of Cambodia's population, and television is becoming more accessible and is extremely popular, particularly among youth.

The Royal Government of Cambodia has developed projects that address the involvement of men in reproductive health. Projects have included the Ministry of Women's Affairs community outreach activities, which involved village leaders in reaching men through informal meetings and at special events. The pilot program, lasting from 2000 to 2003, reached thousands of men and increased their participation in reproductive health (Hou, 2004). The Ministry of Health's National Maternal and Child Health Centre (NMCHC) established a safe motherhood initiative that promotes the involvement of men as participants in ante- and postnatal care. The NMCHC's program for prevention of mother-to-child transmission of HIV (PMTCT) found much higher female continuation when husbands are involved than when they are not (Koum, 2004).

## 7. Recommendations

Several options are available to men motivated to participate in RH activities in Cambodia. Men may become involved as service providers, journalists, NGO staff, employers, village health volunteers, peer educators, community-based distributors, consumers, and community and religious leaders. They may also accompany their wives and partners to RH appointments and participate in single-sex and couple discussion forums. As beneficiaries, men may receive treatment for STIs, undergo voluntary surgical contraception, and receive counseling on HIV and birth spacing, alone and with their partners. Cambodia does not explicitly restrict any of these activities.

Many working in the health sector and beyond in Cambodia increasingly recognize the need to strengthen male involvement in the nation's RH issues. The following recommendations highlight how the Cambodian government and NGOs could more actively support male involvement in reproductive health. The recommendations are organized into three categories under the headings of policy, education and IEC, and service improvement.

### A. Policy

- *An important first step is to promote male involvement as a central tenet of reproductive health policy in Cambodia.* Though some Cambodian policy instruments recognize male involvement, they often include only a token mention, unsupported by specific guidelines or concrete recommendations.
- *A set of guiding principles needs to be developed to assist those involved in the health sector with mainstreaming male involvement into reproductive health strategies.* The guidelines should be short, clear, and constructive and permit implementing agencies to adapt existing activities and approaches rather than initiating new projects or using additional resources.<sup>5</sup> A clear example is the adoption of

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<sup>5</sup> Respondents for this research agreed unanimously that guidelines for male involvement in RH care would be beneficial. Some saw guidelines as helping promote gender equality in policy development; others saw guidelines as useful for helping program implementers and donors incorporate male involvement into their workplans. Respondents wanted the guidelines to be practical

male involvement guidelines for incorporation into the new National Reproductive Health Strategy. Men should be involved in all stages of the guidelines' development.

- *Agencies motivated to involve men in their reproductive health initiatives should plan for a long-term commitment.* Changing the perceptions of men—and women—with respect to their reproductive roles and successfully integrating men into available RH care services will necessitate multiyear projects with corresponding budgets and indicators. The decision to enter into a long-term commitment will require agencies to lobby both donors and policymakers. Donors need to understand the difficulties of working with deeply entrenched social values, and policymakers need to recognize how male involvement can help achieve major development objectives.
- *Any measure that seeks to challenge gender roles must be introduced and implemented as sensitively and as appropriately as possible.* For example, men generally take little interest in family planning but may see themselves as the protector of the family and its financial provider. Therefore, educating men about the economic benefits of family planning might be more effective than attempting to persuade them to accompany women to family planning consultations purely on the basis of their responsibility as husbands and partners.

## **B. Education and IEC**

- *Male involvement campaigns need to start finding ways to educate seemingly “safe” demographic and social groups.* All men should be educated in all aspects of reproductive health as both direct beneficiaries and partners. A focus solely on traditional high-risk groups is no longer likely to succeed now that HIV/AIDS has spread beyond these groups.
- *Current education campaigns need to be reviewed to assess their value in promoting male involvement.* Programs that inadvertently stigmatize condom use so that it is associated only with high-risk situations may reduce condom use in noncommercial relationships.
- *Education campaigns should not reinforce gender inequities but rather work to reduce them.* Programs should not, for example, put men in sole control of contraceptive choices.
- *Education must be linked to service provision.* Education will be insufficient without a clear understanding of what services are provided, how they can be used, and in what way they benefit both individual males and their families.
- *Establishing effective ways of delivering education messages to the male populace requires greater analysis.* Outreach services that use role models and structures familiar to the client base may sometimes be more effective in reaching men than merely encouraging clinic use, which is often seen as the domain of women (UNFPA, 2003). An instructive example is the uniformed services, which respond well to peer education techniques. Conversely, men who have sex with men (many of whom also have sex with women) may respond better to methods that do not depend on personal contact, such as radio and television broadcasts (POLICY Project, 2004).
- *The mass media should be used more frequently and more effectively.* Radio is widely accessible and can reach even highly mobile groups such as fishermen and the military. Television is hugely popular with the urban young. Both media are highly useful in conveying messages in a country with an illiteracy rate of 36 percent (UNDP/UNESCO, 2000).
- *Traditional role models, including community and religious leaders, should be promoted to men.* The visible support of influential people in the community (most of whom are men) reportedly encourages people to perceive health programs as relevant and socially acceptable (KHANA, 2000).
- *Teaching negotiation skills should be accompanied by efforts to raise awareness of the legitimacy of challenging gender stereotypes and not accepting them as the norm.* Female cultural expectations have socialized women to be unaware of and ashamed to talk about sexual matters. For example,

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and realistic. Guidelines should not support interventions that promote male involvement as a separate program component, which could otherwise lead to financial and operational difficulties.

women who do not know that it is their right to ask their husbands to use condoms may not feel that they are in a position to negotiate condom use. Men, in contrast, tend to control the terms and conditions of sexual encounters. Education and negotiation skills can equip men and women with the skills needed to find alternatives to harmful stereotypes.

### C. Service Improvement

Respondents suggested that promoting separate services for men may not be appropriate. In fact, the integration of services, with specific indicators for male involvement, may permit a more productive use of funds and ensure greater compatibility with the existing infrastructure. It is also important that an emphasis on male involvement not dilute donors' focus on important services for women and children. Again, the integration of services should help avoid an exclusive focus on male involvement

- *Existing RH services should be more “male-friendly.”* Understandably, specialized RH care facilities are female-oriented. While such facilities are essential and successfully provide much-needed RH support to women, they are generally perceived as inaccessible to men, thus embarrassing or intimidating prospective male clients. Certain basic measures that would begin to address such gender issues include the hiring of male service providers, reassessing clinic opening times, and perhaps scheduling male-only clinics and improving the privacy of male clients.
- *Existing service providers need further training in counseling male clients and couples.* Service providers must be trained according to the specific priorities of a program and its beneficiaries. For example, some providers work with large numbers of clients concerned with HIV/AIDS (Ndong et al., 1999).
- *Effective outreach activities need to be developed to facilitate both men’s and women’s access to RH services.* Limited access to, and perceptions of, formal health services suggests that culturally and socially appropriate outreach activities might be particularly effective for assisting some people in some areas in obtaining RH information and care. For example, evidence collected from young people suggests that youth value information and discussion from their peers but do not consider the staff of health facilities as valid sources of information (MoEYS, 2004). Furthermore, community-based distribution networks have been shown to have an impact in facilitating the access of rural Cambodians to some contraceptives (Walston, 2005b), particularly condoms, often because such networks ensure greater privacy, help reduce transport costs, and offer greater convenience (KHANA, 2000).
- *Male involvement should be supported by efforts to facilitate access to RH services.* Distance, cost, social and cultural barriers, limited awareness, and perceived efficacy of treatment are important factors in influencing the use of public health services (KHANA, 2000). While standard RH services are available at health centers (antenatal care, midwife consultations, birth spacing counseling), services such as STI treatment and HIV testing are not. Agencies hoping to implement male involvement initiatives should therefore be aware of the problems couples will face in accessing and budgeting for nonstandard services, many of which require transportation, medication, and repeat visits. Options such as user-fee exemptions may have to be developed to help increase financial access to services (MoP, 2003b). Agencies should also be aware of the need to support hospitals and clinics that provide nonstandard services to ensure that drugs, equipment, and trained staff are consistently available and to make certain that such facilities can respond to increased demand through successful male involvement measures.
- *The private health sector should participate directly in male involvement efforts.* To a great extent, Cambodians rely on the nation’s private health sector, thereby providing an important opportunity to reach male service providers and male clients.

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# Annex 1. Male Involvement Questionnaire

## Reproductive Health Promotion Working Group Male Involvement in Reproductive Health Questionnaire

*If you require more space for the answers, please continue on a separate sheet, but clearly mark the answers A1, A2 etc.*

### A. The Challenge/Issue

1. What do you think the term “male involvement” in reproductive health means?
2. What are the issues of male involvement in reproductive health in Cambodia?
3. Are there any Ministries/Agencies/Working Groups that have been specifically supporting male involvement in reproductive health? If yes, what issues are they focused on?
4. What opposition has there been to male involvement in reproductive health?

### B. Background on Organizations’ Current Male Involvement Work

5. Please describe briefly your organization’s work in reproductive health (including family planning, maternal health, STI prevention, diagnosis and treatment, and HIV/AIDS).
6. Who are the beneficiaries of your organization?
7. Does your organization include men in any of its reproductive health activities? (e.g., as partners of women, as direct clients) Please describe.

*If men are not included in any of your activities, please go to Question 8a.*

*If men are included in your activities, please go to Question 8b.*

- 8a.** Do you have any plans to work with men in your reproductive health programs?

Yes\_\_\_\_\_ No\_\_\_\_\_

If not, why not?

- 8b.** What were the reasons your organization started to work with men?

- 9.** Besides your beneficiaries, in what *other* ways does your organization have contact with men? (e.g., as service providers, policymakers, program managers, or community leaders). Please describe.

10. Do the women beneficiaries of your RH programs want men to be more involved?  
How?

### **C. Possible Areas in Which to Expand Work with Men**

*To respondents of 8a: The questions in section "C" are optional.*

11. Would your organization like to work more extensively with men in reproductive health?
12. In what additional ways would you like men to be involved in your reproductive health programs?
13. What would make it easier to work more extensively with men?
14. Would it help your organization if there were guidelines on working with men in reproductive health? How?

### **D. Overall Benefits and Challenges**

15. What are the benefits of working with men?
16. What are the difficulties of working with men?

### **E. Policies, Laws, and Regulations and the Development of Guidelines**

17. Are there any policies, laws, or regulations that you are aware of that are related to male involvement in reproductive health? If so, which ones?
18. Are there any policies, laws, or regulations that could make it more difficult to involve men in reproductive health? If so, which ones?
19. Is there anything in Cambodian culture that could be a barrier to male involvement in reproductive health? How do you think these barriers could be overcome?
20. What do you see as the most important components of a program that works with men in reproductive health?
21. To which sources did/do you look for guidance on working with men in reproductive health? (e.g., documents, websites, organizations)