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Ricardo Wray

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Reproductive Health

New Perspectives on Men's Participation

New information, new understanding, and new approaches promise to help men become full partners in better reproductive health. Men, as well as women, play key roles in reproductive health, including family planning, but increasing men's participation has been difficult. Adopting new perspectives can help.

Today's new perspectives recognize that:

- Men play important, often dominant roles in decisions crucial to women's reproductive health;
- Men are more interested in family planning than often assumed but need communication and services directed specifically to them;
- Understanding—and influencing—the balance of power between men and women can help improve reproductive health behavior;
- Couples who talk to each other about family planning and reproductive health can reach better, healthier decisions.

Why Men Now?

Men's participation is a promising strategy for addressing some of the world's most pressing reproductive health problems. With HIV now spreading faster among women than among men in some regions, the AIDS epidemic has focused attention on the health consequences of men's

sexual behavior. Also, millions of pregnancies are unintended, and each year many thousands of women die as a result of these pregnancies.

At the same time, surveys, mostly in Africa, find that many men favor family planning and are concerned about reproductive health. For example, in 8 of 12 countries with surveys of men, at least 70% of men approve of family planning. Increasingly, men make reproductive decisions together with their wives. Such findings suggest that men's reproductive health behavior is ready to change.

If men are ready, why have some programs to involve them fallen short? Some efforts may have been too weak and too brief or based on incomplete understanding of men's motivations, couples' interactions, and what engages men.

Gender, Communication, and Decision-Making

Gender—the different roles that men and women play in a society and the rights and responsibilities associated with those roles—is a powerful force. In many countries gender roles make it difficult for men and women even to discuss family planning. Men often dominate decision-making and so can seriously harm or help women's reproductive health.

Communication plays a key role in new approaches to men. Communication can help promote equity between partners. Encouraging couples to discuss contraceptive use and other reproductive decisions can lead to and healthier practices. Messages in the mass media can address men's specific concerns and give men positive models to follow. At the same time, service delivery now recognizes men's distinct reproductive health needs.

Program Lessons

Nine major lessons learned from research and program experience can help to increase men's participation:

- **Reach Male Audiences with Appropriate Messages**
  Lesson 1. Build on men's approval of family planning.
  Lesson 2. Use the mass media to communicate with men.
  Lesson 3. Reach out to young and unmarried men.
- **Use Communication to Promote Behavior Change**
  Lesson 4. Understand the influence of gender.
  Lesson 5. Encourage couple communication.
  Lesson 6. Bring information to where men gather.
- **Offer Information and Services That Men Want**
  Lesson 7. Inform men about condoms and vasectomy.
  Lesson 8. Counsel men with respect and sensitivity.
  Lesson 9. Offer men a range of health services.

With new information and new perspectives, policy-makers and service providers increasingly recognize that reaching men is a winning strategy, offering benefits for the reproductive health of both men and women.

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New Attention To Men

A growing number of family planning and other reproductive health care programs and providers are seeing that men deserve more attention—for their own sake, for women's sake, and for the health of their families and communities. From this new perspective, men are potential partners in and advocates for good reproductive health rather than bystanders, barriers, or adversaries.

This new attention contrasts with several decades of neglect that began in the 1960s after the development of modern contraceptive methods for women. Many family planning programs and other reproductive health care providers were accustomed to paying little attention to men except for the diagnosis and treatment of sexually transmitted diseases (STDs) (21, 100, 157, 240, 242). Now, reproductive health programs are seeking better ways to understand men, to communicate with them, to engage them, and to help them take better care of themselves and their partners.

Family planning programs in the past have focused on women instead of men for several reasons: Women bear the risks and burdens of pregnancy and childbearing; most modern contraceptives are for women; and many providers have assumed that women have the greatest stake, and interest, in protecting their own reproductive health.

Reflecting these assumptions, the clinic-based service delivery design for family planning has made it difficult to include men (70, 272). Services have often been offered in maternal and child health (MCH) clinics. Many men see MCH clinics and their staffs as serving only women and children and feel uncomfortable seeking information or services in that setting.

Some family planning programs have avoided men because they assume that men are indifferent or even opposed to family planning (57, 76, 90, 100, 155, 157). Indeed, men as a group are frequently blamed for many of women's reproductive health problems.

Men are a diverse group of individuals. They reflect the spectrum of humanity, from kind and caring to abusive and dangerous. While some men do prevent women from using family planning, spread STDs to their female partners, or act in other harmful ways, most men do not. It is important that health programs abandon stereotypes of men and learn more about their concerns and needs, especially when designing programs for different groups of men (57).

An Evolution in Thinking

New perspectives on men come from an evolution in thinking about reproductive health rather than from a revolution in attitudes. Interest in men has waxed and waned over the past several decades (9, 90). Although reproductive health programs have never given as much emphasis to men as to women, in the 1980s many began workplace programs and condom social marketing to reach out to men (90, 203). These programs, which have continued in the 1990s, often have increased condom use among some key groups of men (81, 197).

Many providers and program designers have concluded that neglecting men and their reproductive health is a losing strategy with adverse consequences for both men and women (63, 100, 221). As a result, interest in and commitment to involving men in reproductive health has intensified during the 1990s. The reasons for more attention to men include:

- Growing concern about the spread of HIV/AIDS and other STDs, such as chlamydia and gonorrhea (4, 100, 157, 286);
- Evidence of the ill effects of some men's risky sexual behavior on the health of women and children (29, 61, 157, 202, 222);
- Survey findings that many men approve of family planning (72, 76, 213);
- Greater recognition that in many cultures men make decisions that affect women's reproductive health as well as their own (53, 157, 202);
- Increasing awareness that gender—men's and women's differing social roles and the power associated with these roles—affects sexual behavior, reproductive decision-making, and reproductive health in many different ways (171, 187, 202, 292);

IHC/CCP

A Bangladeshi villager talks outside his home with a family planning field worker. In the 1990s more men want to participate in achieving good reproductive health, and more health programs are seeing that paying attention to men's concerns is a winning strategy for both men and women.

- Demands from female health care clients that men become more involved and included in family planning and other reproductive health care (57, 153, 273).

At the 1994 International Conference on Population and Development (ICPD), held in Cairo, representatives from more than 180 countries formally recognized the importance of men to women's reproductive health and also recognized the importance of men's own reproductive health (25, 106, 228, 251, 259). The ICPD Program of Action urges all countries to provide men, as well as women, with reproductive health care that is "accessible, affordable, acceptable, and convenient" (251).

The ICPD Program of Action encourages reproductive health care programs to move away from considering men and women separately and to adopt a more holistic approach that includes men and focuses on couples. It also draws attention to the unfairness inherent in many men's and women's gender roles, calling for men to take more responsibility for household work and child-rearing (251). Similarly, the report of the 1995 United Nations Fourth World Conference on Women, held in Beijing, encourages men to take steps toward achieving gender equality and better reproductive health (252).

Family Planning Association of Turkey

Organizations from Turkey and many other nations, meeting in Cairo in 1994 and Bejing in 1995, urged men to share responsibility for child-rearing and take on other tasks traditionally done by women. Providing positive images can help men play new roles.

Participation or Competition?

Many health care providers see opportunities for men—as individuals, family members, community leaders, and policy-makers—to promote better reproductive health for all (12, 59, 100, 157, 251, 262). Some also argue that more good can be done for women if men participate fully in reproductive health programs (225).

Not everyone agrees, however, that encouraging men's participation in reproductive health activities is a good way to improve women's reproductive health (43, 109, 110, 262). Some argue that men are already too involved—that is, men hold too much power over decisions that affect women's fertility and health. They point out that more attention to men, if not well planned and wisely developed, could reinforce this imbalance rather than correct it.

Some also fear that more attention to men could jeopardize reproductive health services for women (12, 19, 179, 199, 235, 262). They worry that new programs for men will mean more competition for limited, and sometimes shrinking, reproductive health funds.

These concerns are legitimate. Men's policies and programs should be planned using the same criteria as other public health programs—considering the seriousness and prevalence of health problems, the effectiveness of the intervention, program costs, cultural appropriateness, and resource limitations (162). For each country or program, the approach to men depends largely on the available resources and on health priorities (260). It also depends on what mix of programs and services will best serve clients' health needs (12, 59, 100).

Engaging men's participation and providing reproductive health care to men can be scaled to suit resources and priorities. At the least, some programs can designate several clinic hours each week for male clients or encourage female clients to bring their male partners to the clinic. At the other end of the spectrum are special clinics for extensive men's services, expanded contraceptive social marketing programs, and national communication campaigns directed to men. In some places programs can start at once to promote men's participation in reproductive health. In other places, there may be more immediate health priorities, and promoting men's participation may start small or come later.

The Scope of Men's Participation

The movement to involve men in reproductive health has many names, including men's participation, men's responsibility, male motivation, male involvement, men as partners, and men and reproductive health (61, 84, 110, 262, 265). As yet, there is no consensus about which term best describes the new perspective on men, what these terms mean, and how men can best be involved in reproductive health activities (60, 61, 102, 265). This issue of **Population Reports** uses the term "men's participation" to describe men's active, positive involvement in achieving good reproductive health.

Whatever the term used, the purpose is to describe a complex process of social and behavioral change that is needed for men to play more responsible roles in reproductive health. Men's participation can be seen as a means to an end, rather than as a goal in itself (101). The goal is good

reproductive health for all, and men can help in many different ways to make that a reality.

New methods. One aspect of efforts to increase men's participation is the continuing quest for new contraceptive methods for men. It is argued that men do not have enough methods to choose from; if there were more choices, more men would use family planning. The search for safe, acceptable male hormonal methods has continued for more than 20 years (38, 205). Research in recent years has produced some promising results with various hormonal implants and injections as well as possible vaccines (8, 38, 47, 69, 82, 150, 270, 290). Clinical trials of one new hormonal method took place recently in 15 centers in nine countries (105, 290). It will be at least another decade, however, before a hormonal method for men could become available (31, 38, 60, 82, 156).

The pace of development currently is slow for several reasons. Men's fertility is more difficult to control than women's because men are fertile all the time. Also, major pharmaceutical companies have been reluctant to invest in research, development, and marketing of new male methods (105, 156). The World Health Organization (WHO), the United Nations, the World Bank, and the US Agency for International Development (USAID), with modest resources, have funded much of the research. Finally, men are not demanding new contraceptive methods, as women did in the 1960s (156, 204, 269).

New models. Proven men's programs, such as condom social marketing, workplace programs, and male clinics, serve men in many countries (90, 197). Providers seeking to go beyond such programs and to encourage men to adopt more positive roles in reproductive health need new program models. New examples of best practices can help translate the new perspective into action.

While a great deal of operations research has been carried out, and pilot programs developed, progress has been slow (59, 83, 132). Evaluations have been difficult, partly because there is no consensus on what indicates improvement or success (59, 263, 295).

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Strengthening Men's Participation Activities

Increasing men's participation involves more than program activities conventionally associated with men, such as preventing and treating STDs, promoting condom use, or opening male clinics. It also involves encouraging a range of positive reproductive health and social behavior by men to help ensure women's and children's well-being (60, 101, 110, 251, 262).

As the new thinking has evolved, a consensus is forming. To improve women's and men's reproductive health, policies and programs must:

- Encourage men to take more responsibility for their sexual behavior;
- Increase men's access to reproductive health information and services;
- Help men to communicate with their partners and make contraceptive choices together; and
- Address the reproductive health care needs of couples (27, 32, 60, 61, 100, 157, 209, 210, 221, 222, 259, 276).

The changes needed in men's sexual and reproductive behavior suggest that programs should focus on communicating with men and couples (12, 101, 209). Since 1990 the number of reproductive health activities that include men has increased sharply (59, 100). New studies of men and couples, creative interventions, and extensive HIV/AIDS-prevention outreach efforts have yielded a number of lessons that can help programs communicate with male audiences, encourage men's positive health behavior, and provide information and services that men want (see p. 24).

Men Make A Difference

Men's participation is a promising strategy for addressing some of the world's most pressing reproductive health problems. Men can help slow the spread of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and other sexually transmitted diseases (STDs); prevent unintended pregnancies and reduce unmet need for family planning; foster safe motherhood and practice responsible fatherhood; and stop abusing women (45, 58, 59, 100, 108, 251).

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Slowing the Spread of HIV/AIDS and Other STDs

As HIV/AIDS spreads throughout the world, along with an increase in some other STDs, the need for men to practice safer sexual behavior is becoming ever more urgent. Above all, men need to use condoms correctly and consistently and to limit their number of sexual partners (32, 139, 176, 274). Also, social change is needed in cultures that tolerate men's sexual promiscuity and condone unhealthy gender norms.

The HIV/AIDS epidemic. By the end of 1997 more than 30 million adults worldwide were estimated to be infected with HIV, the virus that causes AIDS, a usually fatal condition that has no cure. Of these, about 17 million are men and 12 million are women. The majority of these cases are in the developing world. India has the greatest number of people infected with HIV—more than 4 million (124).

In many developing countries HIV/AIDS is devastating families and communities, striking mostly people in the prime of adulthood. In some sub-Saharan African countries—for example, Burkina Faso and Côte d'Ivoire—AIDS has reduced average life expectancy at birth by more than a decade (286). In Zimbabwe life expectancy is expected to decrease by 25 years by 2010 because of deaths related to AIDS (255).

An estimated 1 million children in developing countries also are infected with HIV or have AIDS. The epidemic is spreading so rapidly and so widely that it jeopardizes many previous gains in child survival, warns Peter Piot, executive director of the Joint United Nations Program on HIV/AIDS (256). Currently, according to the United Nations Children's Fund (UNICEF), about 1,000 children die from AIDS every day. Millions more are left without support when their parents die of AIDS, or they suffer because their parents have AIDS-related diseases, such as tuberculosis, and cannot properly care for their children.

The HIV/AIDS epidemic has put men's sexual behavior in the spotlight (56, 61, 63, 143, 268, 286). Prevention is the only solution. Yet too many men still engage in risky sexual practices, such as having multiple sex partners, including other men, and not using condoms consistently. In some

countries, such as Thailand, many married men frequent commercial sex workers and do not use condoms, either with the prostitutes or with their wives (135, 216, 243). In several Asian and African countries, some older men seek out virgin girls, known as cherry girls, whom they believe to be safe from HIV (42, 234).

Men's sexual behavior puts women at risk. In some countries, including the US and several sub-Saharan African nations, HIV is now spreading faster among women than men (124, 149, 201). In India a study of married and monogamous women at STD clinics found a high rate of HIV and other STDs in this apparently low-risk group (5). The strongest predictor for HIV infection among these women was having a husband who had been diagnosed with an STD.

HIV and other STDs have been described as showing "biological sexism" (107). That is, women are more susceptible physiologically to the viral and bacterial agents that cause them (56, 125, 149). As a result, men transmit infections to women more efficiently than women do to men. For example, men are eight times more likely to transmit HIV to a female partner through repeated, unprotected sexual intercourse than women are to transmit the virus to men (185).

Other STDs. The resurgence in some other STDs also underscores the need for men to practice safe sex. The World Health Organization (WHO) estimates that each year there are more than 330 million cases of curable STDs among adults worldwide (261). This figure includes 89 million new cases of chlamydia infection, 62 million new cases of gonorrhea, and 12 million new cases of syphilis (56). The vast majority of these cases, as with HIV/AIDS cases, occur in the developing world, particularly sub-Saharan Africa.

STDs are more difficult to detect in women, making accurate diagnosis harder (139, 261). Women are less likely than men to receive timely treatment because they may have no symptoms at first, they are embarrassed, or they cannot get to a clinic. As a result, sexually transmitted infections can progress to more serious medical conditions before women seek treatment (56, 139, 261). Thus women suffer more long-term and more painful consequences from STDs, such as ectopic pregnancy, pelvic inflammatory disease, and infertility (125, 261, 280).

Each year an estimated 500,000 women worldwide get cervical cancer (177). It is the leading cancer killer of women in developing countries (186, 245). Cervical cancer is caused by several human papilloma viruses (HPV) that are transmitted through sexual intercourse (50, 175, 177). This type of cancer is entirely preventable and, if caught early, treatable. Early diagnosis, which can be done with a Pap smear of the cervix, can detect the infection at a precancerous stage. Cervical cancer remains a major killer, however, because so few women have access to early diagnosis and treatment (191).

STDs such as gonorrhea and chlamydia can cause infertility in men and women, if left untreated. Often, however, women are blamed for infertility when, in fact, the man may be infertile (16, 56, 72, 287). WHO estimates that 8% to 22% of infertility worldwide is due to male causes (291). Treating men's STDs early and correctly diagnosing fertility problems would help to reduce the social stigma and abuse some women receive when they do not conceive (56).

Avoiding Unintended Pregnancies, Meeting Unmet Need

Men's participation is crucial to enabling millions of women to avoid unintended pregnancies. Of the 175 million pregnancies each year, about 75 million are unintended, according to estimates by the United Nations Population Fund (UNFPA) (261).

An estimated 100 million married women have unmet need for family planning (208). There is probably much unmet need among unmarried women as well, although estimates based on surveys exist only for married women. Women are considered to have unmet need if they are sexually active, fecund, and do not want to become pregnant, but they are not using either modern or traditional contraception (279).

While most husbands and wives agree about using contraception, couples who disagree (or in which the wife thinks that her husband disapproves) make up a substantial share of couples with unmet need. Many married women who want to avoid pregnancy are not using contraception because their husbands object, according to the Demographic and Health Surveys (DHS) (37, 208, 261, 278). On average, in the DHS 9% of married women with unmet need cite husband's disapproval as the principal reason that they do not use contraception (37). When interviewed in-depth, women with unmet need are even more likely to cite their husbands' opposition as a reason for not using contraception than is apparent from survey responses (208).

Qualitative studies among married women with unmet need for family planning demonstrate the powerful role that their husbands play in determining whether they use contraception. In Uttar Pradesh, India, 87% of women with unmet need said that the decision to use contraception ultimately rests with the husband. More than one-quarter agreed with the statement: "My husband would get very angry if I talked to him about family planning methods" (296).

In urban Guatemala women with unmet need told interviewers that they often deferred to their husbands' wishes despite their own preferences. For example, a woman who had been pregnant 11 times and had six living children said that, while both she and her husband wanted to space future pregnancies, she was waiting for her husband to take the initiative and decide which method they would use. If her husband decided not to use any method, she would be too embarrassed to do or say anything (296).

Husbands' objections reflect a variety of reasons, including not only desire for more children or opposition to family planning but also worries about their wives' health, side effects of contraception, lack of information, and little discussion of family planning—reasons that women with unmet need also cite. As well as husbands' opposition, other factors that explain women's unmet need for family planning include family and social opposition, lack of access to appropriate contraceptives, health concerns, worries about side effects, lack of information, and little spousal communication about family planning.

Most women with unmet need probably have a number of reasons for not using contraception, and these reasons may not be well formed and may change over time (49, 208). In Manila and several rural areas of the Philippines, for example, women's fears of side effects, together with their hus-

bands' fears, explained much of the unmet need (49). In a rural area of Kenya many women used contraception tentatively, ready to discontinue should they change their minds, experience side effects, or face opposition from their husbands (215). In Nepal many women with unmet need expressed concerns about their health and also said that their husbands opposed family planning (237).

Sometimes, women do not use contraception because they think that their husbands object, when in fact their husbands approve (see p. 23). For example, among couples surveyed in the 1991–92 Tanzania DHS, 63% of wives reported that their husbands disapproved of family planning when this was not so. In fact, in 59% of the cases both husband and wife approved (208). Often, a wife does not know her husband's views about reproductive matters because the couple rarely or never discusses family planning.

Safe Motherhood and Child Development: How Men Can Help

Men can help protect the lives and health of women as they become mothers and can attend to the health of their children. WHO estimates that 585,000 women die each year from complications of pregnancy, childbirth, and unsafe abortion—about one death every minute (289, 291). Nearly all of these deaths could be prevented (137).

Pregnancy-related complications cause one-quarter to one-half of deaths among women of reproductive age in developing countries. In some countries pregnancy-related complications are the leading cause of death for reproductive-age women (87, 214, 288). Many thousands of women in developing countries suffer serious illnesses and disabilities, including chronic pelvic pain, pelvic inflammatory disease, incontinence, and infertility, caused by pregnancy or its complications (86).

WHO defines a maternal death as a death occurring within 42 days after pregnancy, irrespective of the duration or the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management (288). Five direct causes—hemorrhage, sepsis, pregnancy-induced hypertension, obstructed labor, and complications of unsafe abortion—account for more than 80% of maternal deaths (218).

Safe motherhood consists of ensuring good health for women and their babies during pregnancy, delivery, and in the postpartum period. Men play many key roles during women's pregnancy and delivery and after the baby is born. Their decisions and actions often make the difference between illness and health, life and death (6, 229, 244).

Planning their families. The first step that men can take to promote safe motherhood is to plan their families (6). Limiting births and spacing them at least two years apart are good for maternal and child health. Every pregnancy carries potential health risks for women, even for women who appear healthy and at low risk (6, 217, 229). Unintended pregnancies are particularly likely to be risky because they are more likely to end in abortion. Complications of unsafe abortion cause 50,000 to 100,000 deaths each year (218, 288).

Supporting contraceptive use. Men can accompany their partners to meet with a family planning counselor or health worker. Together, they can learn about the available contraceptive methods and choose the one that best meets their needs. A man can help his partner use modern methods correctly (for example, he can help her remember to take her pill each day), he can use a male method himself, or the couple can practice periodic abstinence. Men can encourage their partners to seek help from a health care provider if side effects occur. They also can endorse trying another method if one method proves unsatisfactory.

Helping pregnant women stay healthy. When his partner becomes pregnant, a man can make sure that she gets proper antenatal care, which may entail providing transportation or funds to pay for her visits. He can also accompany her on the antenatal visits, where he can learn about the symptoms of pregnancy complications.

Good nutrition and plenty of rest also are important during pregnancy. Men can help women have safe pregnancies and healthy babies by ensuring that they receive nutritious food, especially food strong in iron and fortified with vitamin A (6, 227, 229, 257, 277). Anemia, while not a direct cause of maternal deaths, is a factor in almost all such deaths. An anemic woman is five times more likely to die of pregnancy-related causes than a woman who is not anemic (267).

Vitamin A is important to the health of both the mother and the fetus (227, 257). Women need to have enough vitamin A both to support the healthy development of their baby and to protect their own health, particularly their eyesight and immune system. Night blindness among pregnant women is a symptom of vitamin A deficiency. Antenatal vitamin A supplements, often provided in pill form, can greatly reduce maternal and child deaths (257). A study of pregnant women

Bolivian National Secretariat of Health/National Committee on Reproductive Health Subcommission (EC)

In this video a woman breastfeeds her baby as her husband offers encouragement. Around the world more men are joining their wives in planning their families and caring for reproductive health.

Lamia S. Jaroudi

In Egypt and other countries fathers are concerned about the healthy development of their children. Men can see that all of their sons and daughters receive childhood immunizations and a good education. They also can be examples of responsible fatherhood.

in southern Nepal found that low-dose vitamin A or supplements of beta-carotene, the nutritional precursor of vitamin A, reduced maternal deaths by an average of 44% (277).

Arranging for skilled care during delivery. In developing countries the majority of women deliver their babies without skilled assistance, helped only by untrained traditional birth attendants or family members. A trained attendant present during childbirth can mean the difference between life and death. Men can help by arranging for a trained attendant to be available for the delivery and by paying for the services. They also can arrange ahead of time for transportation and can buy supplies, if necessary.

Avoiding delays in seeking care. Delay often contributes to maternal deaths when complications of pregnancy occur (244). Three types of delay put mothers' health at risk—delay in deciding to seek care; delay in getting to a health care facility; and delay in receiving adequate care at the facility. Men and other family members play crucial roles in assuring prompt care (41, 244). Men are often the ones who decide when a woman's condition is serious enough to seek medical care. They also decide how a woman will be transported to the clinic. Men can avoid delays by learning the symptoms of imminent delivery and of delivery complications.

Helping after the baby is born. Most maternal deaths occur within three days after delivery, due to infection or hemorrhage, new research suggests (212). To prevent deaths, men can learn about potential postpartum complications and be ready to seek help if they occur. Men also can make sure that women get good nutrition. While they are breastfeeding, women continue to need extra vitamin A to ensure that they pass enough of the vitamin on to their infants.

During the postpartum period men can help with heavy housework, such as gathering wood and water and taking care of other children. They can encourage breastfeeding, which helps the uterus contract. Finally, they can begin using contraception, either a temporary method to space the next birth or possibly a vasectomy if no more children are desired (6, 182, 229).

Being responsible fathers. The roles that men play as fathers and the ways in which they affect their children's health have been gaining attention (44, 58, 70, 96). Men can become more involved in helping their children's healthy development—for example, ensuring that their children receive all of the needed immunizations. In Ghana a study found that the more education fathers have, the greater their role in deciding to immunize their children (40).

In the US, Baltimore's Urban Fatherhood Program helps young men become responsible fathers by promoting positive male role models. Program staff members, many of whom were teenage fathers themselves, encourage other young men to be good fathers through support groups, counseling sessions, and life skills classes. They also teach young men about fertility, reproduction, the menstrual cycle, pregnancy, and infant nutrition and care (127). In Newark, New Jersey, a similar program also teaches young fathers about contraception, including correct condom use (70).

Fathers, as role models, help to socialize their children (256). In particular, fathers can teach their sons to respect women and treat them as equals, support their daughters' school attendance, and encourage their daughters to play an active role in the family. In these ways, fathers can help to improve women's status and make a better future for their daughters (256).

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Ending Violence Against Women

In developed and developing countries alike, many men abuse women physically and emotionally, even when they are pregnant (91, 108, 256). Based on data from 35 countries, the World Bank has reported that between one-quarter and one-half of women have been physically abused by a current or former partner (108). Sexual violence, including rape, is increasing worldwide (261). Mounting evidence of the extent of violence against women requires new attention to ending it (22).

In countries around the world many women report that men have abused them. For example, a study of women in La Paz and El Alto, Bolivia, found that 37% had suffered either physical or verbal abuse at one time or another. Of these, 42% said violence occurred often (298). In Colombia about 20% of women report that they have been beaten. In Papua New Guinea more than half of all rural and urban women report physical abuse. In one Kenyan district 42% of wives said their husbands beat them regularly. In the US an estimated 21% to 30% of women are beaten by a male partner at least once during their lives (261).

Men play many roles in society that place them in positions to discourage the abuse of women. As fathers, judges, police officers, and community leaders, as well as husbands and sex partners, men have the status and power to help change social and behavioral norms to end the abuse of women (261). Men can play critical roles in ending abusive traditional practices, too, such as female genital cutting, or female genital mutilation (FGM) (48). (See *Female Genital Mutilation: A Reproductive Health Concern*, Supplement to **Population Reports,** Series J, No. 41, October 1995.)

Recently, for example, two men in Senegal, an imam and a village leader, helped village women to begin eliminating FGM. After learning about the dangers of FGM in an educational program, these two men visited 10 neighboring villages to talk with elders and community members. As a result, the 8,000 villagers promised to stop FGM in their communities. Their efforts encouraged the president of Senegal to call for a law against female circumcision (166).

New Survey Findings About Men

New surveys of men show that many know and approve of family planning—in marked contrast to the stereotype of men as uncooperative and uninterested in family planning or reproductive health (76, 207, 213). While many men use contraception or support their partners' use of it, survey results suggest that most men need more family planning information, education, and services.

Almost all Demographic and Health Surveys (DHS) of men have been conducted in Africa. Thus findings are not representative of men everywhere. Other, smaller studies come from other regions. In the DHS most information is about family planning, but some data cover other reproductive health issues, such as HIV/AIDS.

Data from DHS of men are available for 29 countries, with more than one survey in 8 of them. Alex Ezeh and colleagues have analyzed DHS findings from 17 surveys of men in 15 countries (76). Also, **Population Reports** has analyzed data from 11 other DHS of men (see box, p. 16). These analyses, totalling 28 surveys in 21 countries, are the basis for the DHS findings reported here. In addition, DHS of men have been conducted in nine other countries, but data were not available for this report.

Information about young men comes from the Young Adult Reproductive Health Surveys (YARHS), conducted between 1985 and 1997 by in-country institutions with support from the US Centers for Disease Control and Prevention. These surveys have taken place in cities of eight Latin American and Caribbean countries and also in Romania. They explore young men's and women's sexual knowledge and behavior, providing valuable information about this under-served group.

Knowledge of Contraception

In virtually all surveys of adult men, a large majority can identify at least one contraceptive method. In 15 of the 21 countries with DHS data on men, 90% of men or more know of a contraceptive method. In 10 of these countries all or nearly all men know of a method (see Table 1).

In the DHS knowledge of a contraceptive method means only that a respondent recalls hearing of it. This recall can be either spontaneous (without the interviewer mentioning

Table 1. Men's Knowledge of Family Planning Methods*

Selected Demographic and Health Surveys, 1987–1997

	% of Currently Married Men Who Know of:											
								Sterilization				
Region, Country & Year	Any Method	Any Modern Method	Pill	IUD	Injectables	Vaginal Methods	Condom	Female	Male	Implants	Periodic Abstinence	Withdrawal
WEST AFRICA												
Burkina Faso 1992–93	84	80	54	37	54	22	73	49	19	1	50	26
Cameroon 1991	74	65	44	26	34	17	50	47	10	—	48	39
Central African Republic 1994–95	96	92	42	12	26	12	89	67	50	3	54	45
Côte d'Ivoire 1994	87	85	56	26	52	24	82	48	20	6	61	46
Ghana 1993	94	93	80	44	74	62	87	70	33	6	64	66
Mali 1995–96	88	86	67	36	55	17	81	71	23	13	63	49
Niger 1992	85	74	57	37	57	19	51	56	24	—	31	27
Senegal 1997	90	79	61	38	37	12	68	37	8	12	27	28
EAST AFRICA												
Burundi 1987	92	75	48	20	61	8	35	24	10	—	74	38
Kenya 1993	99	97	94	71	88	34	93	88	56	14	88	43
Malawi 1996	100	100	92	55	89	37	99	88	54	18	71	65
Rwanda 1992	98	97	91	62	92	30	94	80	58	34	89	81
Tanzania 1996	93	93	82	44	67	43	90	75	43	21	56	53
Uganda 1995	98	95	85	23	65	18	90	71	28	8	79	12
Zimbabwe 1994	100	100	99	66	81	31	99	84	53	16	66	83
NORTH AFRICA												
Egypt 1992	97	97	96	95	66	30	69	64	25	35	38	47
Morocco 1992	98	97	98	74	47	14	80	78	9	—	58	51
ASIA												
Bangladesh 1996–97	100	100	100	68	93	0	97	99	90	14	70	49
Pakistan 1990–91	79	78	55	29	50	13	59	66	32	—	39	40
LATIN AMERICA & CARIBBEAN												
Brazil 1996	100	100	99	54	63	35	99	93	77	11	72	69
Haiti 1994–95	100	99	93	37	90	18	96	83	49	50	76	91

— = Implants not available in country at time of survey
* Both spontaneous and prompted responses

Sources: Ezeh et al. (76), Demographic and Health Surveys
Population Reports

Table 2

Men's Approval of Family Planning

Selected Demographic and Health Surveys, 1987–1997

Sources: Ezeh et al. (76), Demographic and Health Surveys

Population Reports

Region, Country & Year	% of Currently Married Men Who Approve of Contraceptive Use by: Total	Residence: Urban	Residence: Rural	Education: None	Education: Primary	Education: Secondary or Higher
WEST AFRICA						
Burkina Faso 1992–93	65	73	63	61	75	90
Cameroon 1991	48	65	37	20	50	75
Ghana 1993	90	91	90	80	92	98
Niger 1992	61	67	60	59	70	85
Senegal 1997	52	64	41	35	67	84
EAST AFRICA						
Burundi 1987	91	95	90	88	88	98
Kenya 1993	90	91	89	70	89	96
Rwanda 1992	93	91	93	93	93	91
NORTH AFRICA						
Egypt 1992	87	90	84	82	87	89
Morocco 1992	92	94	91	89	95	100
ASIA						
Bangladesh 1996–97	92	96	91	91	92	96
Pakistan 1990–91	72	78	69	61	60	83

the method) or prompted (that is, after the interviewer mentions the method by name). DHS results reported here include both types of knowledge. DHS data on knowledge do not necessarily mean that the respondent knows how to use the method, understands its effectiveness or side effects, or approves of it (76).

Other, in-depth studies find that men need more information about family planning, contraceptive methods, and reproductive physiology. For example, a survey of men in five districts of Uttar Pradesh, India, found that, among husbands who were not using a contraceptive method themselves, about 90% knew that they could help their wives avoid pregnancy by abstaining from sexual relations or by allowing their wives to use contraception. Only one-fifth of the men surveyed, however, could identify the time in a woman's cycle when she is fertile, and only half could identify a symptom of pregnancy complications (72, 75).

Although men may be aware of modern contraception, they often still have many questions about the reliability of specific methods as well as their potential side effects. For instance, focus-group studies in the Central Asian Republics of Kazakhstan, Kyrgyzstan, Turkmenistan, and Uzbekistan in 1994 found that married men's knowledge was limited to the IUD, Pill, and condom. These men expressed many concerns about the health effects of the Pill and the IUD and said they needed more information about safety and about other contraceptive choices (238).

In most African countries with DHS surveys, men report higher levels of awareness of contraceptive methods than women do (76, 118). In Niger, for example, 85% of the men surveyed know of at least one method compared with 77% of the women (76). In Bangladesh, Brazil, Haiti, and Pakistan, knowledge levels are almost identical among men and women.

West African men are slightly less likely than men in other regions to know about contraception. In Cameroon, for example, 74% of surveyed men say they know of at least one contraceptive method. Also men in Pakistan report lower levels of contraceptive knowledge than men in many other countries surveyed.

In most countries men and women both are more likely to know of modern contraceptive methods than traditional methods. In five countries—Bangladesh, Brazil, Haiti, Malawi, and Zimbabwe—practically all men report knowledge of some modern methods. Men are most likely to know of the Pill, followed by condoms and female sterilization. Of the two traditional methods, periodic abstinence is better known than withdrawal. Men in East Africa are more likely to know about traditional methods than are men in other regions.

In most countries many more men know of female sterilization than of male sterilization (vasectomy). In Morocco, for example, 78% of men surveyed report knowing about female sterilization but only 9%, vasectomy. In Bangladesh, however, where knowledge of all methods is widespread, 99% of men know of female sterilization, and 90% know of male sterilization.

As might be expected, men with more schooling are more likely to know of at least one method, and urban men are more knowledgeable than rural men. Also, men's awareness of contraception appears to be growing. In Mali, for example, in the 1987 DHS 66% of men reported knowledge of at least one contraceptive method. By 1995 the percentage had increased to 88%.

Other studies. A scattering of other studies find that almost all men surveyed know about contraception (30, 72, 161, 183, 188, 231). A study of 630 couples in Cochabamba, Bolivia, found that husbands' knowledge of contraceptive methods was somewhat greater than wives' knowledge. Among the husbands, 99% could identify at least one modern method, compared with 93% of wives. Among both sexes, condoms and IUDs were best known, while injectables and spermicides were least known (298).

The 1990–91 Botswana Males and Family Planning Survey, conducted among sexually active men ages 13 to 69, found

that almost all men knew about the Pill and condoms. Many also knew about IUDs, injectables, and female sterilization. Fewer knew about vasectomy, periodic abstinence, and vaginal methods (131).

■

Approval of Family Planning

Men generally approve of family planning, according to DHS and other surveys. The level of approval, however, varies from country to country and by men's residential, socioeconomic, and educational status (76, 196, 213).

In 8 of 12 countries with available DHS of men, 70% of men or more approve of contraceptive use (see Table 2). In six of these countries, 90% or more approve. Approval is lowest in West African countries, except in Ghana. Other studies also find that men generally favor family planning (30, 183, 232, 238).

Urban men are more likely than rural men to approve of family planning. The difference is substantial only in a few surveys, however, particularly in Cameroon and Senegal. Also, somewhat higher percentages of younger men tend to approve of family planning than older men do.

In almost all countries men with more schooling are more likely to approve of family planning. The influence of education is most striking in Cameroon, where only 20% of men with no education approve of family planning, but 75% of men with secondary or higher education approve.

Although men's approval rates are high, they are usually lower than women's. For example, in Senegal 72% of women approve compared with 52% of men (76). In Malawi and Pakistan, however, men are more likely than women to approve of family planning. In Pakistan men's approval rates are higher than the approval rates of women by more than 10 percentage points.

Most men surveyed think they should share responsibility for family planning with their wives. Many men may be constrained from exercising this responsibility, however, because the choice of male contraceptive methods is so limited. If men had more contraceptive methods to choose from, they might be more positively involved in family planning (204) (see p. 5).

In the US, for example, a 1997 survey found that about 70% of men agreed that men should share more responsibility for choosing and using contraception. Some 66% said that they would be willing to try a hormonal oral contraceptive, and 36% would consider a hormonal implant, if these methods became available for men (111). Whether in fact men would use a male hormonal method or whether women would trust men to use a hormonal method correctly and consistently remains to be seen (205).

■

Reproductive Intentions

In some countries with recent DHS, many men report that they want no more children. West African men are far more likely to want another child than are men in other regions. Nevertheless, in Ghana 32% of men do not want more children, and in Burkina Faso, 27%. The percentages of men who want no more children are highest in Brazil, at 76%; Egypt, at 61%; and Morocco, at 57% (see Table 3).

In most surveyed countries differences between men's and women's desires for more children are small (18, 30, 33, 76) (see Table 3). Men are somewhat more likely to want another child than women are. In three of the countries surveyed, however—Brazil, Burkina Faso, and Morocco—fewer men than women want another child.

Analyzing DHS data for 18 countries, Akinrinola Bankole and Susheela Singh found that most couples agree on whether or not they want more children. Nevertheless, 10% to 26% of husbands and wives do not agree. In these couples, usually the husband wants another child and the wife does not. Also, when husbands and wives both want another child, often the husband wants to have it sooner than his wife does (18).

■

Men's Use of Contraception

Use of the two modern male-oriented contraceptive methods—the condom and vasectomy—is low compared with use of other methods, but it is slowly increasing in some countries. In most countries traditional methods that require male cooperation—withdrawal and abstinence—also are little used.

Modern methods. Worldwide, condoms and vasectomy are among the least used of all contraceptive methods. Among surveyed married women in developing countries, approximately 4% report using condoms, and 4%, vasectomy. If China is excluded from the vasectomy estimates, the per-

Table 3

Men's and Women's Fertility Preferences

Currently Married Men and Women, Selected Demographic and Health Surveys, 1990–1997

Region, Country & Year	% Who Want No More Children: Men	Women
WEST AFRICA		
Burkina Faso 1992–93	27	23
Cameroon 1991	14	23
Central African Republic 1994–95	14	21
Côte d'Ivoire 1994	10	21
Ghana 1993	32	38
Mali 1995–96	7	18
Niger 1992	4	13
Senegal 1997	9	23
EAST AFRICA		
Kenya 1993	48	52
Malawi 1992	33	32
Rwanda 1992	40	39
Tanzania 1996	13	26
Uganda 1995	21	31
Zimbabwe 1994	37	43
NORTH AFRICA		
Egypt 1992	61	69
Morocco 1992	57	54
ASIA		
Bangladesh 1996–97	49	49
Pakistan 1990–91	36	43
LATIN AMERICA & CARIBBEAN		
Brazil 1996	76	73
Haiti 1994–95	47	58

Sources: Ezeh et al. (76), Demographic and Health Surveys

Population Reports

Table 4

Use of Family Planning Methods Involving Men's Cooperation

Estimated Use Among Married Women of Reproductive Age (MWRA), Selected Surveys, 1980–1997

Region, Country & Year	% of MWRA: Any Method*	Condoms	Vasectomy	Withdrawal	Periodic Abstinence
AFRICA					
Benin 1981–82	9.2	0.1	0.0	2.5	1.3
1996	16.4	0.7	NA	5.2	6.6
Botswana 1984	27.8	1.2	0.0	0.3	0.3
1988	33.0	1.3	0.3	0.3	0.2
Burkina Faso 1993	7.9	0.8	NA	0.0	3.5
Burundi 1987	8.7	0.1	NA	0.7	4.8
Cameroon 1978	2.4	0.2	NA	0.4	1.1
1991	16.1	0.9	NA	1.5	6.8
Central African Rep. 1994–95	14.8	1.0	NA	0.5	4.9
Comoros 1996	21.0	1.0	NA	5.4	3.3
Côte d'Ivoire 1980–81	2.9	0.0	0.0	0.1	0.3
1994	11.4	0.7	NA	NA	6.0
Eritrea 1995	8.0	0.3	NA	0.2	0.8
Gambia 1993	11.8	0.4	NA	NA	3.1
Ghana 1988	12.9	0.3	0.0	0.9	6.2
1993	20.3	2.2	NA	2.1	7.5
Kenya 1988–89	26.9	0.5	0.0	0.2	7.5
1993	32.7	0.8	NA	0.4	4.2
Liberia 1986	6.4	0.0	0.0	0.1	0.6
Madagascar 1992	16.7	0.5	NA	2.1	9.0
Malawi 1992	13.0	1.6	0.0	1.5	2.2
1996	21.9	1.6	NA	1.9	2.0
Mali 1987	4.7	0.0	0.0	0.1	1.3
1995–96	6.7	0.4	NA	0.1	1.6
Mauritius 1991	79.5	13.3	0.2	16.1	9.2
Mozambique 1997	5.6	0.3	0.0	0.0	0.1
Namibia 1992	28.9	0.3	0.2	0.3	0.7
Niger 1992	4.4	0.0	NA	0.0	0.1
Nigeria 1981–82	4.8	0.0	NA	0.1	0.3
1990	6.0	0.4	NA	0.5	1.4
Rwanda 1983	10.1	0.0	0.0	1.5	7.7
1992	21.2	0.2	0.0	3.1	5.1
Senegal 1997	12.9	0.6	NA	0.2	1.1
Sudan 1978–79	4.6	0.1	0.0	0.1	0.5
1989–90	8.7	0.1	NA	0.3	2.2
Tanzania 1996	18.4	0.8	NA	2.6	2.0
Togo 1988	33.9	0.4	NA	2.3	6.4
Uganda 1988–89	4.9	0.0	0.0	0.3	1.6
1995	14.8	0.8	NA	0.6	3.5
Zambia 1992	15.2	1.8	0.0	3.0	0.9
1996	25.9	3.5	0.0	4.5	1.9
Zimbabwe 1988–89	43.1	1.2	0.2	5.1	0.3
1994	48.1	2.3	0.2	4.2	0.1
ASIA & PACIFIC					
Bangladesh 1993–94	44.6	3.0	1.1	2.5	4.8
1996–97	49.2	3.9	1.1	1.9	5.0
China 1988	72.1	1.9	7.9	0.1	0.5
1992	83.0	2.0	10.0	NA	NA
India 1988	43.0	5.2	NA	NA	NA
1992–93	40.7	2.4	3.5	1.4	2.6
Indonesia 1991	49.7	0.8	0.6	0.7	1.1
1994	54.7	0.9	0.7	0.8	1.1
Malaysia 1984	51.4	7.7	0.2	5.9	10.0
1988	48.3	5.6	NA	4.2	7.0
Nepal 1991	22.7	0.6	6.8	0.4	0.5
1996	28.5	1.9	5.4	1.4	0.9
Pakistan 1984–85	7.6	1.7	0.0	0.7	0.1
1990–91	11.8	2.7	0.0	1.2	1.3
Philippines 1986	43.6	0.7	NA	8.7	8.5
1993	40.0	1.0	0.4	7.4	7.3
Rep. of Korea 1991	79.0	10.0	12.0	NA	NA

* Includes female-oriented methods as well as methods involving men's cooperation

NA = Not available

Sources: United Nations (250, 253), Abma et al. (3)

Region, Country & Year	% of MWRA				
	Any Method*	Condoms	Vasectomy	Withdrawal	Periodic Abstinence
ASIA & PACIFIC cont.					
Sri Lanka 1982	54.9	3.2	3.7	4.7	13.0
1987	61.7	1.9	NA	3.4	14.9
Thailand 1987	65.5	1.1	5.7	0.9	0.9
Vietnam 1988	53.2	1.2	0.3	7.0	8.1
1994	65.0	4.0	0.2	11.2	9.8
LATIN AMERICA & CARIBBEAN					
Belize 1991	46.7	1.9	NA	NA	2.5
Bolivia 1989	30.3	0.3	0.0	1.0	16.1
1994	45.3	1.3	NA	1.7	22.0
Brazil 1986	65.8	1.7	0.8	5.0	4.3
1996	76.7	4.4	2.6	3.1	3.0
Colombia 1990	66.1	2.9	0.5	4.8	6.1
1995	72.2	4.3	0.7	5.8	5.2
Costa Rica 1986	70.8	13.7	0.6	3.1	8.1
1993	75.0	15.7	1.3	3.3	6.9
Dominican Rep. 1996	63.7	1.4	0.1	1.9	1.8
Ecuador 1987	44.3	0.6	0.0	2.0	6.1
1989	52.9	1.3	0.2	2.5	8.8
El Salvador 1988	47.1	2.4	0.6	1.0	2.4
1993	53.3	2.1	0.4	2.0	3.0
Guatemala 1987	23.2	1.2	0.9	1.2	2.8
1995	31.4	2.2	1.5	0.9	3.6
Haiti 1989	10.2	0.5	0.0	0.4	0.4
1994–95	18.0	2.6	NA	2.4	2.0
Jamaica 1989	54.6	8.6	0.1	2.4	1.0
1993	62.0	16.9	NA	2.9	0.7
Mexico 1982	47.7	0.9	0.3	0.4	3.8
1987	52.7	1.9	0.8	3.5	4.4
Nicaragua 1981	27.0	0.8	0.1	0.4	1.0
1992–93	48.7	2.6	0.3	1.1	2.6
Panama 1984	58.2	1.6	0.4	1.4	2.3
Paraguay 1990	51.6	2.6	0.0	2.9	3.3
Peru 1991–92	59.0	2.8	0.1	3.9	20.7
1996	64.2	4.4	0.2	3.2	18.0
Trinidad & Tobago 1987	52.7	11.8	0.2	5.3	2.6
NEAR EAST & NORTH AFRICA					
Egypt 1988–89	36.7	2.4	0.0	0.5	0.6
1995	47.9	1.4	NA	0.5	0.8
Jordan 1983	26.0	0.6	0.0	2.4	2.9
1990	35.0	0.8	0.0	4.0	3.9
Morocco 1987	35.9	0.5	0.0	3.1	2.3
1995	50.3	1.4	NA	2.8	4.6
Tunisia 1983	41.1	1.3	0.0	1.8	4.4
1988	49.8	1.3	NA	2.4	6.3
Turkey 1988	63.3	7.2	0.1	25.7	3.5
1993	62.6	6.6	0.0	26.2	1.0
Yemen 1991–92	9.7	0.1	0.1	0.6	0.0
1997	20.8	0.3	0.1	1.7	1.1
EASTERN EUROPE & CENTRAL ASIAN REPUBLICS					
Belarus 1995	50.2	5.0	NA	NA	NA
Czech Republic 1993	68.9	16.7	NA	22.2	NA
Kazakhstan 1995	59.1	3.7	NA	3.2	6.5
Kyrgyz Republic 1997	59.5	5.7	NA	6.0	NA
Latvia 1994	48.0	10.0	NA	NA	NA
Lithuania 1995	59.0	18.0	NA	NA	NA
Moldova 1997	74.0	6.0	NA	NA	NA
Romania 1993	57.3	4.0	NA	NA	NA
Slovakia 1991	74.0	21.0	NA	NA	NA
Uzbekistan 1996	55.6	1.7	NA	2.8	1.1

centage of women in developing countries relying on this method is just 3% (see Table 4).

Condoms are the major method of family planning in Japan, where 46% of all married couples use them (253). Condom use is widespread in Eastern Europe and the former Soviet Union. In Slovakia 21% of married couples rely on condoms for family planning; in Lithuania, 18%; and in the Czech Republic, 17%. In the US, 13% of married couples rely on condoms; in New Zealand, 12%; and in Canada, 10% (253). In Latin America and the Caribbean condom use is highest in Jamaica, at 17% of married couples, and in Costa Rica, at 16%. In Asia and the Pacific, condom use is highest in South Korea, where one in every 10 married couples relies on the method. About 6% use condoms in Malaysia, and 4% in Bangladesh and Vietnam.

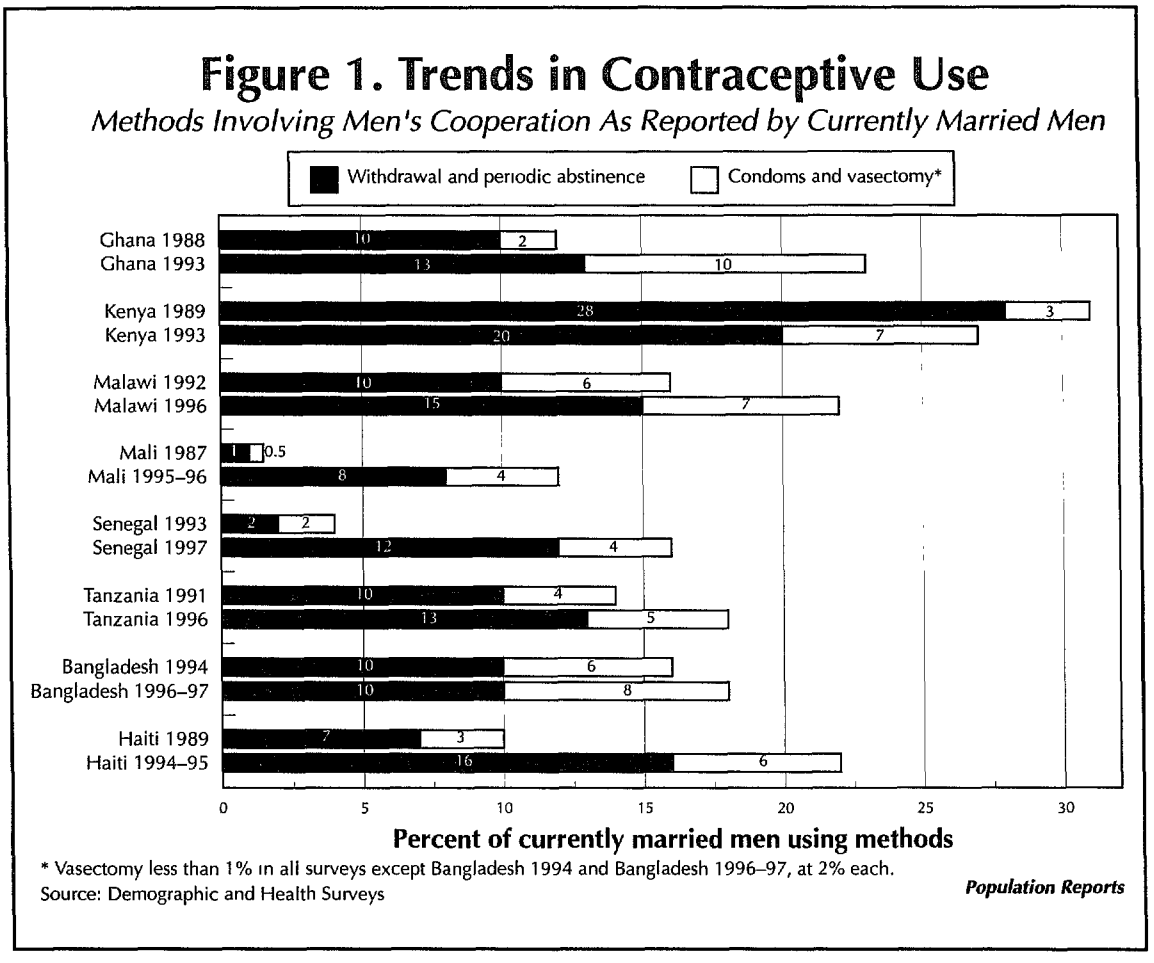
As with most other methods, condom use is low throughout most of sub-Saharan Africa and the Near East and North Africa. Exceptions are Mauritius, where about 13% rely on condoms; Turkey, 7%; and Zambia, about 4%. Elsewhere in these regions, about 2% or less of couples in surveyed countries report using condoms.

Vasectomy is popular in only a few countries. Among developing countries with recent surveys of married women, vasectomy is widely used only in South Korea, at 12% of married couples; China, at 10%; Nepal, at 5%; and India, at 4% (see Table 4). Also, about 6% of respondents reported reliance on vasectomy in Thailand in 1987, and about 4% in Sri Lanka in 1982. No surveys have been conducted in these two countries since. Among developed countries, use of vasectomy is widespread in New Zealand, at 18% of married couples; Canada, at 16%; the US, at 13%; and the Netherlands, at 11% (253).

In Latin America and the Caribbean, vasectomy use is highest in Brazil, at about 3% of married couples, and between 1% and 2% of couples in Costa Rica and Guatemala. In all surveyed countries in sub-Saharan Africa and in the Near East and North Africa, less than 1% of married couples rely on vasectomy.

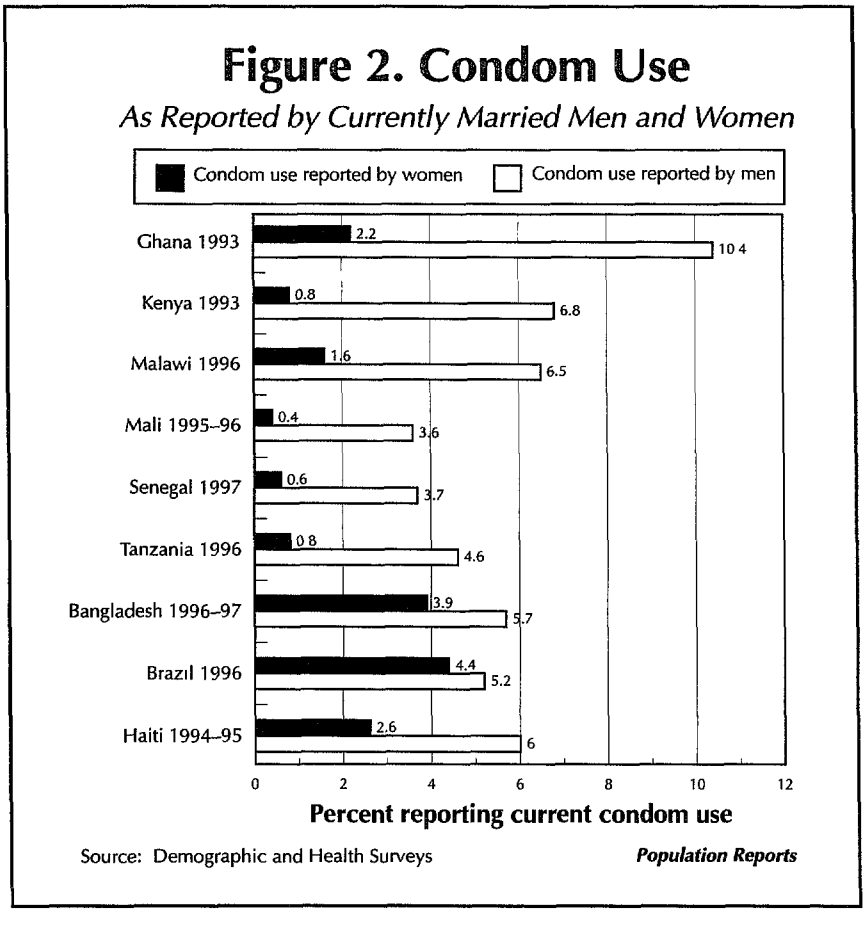
Traditional methods. Among surveyed married women in developing countries, 3% use periodic abstinence, and 4%, withdrawal. While in most regions withdrawal is not a common method, use is substantial in some countries. In Turkey 26% of married couples rely on withdrawal for contraception; in the Czech Republic, 22%; and in Mauritius, 16%.

Worldwide, periodic abstinence is the least used of methods involving male cooperation. Nevertheless, use is substantial in some countries. For example, in Bolivia 22% of married couples use periodic abstinence; in Peru, 18%; and in Ecuador, 9%. In Vietnam



about 10% of couples rely on the method, and in the Philippines and Malaysia, 7%. Also, in Kazakhstan about 7% of couples rely on it. In 10 countries of sub-Saharan Africa, surveys find that at least 5% of couples use periodic abstinence as a family planning method.

Use of traditional methods is probably greater than most surveys suggest. One reason is that traditional methods, especially withdrawal, are often used in combination with modern contraceptive methods. For example, women who use oral contraceptives may practice withdrawal or abstinence if they forget to take pills. Since most surveys, including the DHS, do not report such use of multiple methods, they may underestimate traditional method use (211, 246).



Increasing use. While use of male methods of contraception in developing countries overall shows little change during the past decade according to estimates by **Population Reports**, in several countries repeat DHS show that use of methods involving male cooperation has increased (see Figure 1). In Ghana, Mali, and Senegal, for example, use of male methods is now substantially higher than a few years ago.

Also, surveys of married women of reproductive age show that condom use has been increasing in several Latin American and Caribbean countries, although it is still low compared with other method use. For example, in Brazil condom use appears to have increased from about 2% to over 4% between 1986 to 1996, and in Peru from less than 1% to over 4% in the same period (250, 253).

Differences between men's and women's reports. As might be expected, surveys of married men, like surveys of married women, also report little use of male-oriented contraceptive methods (see Table 5). Generally, however, married men report higher levels of contraceptive use than married women do. According to analysis of DHS data by Ezeh and colleagues, the discrepancy is largest in the two Kenya DHS, where the gap between male and female responses is over 20 percentage points in each survey. In Ghana there is a 14 percentage point difference. In just two countries—Mali and Morocco—women report slightly higher rates of contraceptive use than men do (76).

Table 5. Current Method Use: What Men Say

Selected Demographic and Health Surveys, 1990–1997

Region, Country & Year	% of Currently Married Men Reporting Contraceptive Use by Method									
	Not Using Any Method	Using Any Method[a]	Any Modern Method[b]	Pill	IUD	Condom	Female Sterilization	Other Modern Methods[c]	Periodic Abstinence	Withdrawal
WEST AFRICA										
Burkina Faso 1992–93	88	12	7	2	1	4	0	0	5	0
Cameroon 1991	80	15	6	1	0	2	3	0	7	3
Central African Republic 1994–95	76	24	4	1	0	3	1	0	9	1
Côte d'Ivoire 1994	74	26	14	2	0	3	0	1	11	1
Ghana 1993	67	34	20	5	1	10	1	3	9	4
Mali 1995–96	82	18	8	4	0	4	1	0	7	1
Niger 1992	93	7	3	2	0	1	0	1	1	0
Senegal 1997	84	16	9	3	1	4	0	1	2	0
EAST AFRICA										
Kenya 1993	46	54	32	11	3	7	5	6	20	1
Malawi 1996	75	40	21	5	0	7	3	7	13	3
Rwanda 1992	66	34	13	3	0	0	1	8[d]	18	4
Tanzania 1996	67	29	16	7	0	5	1	3	9	4
Uganda 1995	75	25	10	3	0	3	1	3	11	1
Zimbabwe 1994	40	60	55	43	1	6	1	3	1	3
NORTH AFRICA										
Egypt 1992	50	50	47	14	30	2	1	1	1	1
Morocco 1992	61	39	35	28	2	1	3	0	3	1
ASIA										
Bangladesh 1996–97	40	60	49	25	2	6	8	9	9	2
Pakistan 1990–91	85	15	10	1	1	4	4	1	3	2
LATIN AMERICA & CARIBBEAN										
Brazil 1996	26	74	69	19	1	5	40	3	3	3
Haiti 1994–95	68	32	17	3	NA	6	3	4	9	7

NA = Not available
[a]Includes other traditional methods not listed
[b]Includes Pill, IUD, condom, female sterilization, and "other modern"
[c]Other modern methods include injectables, vaginal methods, vasectomy, and implants
[d]7.8% use injectables, making this the most widely used method in Rwanda
Sources. Ezeh et al. (76), Demographic and Health Surveys

Population Reports

There is no obvious explanation for the discrepancy between men's and women's reports of contraceptive use. Some have proposed that men overreport the use of both male and female methods (76, 118). Others have suggested that men's extramarital use of condoms explains some of the gap in men's and women's reports on condom use (see Figure 2). Ezeh and colleagues doubt this explanation, however, pointing out that married women often underreport use of all male methods. This bias would compound men's overreporting of condom use. Further, polygamy is a poor explanation because it is not practiced in all of the countries surveyed, and, in any case, monogamous men are more likely to use contraception than polygamous men (76).

The Gap Between Approval and Use

While many men know about contraception and approve of it in general, not all who approve of contraception use it. Some are not currently using contraception because they want another child. Others say that they or their partners are sterile. Still others want to prevent pregnancy but do not use contraception for a variety of reasons that family planning programs could address.

When nonusers are asked by the DHS why they do not intend to use contraception, many say they would like more children. Throughout the surveyed countries of West Africa, this is the main reason that men give. For example, in Cameroon more than 70% of these men say they want more children. Desire for more children is also the main reason for nonuse in Morocco, Pakistan, and Tanzania (76).

Men who do not use contraception cite a number of other reasons for not intending to do so. In countries where Islam is strong, men often cite religion—even though, in fact, Islamic teachings do not prohibit family planning. For example, in Senegal 35% of nonusers cite this reason, and in Bangladesh and Egypt, 23% (76). Other reasons for not intending to use family planning include lack of communication between spouses, lack of access to contraceptives, the belief that women are responsible for fertility control, and the need for more family planning information (118).

Many men have fears or misconceptions about contraception (30, 100). Men may worry that certain contraceptive methods, such as the Pill or IUD, will have serious side effects and make their wives sick. Also, some men fear that, if a woman is not at risk of pregnancy, she will be promiscuous (100, 118).

Millions of men, like millions of women, have unmet need for family planning (100, 178, 208, 213) (see p. 6). While there is no generally agreed-upon formulation of unmet need among men comparable to that among women, men's surveys could provide the basis for it. One such formulation,

Evolving Information About Men

Until recently, data about men's family planning knowledge, attitudes, and practices were scarce (76, 90, 106). Most family planning surveys interviewed only married women of reproductive age, not their husbands or other men, married or unmarried. The small amount of information available about men was gathered by proxy from their wives (196, 206).

A few large-scale sample surveys—such as the Caribbean Contraceptive Prevalence Surveys, conducted in the early 1980s, the 1980 Egyptian Fertility Survey, and the 1975 Thailand Fertility Survey—questioned men directly about family planning (90). Based on evidence from these surveys, Moira Gallen and colleagues concluded in 1986 that men generally favored family planning (90). Most of the men surveyed as part of the World Fertility Survey in the 1970s and the Contraceptive Prevalence Surveys in the early 1980s wanted to share responsibility for making family planning decisions. They knew of at least one family planning method, but many did not know where to get family planning services or supplies. Men tended to know male-oriented methods but not female-oriented methods. Surveys in the Dominican Republic and Thailand suggested that men and women wanted about the same number of children (90).

Recent surveys of men confirm these earlier findings. Since 1987, when the first of the Demographic and Health Surveys (DHS) of married men was conducted in Burundi, about 40 DHS have interviewed more than 45,000 men in East Africa, West Africa, North Africa, and Asia (147). Most DHS data on men are from sub-Saharan Africa. The DHS, which at first interviewed only the husbands of women also being interviewed, now also interview single men. Also, the US Centers for Disease Control and Prevention in collaboration with national institutions have conducted representative surveys of adult men in Honduras and Jamaica.

Alex Ezeh and colleagues analyzed DHS findings on men's contraceptive knowledge, attitudes, and practices in 15 countries, where more than 21,000 married men were interviewed between 1987 and 1993 (76). Ezeh's study is one of the first to present comparable data on men in different countries (147).

In addition, for this issue, **Population Reports** has analyzed DHS data from 11 other men's surveys: Bangladesh (1996–97), Brazil (1996), Central African Republic (1994–95), Côte d'Ivoire (1994), Haiti (1994–95), Malawi (1996), Mali (1995–96), Senegal (1997), Tanzania (1996), Uganda (1995), and Zimbabwe (1994). Findings from these data are similar to those of Ezeh and colleagues. (See p. 9–15.)

With these large-scale surveys, as well as smaller studies, men's family planning and other reproductive health knowledge, attitudes, and practices are more clearly understood than a decade ago. Nevertheless, the picture is still incomplete and offers only a broad look at a group that is far more complex than survey statistics alone can suggest (46, 118, 157, 262). More in-depth, qualitative studies could help to probe such issues as men's reproductive decision-making, men's unmet need for family planning, the gap between men's approval and use of contraception, and how different groups of men regard reproductive health issues.

A new men's questionnaire being developed for inclusion in 1999 DHS+ surveys will attempt to fill in many of the gaps in knowledge. The earlier men's DHS questionnaire was modeled on the women's questionnaire. The new men's module is part of the Monitoring and Evaluation to Assess and Use Results Project (MEASURE), which, like the earlier surveys, receives support from the US Agency for International Development.

Some of the research areas under consideration in the new surveys include: the role men play in the adoption of contraception; men's health-related behavior, such as drinking and smoking; and the participation of husbands in the health care of their children (220). More information about the new men's survey is available from the MEASURE website: http://www.measureprogram.org/.

for example, defines men as having unmet need for family planning if they are sexually active, their partners are fecund and not pregnant, and they do not want their partners to become pregnant, but neither they nor their partners use contraception (160, 208).

While DHS data do not yield estimates of unmet need among men, one indication of unmet need is that, in 8 of 13 countries surveyed, there are more married men who do not want any more children than there are married men who are using contraception (including use by their wives) (76). Also, the Population Reference Bureau used DHS data on men in six African countries to estimate that one-quarter to two-thirds of husbands do not want more children but are not using contraception (213).

■

Unmarried Young Men

New surveys of young men are providing valuable information about this often under-served group, but more research is needed on how to reach youth most in need (116, 251, 275). Like older, married men, young unmarried men and boys need information about contraception, STDs, reproductive physiology, sexuality, pregnancy, and other reproductive health issues. Many also need more access to reproductive health care, including family planning (see p. 26).

Young men today comprise half of the largest generation in history to enter adulthood—a generation of one billion boys and girls ages 10 to 19, or about one-sixth of the world's population. When they marry and begin to raise families, these young people will have an enormous impact on worldwide health, fertility, and population growth (4).

Most sexual activity of young people takes place within marriage (159). In the developing world the majority of young unmarried people, especially young women, are not sexually active. Nevertheless, millions of young men are sexually active before marriage. Among young adults who are sexually active, sex is usually episodic, averaging a few times a month (95, 168).

Almost everywhere, the average age at first marriage has been rising, while the average age of sexual initiation is getting progressively younger (159, 168). As this gap widens, young people have more sexual partners before marriage, putting themselves at greater risk for pregnancy and STDs, including HIV/AIDS (51, 148, 159). Earlier sexual initiation may be explained partly by the decline in the age at which puberty begins in boys and girls. For boys, puberty now begins between the ages of 9 and 14 (224).

The influence of testosterone, a hormone that motivates people to engage in sex, is an important and often overlooked factor in the sexual behavior of young men. During men's adolescence and into their early 20s, testosterone levels are very high and account for much of their strong sexual urge (145, 247).

Social pressures as well as physiologic changes encourage young men and boys to take sexual risks, often to the detriment of their own health and especially their partners' (95, 159). Young men are more likely than young women to be sexually active, to have multiple partners, and to have intercourse with casual acquaintances. Their sexual behavior reflects a double standard that exists in most societies—accepting premarital sexual activity by young men while punishing such behavior by young women (159).

Unmarried men generally become sexually active at a younger age than unmarried women do, and these young men have sex more often (24, 159, 168). The average age of first sexual activity varies by country, but most young men have had sex well before age 20. According to Young Adult Reproductive Health Surveys (YARHS) conducted in Latin America, the mean age of young men's first intercourse ranged from 13.9 years in Jamaica to 16 years in Santiago, Chile (170). In these surveys sexually active young men report having sex two to five times per month, although these self-reports may be exaggerated (168).

A 1995 study of unmarried, urban youth in Guinea found the mean age of first intercourse for males was 15.6 years (95). About half of the sexually active young men reported having sex one to three times in the previous month, and the other half, more frequently (95). In Thailand more than half of the boys surveyed reported having sex by age 18, often first with a prostitute (293).

Limited knowledge, limited protection. Most young men have a lot to learn before they can become responsible sex partners. Millions of young, unmarried men are having sexual relations but know little about the consequences. Few young men, for example, understand fertility or the menstrual cycle (95, 168). Many think, mistakenly, that pregnancy cannot occur if their partner is a virgin (95) or that a woman is most fertile during menstruation (168). Furthermore, many young men do not know about modern contraceptives or where to get information and services (159). Even if they do know of contraceptive methods, many believe common misconceptions—for example, that contraception causes infertility (95).

In the YARHS the percentage of young men reporting use of contraception at first premarital intercourse ranged from 11% in Jamaica to 33% in Costa Rica. Condoms were the most common choice of men in the 14 surveys as a whole. In Guatemala City, Rio de Janeiro, and São Paulo, the Pill was the most commonly used method. In Santiago and Mexico City the rhythm method was used most often (168). In Romania 35% of all sexually experienced young men used some contraception at first premarital intercourse. Condoms and withdrawal were the most common methods (226). In the Romania, Jamaica, and Mexico City YARHS, young men's most common reasons for not using contraception at first intercourse were that sex was unexpected and that they did not know about any method (169, 170, 226).

In Guinea, among sexually active young men ages 15 to 19 who were in school, 31% said they had used contraception at first intercourse. Among similar men not in school, 22% had used a method. Condoms were the most common method for both groups (95).

Contraceptive failure is common among young adults because they do not understand how contraceptives work or do not have the skills and practice to use them effectively (4). Even if young adults do seek to learn about contraception and to use it correctly, they are often discouraged by unfriendly, even rude, treatment from providers who disapprove of sexual activity among unmarried youth (4).

Exposure to HIV/AIDS and other STDs. About half of all people infected with HIV are younger than age 25 (4). Given the slow progression from initial HIV infection to AIDS, the high incidence of AIDS among men in their 20s indicates that many contracted HIV before age 20 (159). The younger that people are when they become sexually active, the more likely they are to have multiple sexual partners. Thus they face greater risk of exposure to STDs, including HIV (4, 159). Most sexually active young men know little about STDs or how to prevent them (159).

Even when young men do know about STDs, inexperience or denial as well as cultural pressures can make them take

John Harris for JHU/CCP

In Nigeria and many other countries young men are sexually active but know little about HIV/AIDS and other sexually transmitted diseases. Programs need to find effective ways to reach out to youth.

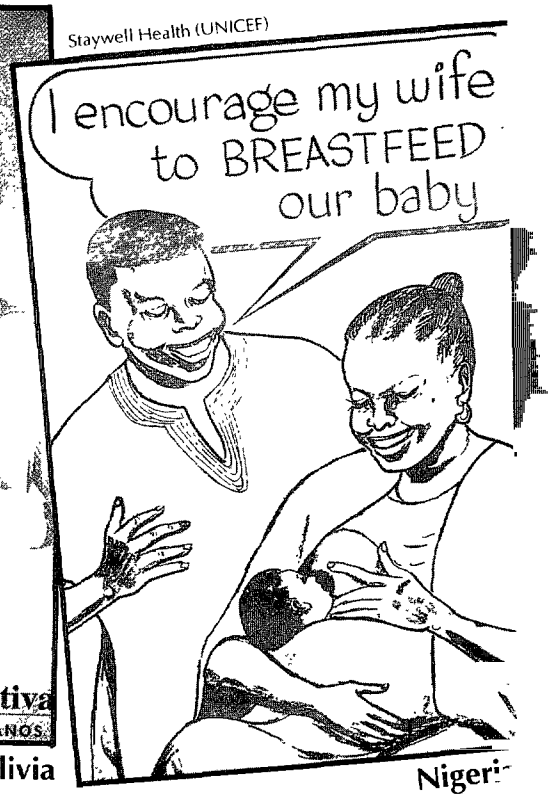
State Innovations in Family Planning Services Agency (SIFPSA)

India

Secretariat Nacional de Salud (SNS)

Bolivia

Staywell Health (UNICEF)



Nigeri-

unnecessary risks. For example, in Brazil, Ecuador, and Chile, almost all the young men surveyed reported that they had heard of HIV/AIDS. About 80% knew that a person can be infected with HIV but show no symptoms. Despite this knowledge, most did not think that they faced much risk for HIV infection, even though they were sexually active (168).

Gender and Reproductive Behavior

Understanding gender provides insights into men's and women's behavior, relationships, and reproductive decisions (251, 262, 263). These insights are crucial to communicating with and serving both men and women effectively (53, 67, 106, 187).

"Gender" refers to the different roles that men and women play in society and also to the rights and responsibilities that come with these roles (39, 53, 202, 283). "Gender" differs from "sex," which refers to the biological and physical differences between men and women (53, 104, 154, 171).

So strong are gender roles that they usually are taken for granted. They are reflected in virtually every social institution, including family structures, household responsibilities, labor markets, schools, health care systems, laws, and public policies. The influence of gender is similar in strength to that of religion, race, social status, and wealth (53, 171, 202).

Worldwide, health care providers, policy-makers, and donors are recognizing the direct connection between men's and women's gender roles and their reproductive health (53, 106, 110, 157, 254, 261, 262). In particular, they are concerned about the effect that inequities in gender roles have on women's well-being. The ICPD Program of Action recognizes the importance of gender in stating: "In all parts of the world, women are facing threats to their lives, health, and well-being as a result of being overburdened with work and of their lack of power and influence" (251).

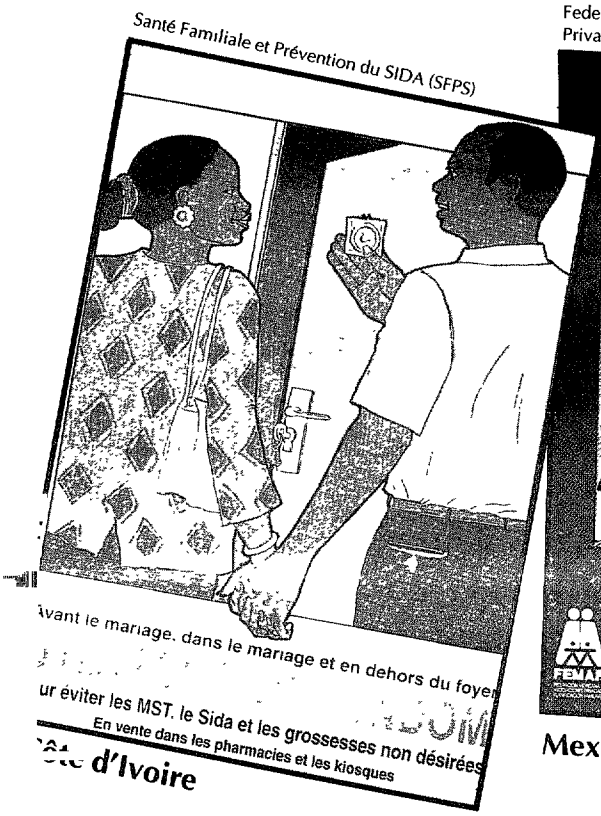
In many countries traditional male and female gender roles deter couples from discussing sexual matters, condone risky sexual behavior, and ultimately contribute to poor reproductive health among both men and women. Programs can encourage men to adopt positive gender roles, such as being supportive husbands and caring fathers (see p. 28).

Understanding Gender

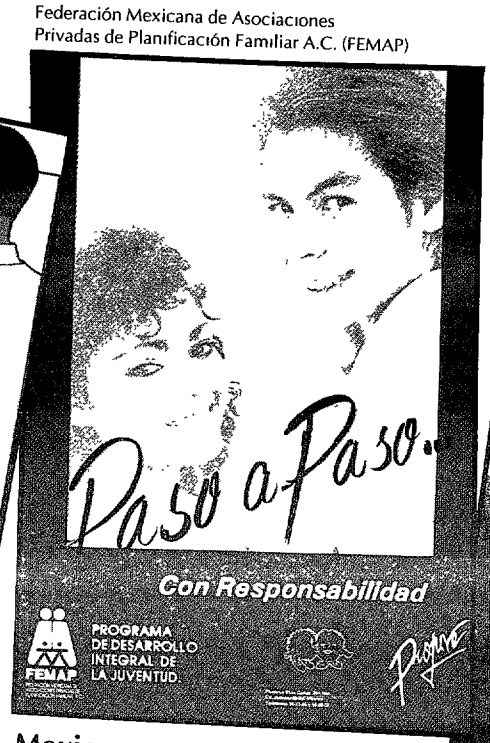
Gender roles and gender norms are culturally specific and thus vary tremendously around the world. Almost everywhere, however, men and women differ substantially from each other in power, status, and freedom. In virtually all societies men have more power than women have (29, 72, 110, 171, 202).

The term "power" is often used when describing gender differences. "Power" is a broad concept that describes the ability or freedom of individuals to make decisions and behave as they choose (52, 53, 115, 187, 202). It also can describe a person's access to resources and ability to control them. When the term "power" is associated with gender, it usually refers to inequities between men and women.

Two types of power help to describe the inequities in male and female gender roles—"power to" and "power over." "Power to" describes the ability of individuals to control their own lives and to use resources for their own benefit. For instance, a man is more likely than a woman to have the power to go where he wants, find a good job, and earn money. "Power over" means that individuals can assert their wishes, even in the face of opposition, and force others to act in ways that they may not want to (115, 202). In many



d'Ivoire



Mexico

Indonesia

cultures, for example, men make reproductive decisions, such as how many children their wives will have, that can have consequences for women's health and well-being (72, 73, 106, 157).

Differences in power between men and women are not absolute or universal. Some men, especially those who are poor, illiterate, unemployed, or homosexual, usually have little power and few resources (20, 25). Also, especially among younger men and women in some cultures, gender roles are changing toward more equality.

Women's gender roles do give them some power. Usually, however, it is much more limited in scope than men's (15, 89). Like a man's power, a woman's power is influenced by such factors as her culture, age, income, and education. Some studies have found that women's power increases as their status in the community improves (36, 164). In Nigeria, for example, Yoruba women who have many children, especially sons, have more say than their husbands about whether or not they will have more children. Among Yoruba women with few or no children, however, their husbands' fertility desires usually prevail (17).

Type of marriage also can affect a woman's power. If a woman can choose her husband, she usually has more influence within her marriage than if her family chooses her husband (89, 138, 140). A woman's power to make decisions sometimes increases with her level of education and also with her husband's level of education. It may also depend on her age. Generally, younger women who marry much older men have less power than women who marry someone closer in age (15, 65, 89).

Gender roles begin at birth and span a lifetime. At very young ages boys and girls learn from their families and peers how they are expected to act around people of the same sex and of the opposite sex (39, 283). Almost universally, adolescent males experience more sexual freedom than adolescent females. Potentially harmful sexual attitudes and behavior that can develop during youth are often difficult to change during adulthood.

Because gender lies at the heart of social organization and the distribution of power, calls for changes in gender roles, and hence behavior, often touch emotional and political nerves. Some people see such change as threatening, while others see it as part of the global trend toward equality and justice (262). However sensitive the topic, taking a fresh look at how gender affects reproductive behavior is a necessary step toward improving reproductive health for all (53, 104, 110, 187, 262).

■

How Gender Roles Affect Reproductive Behavior

Gender has a powerful influence on reproductive decision-making and behavior (36, 158, 262). In many developing countries men are the primary decision-makers about sexual activity, fertility, and contraceptive use. Men are often called "gatekeepers" because of the many powerful roles they play in society—as husbands, fathers, uncles, religious leaders, doctors, policy-makers, and local and national leaders (60, 100, 103). In their different roles men can control access to health information and services, finances, transportation, and other resources (52, 53, 61, 100, 157, 209).

Little is known about the dynamics of couples' sexual and reproductive decision-making or about how gender roles affect these decisions. Such decisions can include whether to practice family planning, choosing when and how to have sexual relations, engaging in extramarital sexual relations, using condoms to prevent STDs, breastfeeding, and seeking prenatal care (28, 36, 117, 126, 148).

Comisión Interagencial de Salud Reproductiva

"Together, We Decide When," says this Nicaraguan family planning poster promoting joint childbearing decisions by husbands and wives. As gender roles change, more couples are making decisions together.

Gender is just one of many factors that influence couples and affect their reproductive decisions. Education level, family pressures, social expectations, socioeconomic status, exposure to mass media, personal experience, expectations for the future, and religion also shape such decisions (28, 115, 117). Consequently, no two couples' "decision-making environments" are identical (117).

Some researchers have suggested that personal reproductive decisions result from many smaller, incremental decisions (35, 174, 281). Other researchers suggest that in fertility decisions social and cultural norms and expectations often prevail over individual preferences (117). In some traditional societies many couples say that the number of children they expect to have is not up to them at all, but rather up to God or to fate.

In some developing countries husbands dominate reproductive decision-making, whether regarding contraceptive use, family size, birth spacing, or extramarital sexual partners (73, 79, 85, 138, 142, 148, 188, 238). In Ghana, for example, some men in focus-group discussions claimed to make all family decisions. As one man asserted:

> *...We control them from the initial stage. When she comes to the house and maybe she thinks she is now the lady of the house and does something contrary to your regulations, you warn her. We don't allow our women to have influence on us (73).*

A study of more than 3,000 urban Nigerian couples found that, while men do not dominate decision-making, they still wield more power than women do. Men and women were asked who decides such matters as family size, when to have sex, and how long periods of sexual abstinence should last. Close to 60% of men said that they decide, and 40% to 50% of women agreed that men decide (119).

A study of the fertility decisions made by five generations of one South Indian family also found that the men tended to control contraceptive use and to make fertility decisions. The men in the older generations chose to limit their own fertility by getting vasectomies, usually without telling their wives. The men said that economic pressures were their main motivation to limit the number of children. A survey of all five generations in this family revealed that more than half of the men thought the decision-making was mutual, but only 38% of their wives saw it that way (129).

Men's control over reproductive decision-making may be weakening, particularly among younger generations and in certain cultures. In many societies, as social, economic, and educational opportunities for women increase, traditional gender roles are starting to change. As a result, power is being redistributed between men and women. Evidence from several countries demonstrates that, increasingly, reproductive decisions are being made jointly by couples, not by men alone (96, 180, 200).

In Peru, Argentina, and Brazil, for example, research by Gary Barker has identified a group of young men who, contrary to the widespread *machisto* image, negotiate sexual and reproductive decisions with their partners and are willing to initiate contraceptive use (23). In Sri Lanka, where women's levels of education and literacy are high, a study among couples currently using contraception reported that more than half of the wives and about two-thirds of the husbands said that decisions about family planning were made jointly (65). Also, Japan's patriarchal culture has been changing away from decision-making primarily by husbands and parents toward decisions made jointly by couples (180).

Gender Roles Can Harm Reproductive Health

Traditional gender roles can jeopardize the reproductive health of both women and men. Inequities in power often make women vulnerable to men's risky sexual behavior and irresponsible decisions. Gender roles can be unhealthy for men as well because they tend to encourage men's physical risk-taking.

Because of their gender roles, many women around the world have trouble talking about sex or mentioning reproductive health concerns (36, 92, 248, 264). They may not be able to ask their partners to use condoms or to refuse sex, even when they know they risk getting pregnant or being infected with an STD, including HIV (36, 79, 106, 110, 154, 202, 248, 292). In Uganda research found that one person in every four believes that a woman cannot refuse sex, even if she knows her partner has AIDS (36).

Women may submit to men because they are afraid of retaliation, such as being beaten or divorced, and because their gender roles place them in subordinate positions in society (24, 36, 67, 248). For women worldwide, the impact of gender inequality is apparent in many of their reproductive health problems (4, 24, 106, 157, 158, 218, 248, 251, 264, 292).

Male gender roles harm men's health as well women's. A mix of cultural norms, social expectations, and men's sex drive encourages men's risky sexual behavior (21, 53, 58, 236). Some societies, as in Haiti and Thailand, accept that married men will have extramarital sex, either with girlfriends or prostitutes (243, 248). Similarly, in many Latin American and Caribbean cultures, the concept of *machismo* encourages men to be promiscuous to prove their masculinity (21). Such male gender roles can contribute to their contracting STDs and passing them on to their wives or girlfriends. Male gender roles prompt some men to live recklessly in other ways, a fact that is evident in many national health statistics. In Mexico, for example, the top

three causes of death for men are accidents, homicides, and cirrhosis of the liver (21).

Couple Communication

Couple, or spousal, communication can be a crucial step toward increasing men's participation in reproductive health (26, 33, 141, 151, 181, 239). Since men, as well as women, play key roles in reproductive health, communication is necessary for making responsible, healthy decisions.

Communication enables husbands and wives to know each other's attitudes toward family planning and contraceptive use. It allows them to voice their concerns about reproductive health issues, such as worries about undesired pregnancies or STDs. Communication also can encourage shared decision-making and more equitable gender roles.

Research over more than 40 years consistently demonstrates that men and women who discuss family planning are more likely to use contraception, to use it effectively, and to have fewer children (28, 65, 113, 122, 126, 141, 167, 239). In contrast, when men and women do not know their partners' fertility desires, attitudes about family planning, or contraceptive preferences, the consequences can include unintended pregnancies, transmission of STDs, and unsafe abortions (33, 106, 114, 161, 219).

Sometimes, however, communication between partners may not be desirable. For example, a woman may use contraception covertly because it would be unwise and even dangerous for her to inform or try to involve her partner. Counselors need to assess carefully the reasons for covert contraceptive use and the appropriateness of encouraging spousal communication (34).

sion-making. Further, surveys alone cannot determine to what extent communication between partners promotes contraceptive use and to what extent the use of contraception leads to spousal communication (28, 141, 183, 219).

The DHS report two aspects of couple communication about family planning, occurrence and frequency. First, the DHS ask husbands and wives whether or not they discussed family planning with their partner in the preceding year (76). Of husbands and wives who report discussing family planning at all, the DHS then ask how often they did so—once or twice, or more often (76).

In West African countries only a minority of married men surveyed reported discussing family planning with their wives in the past year—from 23% in Niger and Senegal to 43% in Mali (see Figure 3). In East African countries surveyed men were more likely to have discussed family planning—from 49% in Burundi to 68% in Kenya.

In Egypt, Morocco, and Bangladesh, couples were even more likely to have discussed family planning in the past year (76). In Pakistan, however, just 25% of men reported doing so (151).

Among couples who discussed family planning, husbands and wives reported similar frequencies of discussion. Most said that they discussed it more than twice within the past year. Couples in East Africa were most likely to report frequent discussions, with men reporting more frequent discussions than women. Couples in Mali, Niger, and Pakistan reported the lowest frequencies of discussion (76).

Studies in other regions also find that spousal communication about family planning is uncommon (78, 161, 188). For example, qualitative studies in the Central Asian Republics of Kazakhstan, Kyrgyzstan, Turkmenistan, and Uzbekistan reveal that married couples rarely discuss matters related to sex or reproductive health. In focus-group discussions men and women said they were too embarrassed to talk about

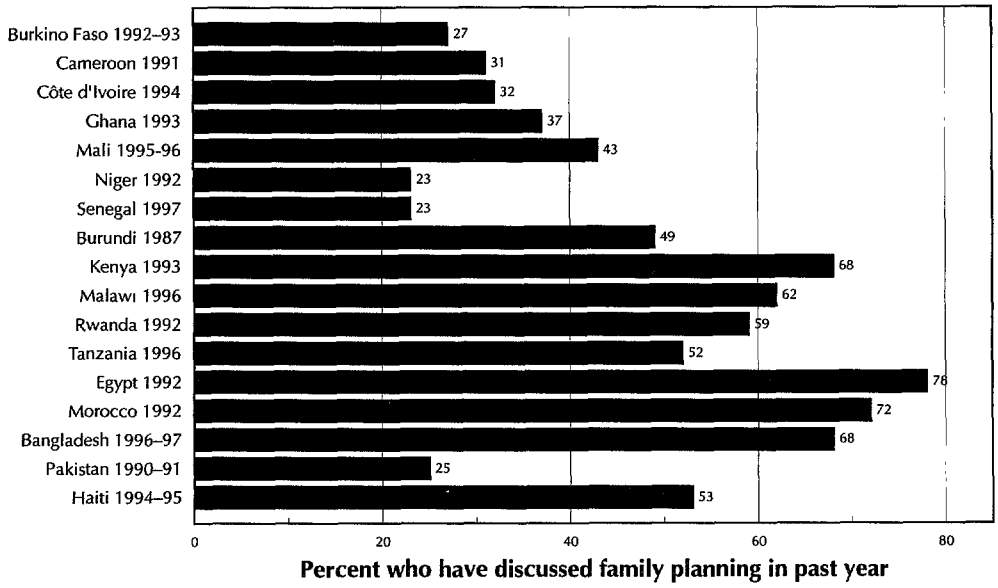
Extent of Couple Communication About Family Planning

Many couples rarely discuss fertility and family planning. Several studies suggest that spousal communication about family planning usually begins only after the birth of one or two children (36, 65, 85).

The DHS and other studies that have interviewed husbands and wives about fertility and family planning offer insight into the extent of their communication on these topics (36, 54, 72, 76). Using surveys to assess spousal communication is difficult, however (28, 33, 103). Communication is an ongoing process, but surveys capture information from only a single point in time. They do not chart the progression of a couple's discussion or deci-

Figure 3. Spousal Communication

Currently Married Men Who Report That They Discussed Family Planning with Their Wives in the Past Year



Source: Demographic and Health Surveys

Population Reports

Cate Wilcox for JHU/CCP

Many husbands and wives have difficulty talking about family planning and other reproductive topics. Often this is due to embarrassment or cultural taboos. Counseling can aid communication.

these subjects. Most men said that they leave family planning decisions to their wives, but they expect their wives to ask for approval to use contraception. Rarely, however, do they reject the wife's choice of method (238).

Similarly, in urban Peru women said in focus-group discussions that husbands and wives rarely talk about the number of children they want to have. Women said that they must have children soon after marriage to please their husbands (85). A study of Bolivian couples found that most men and women have positive attitudes toward family planning, but only half said that they discussed with their partner the number of children they desired (298).

In Uganda researchers found that fewer than half of respondents had ever discussed family size with their spouses. On average, only about one-third of men or women reported ever talking with their partners about the number of children they would like to have. Couples in urban areas were more likely to talk about childbearing than rural couples (36).

Partners may communicate their reproductive desires or concerns through nonverbal or indirect means, if they do so at all (36, 85, 117). In Uganda, for example, most communication between men and women regarding reproductive issues took the form of suggestions, hints, and talking to friends or relatives in the hope that they would convey the information to the sex partner (36).

Obstacles to Couple Communication

Many obstacles prevent men and women from talking about sexual and reproductive issues. While research is slight, it suggests that a complex web of social and cultural factors impede such discussions (71, 164). In many societies sex is a taboo subject for men and women to discuss. Also, men and women are often afraid of rejection by a sex partner, especially at the beginning of a relationship. Consequently, they may not bring up uncomfortable issues, such as sexual history or use of contraception (193).

As with decision-making in general, women's inferior status and lack of power limit couple communication (66, 67, 71, 74, 88, 106, 164, 219, 292). For many women traditional female gender roles mean they have little say in sexual matters and lack the status to influence their partners' behavior (67, 85, 164, 248, 264, 292). Even when men and women discuss reproductive health issues, it is usually not on equal terms (64).

Traditional cultures often discourage married women from starting discussions about contraception. For their part, men may feel there is nothing to discuss or no need to take account of their wives' feelings and opinions. In countries such as India, Kenya, and Nigeria, traditional male dominance is a major obstacle to spousal communication about family planning (72, 119, 181). Also, a husband might consider his wife promiscuous or unfaithful if she tries to discuss contraception with him (85). In some cultures it is easier for unmarried women and prostitutes to negotiate sexual activity with men, including condom use, than for married women to do so with their husbands (248).

In focus groups Haitian women described a situation that many women face. They said they were afraid of contracting HIV from their husbands but found it hard to discuss the subject with them. Few women thought that their men were faithful, but most felt powerless to change their husbands' sexual behavior. They feared being beaten or raped if they raised the issue of contraception or resisted a husband's sexual advances. They also feared that, if they refused to have sex, their husbands would turn even more to prostitutes or other women (248).

Women's status and communication. As women's equality with men increases, so does their ability to communicate about reproductive matters and to participate in reproductive decisions (28, 164). When a woman shares decision-making power, she is better able to bring up and discuss family planning and sexual relations with her sex partner.

In particular, better-educated women can communicate more easily with their husbands (54, 89, 164, 200). More educated women are better informed, better able to gather information from newspapers and other media, and usually more articulate (203). Education may also increase a woman's earning capacity—and thus her leverage in household decision-making—and raise her self-esteem (164).

The closer a man and woman are in their levels of education, and the more education they have, the more likely they are to discuss and use family planning (54, 65, 164). A study of Nigerian couples found that, when both husband and wife have secondary or higher education, 61% of couples reported discussing family planning. When neither spouse was educated, only 15% reported discussion (164).

A woman who has some economic power also may be more likely to discuss family planning with her husband (89). In Togo women who worked for cash and invested some of it in credit or savings plans reported the highest levels of communication with their husbands about family planning. The level was substantially higher than among women who worked for cash but did not invest or who did not work for cash at all (89).

The type of marriage—whether free choice, arranged, or polygynous—also affects the relative power a woman has and thus the extent that the couple communicates (89, 138, 140, 164). In Togo, for example, women who chose their husbands without any family advice reported the highest levels of discussion with their husbands about family planning. Those in marriages arranged by their families reported the lowest

levels of communication (89). Women in polygynous marriage often have low status and report little communication.

Also, the age of a woman at first marriage relates to her ability to communicate. The younger the woman, especially if she is much younger than her husband, the less communication there is about family planning (73, 89).

■

Communication Is Key to Accurate Perceptions

Because women and their husbands often do not communicate about family planning, many wives think that their husbands oppose family planning when in fact the husbands approve (33, 161, 183, 219). This misperception may be one reason for the widespread belief that men oppose family planning, despite testimony from many men themselves that they favor it (71, 209).

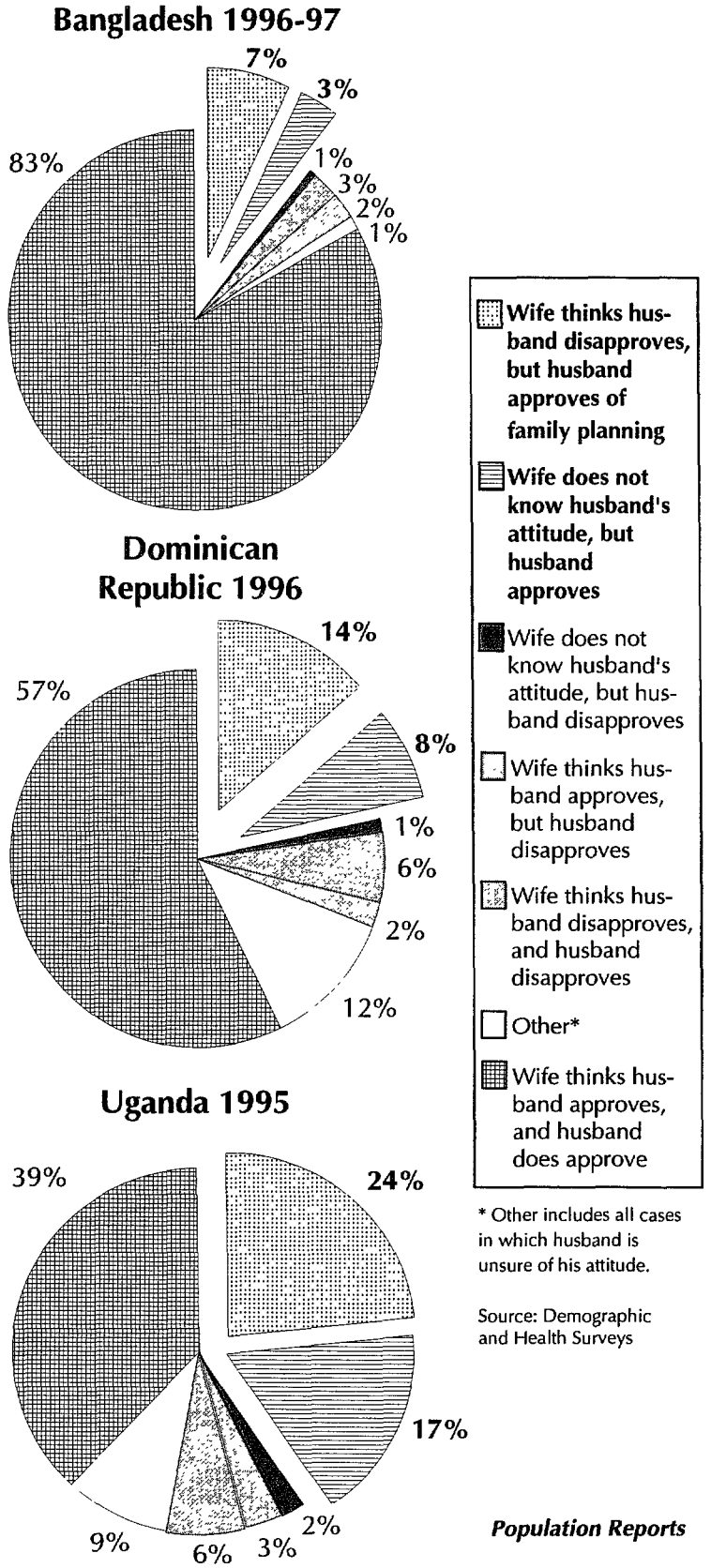
DHS consistently show that, especially in sub-Saharan Africa, many women mistakenly assume their husbands disapprove of family planning (33, 141, 161, 219). Data from matched husband and wife surveys illustrate the extent of wives' misperceptions. In the Dominican Republic, for instance, 14% of women think their husbands disapprove when, in fact, they approve. Another 8% do not know their husbands' attitudes, but the husbands actually approve (see Figure 4). Such findings suggest that women's unmet need for family planning could by reduced by better communication between husbands and wives.

In Burkina Faso, focus-group discussions with men and women separately found that communication between the sexes about family planning was almost nonexistent. Their lack of communication meant that they frequently misperceived each other's views. "The men thought the women were largely ignorant of family planning, generally opposed to it and in need of education.... The women said the same thing about the men" (161).

A woman's perception of her husband's attitude toward family planning strongly influences whether she will use family planning (33, 141, 219). If a woman thinks that her husband approves of family planning, she is much more likely to use it. In an analysis of DHS data from Kenya, for example, a wife's perception of her husband's approval was more significant in explaining whether or not she used contraception than two other communication variables—discussion between partners about family planning and agreement between spouses about approval of family planning (141). One of the oldest studies on couple communication, done in the 1950s in Puerto Rico, found the same pattern. One-third of the women who did not use family planning said it was because they thought that their husbands disapproved (113).

Figure 4. Family Planning Perceptions

Wives' Perception of Husbands' Attitude Towards Family Planning and Husband's Actual Attitude



* Other includes all cases in which husband is unsure of his attitude.

Source: Demographic and Health Surveys

Population Reports

Lessons Learned and Program Implications

The question today is no longer *whether* to involve men, but rather *how* to involve them (61). How can reproductive health care providers best increase men's participation? How can programs communicate effectively with men? How can they reach more men and meet men's needs? How can programs encourage more men to care about reproductive health?

The number of reproductive health activities that address and include men has increased in the past several years (59, 98). The challenge for these expanding activities is to incorporate new perspectives on men's participation into the design and implementation of reproductive health communication and services.

Program experience with men's participation yields many lessons. **Population Reports** has identified nine major lessons that can help guide program managers and policy-makers. These lessons can be grouped as follows:

- **Reach Male Audiences with Appropriate Messages**
  Lesson 1. Build on men's approval of family planning.
  Lesson 2. Use the mass media to communicate with men.
  Lesson 3. Reach out to young and unmarried men.
- **Use Communication to Promote Behavior Change**
  Lesson 4. Understand the influence of gender.
  Lesson 5. Encourage couple communication.
  Lesson 6. Bring information to where men gather.
- **Offer Information and Services That Men Want**
  Lesson 7. Inform men about condoms and vasectomy.
  Lesson 8. Counsel men with respect and sensitivity.
  Lesson 9. Offer men a range of health services.

Reach Male Audiences with Appropriate Messages

While often neglected in the past, men are an important audience. Providing information, education, and communication (IEC) about reproductive health is key to gaining their interest and support (12, 61, 101, 209). Program experience of the last decade demonstrates that communication can change men's health behavior for the better (122).

Lesson 1. Build on men's approval of family planning.

Steps to Behavior Change Model

Knowledge
- Recalls family planning and other reproductive health messages
- Understands what messages mean
- Can name products, methods, or other practices and/or sources of services/supplies

Approval
- Responds favorably to reproductive health messages
- Discusses messages or issues with members of personal networks (family, friends)
- Thinks family, friends, and community approve of practice
- Approves of practice

Intention
- Recognizes that specific health practices can meet a personal need
- Intends to consult a provider
- Intends to practice at some time

Practice
- Goes to a provider of information/supplies/services
- Chooses a method or practice and begins use
- Continues use

Advocacy
- Experiences and acknowledges benefits of practice
- Advocates the practice to others
- Supports community programs

Sources: Johns Hopkins University, Population Communication Services and Piotrow et al. (121, 190)

Many men appear ready to change their reproductive health behavior and willing to participate more in reproductive health activities. In changing their behavior, people generally pass through five steps: knowledge, approval, intention, practice, and advocacy (121, 190) (see model at left).

Surveys and other studies suggest that many men have already gone through the stages of knowledge and approval and are now ready to adopt healthier practices. Hundreds of millions of men and their partners are using family planning. Millions more know and approve of contraception but are not using it (see pp. 6 and 15). Unmet need for family planning is substantial. Even where contraceptive prevalence is low, as in West Africa, many men say that they want to learn about family planning and to improve their own reproductive health and that of their families (10, 12, 60, 207, 276).

More men probably would take better care of their own reproductive health and that of their partners if programs reached out to them with appropriate information. A number of programs are finding ways to do that. Concerned about the spread of HIV/AIDS, the Transport Corporation of India, in collaboration with the AIDS Control and Prevention Project (AIDSCAP), started the Bhoruka AIDS Prevention Project (BAP) in 1995 (7). Thousands of truck drivers spend days waiting to cross the Nepal-India border. Separated from their wives or girlfriends, the men often turn to commercial sex workers. Social workers educate the truck drivers about HIV/AIDS and refer them to the BAP clinic in Raxaul, a checkpost city on the Indian side of the border. Collaboration with outreach workers in Nepal helps to ensure that truck drivers on the Nepali side also are referred to the clinic. At the clinic male and female doctors offer the men medical services, particularly counseling and treatment of STDs.

During the first year of the program, the number of people seeking counseling and testing for HIV increased from 136 to 2,431. Requests for condoms rose from 630 to 26,290. The BAP project adopted a condom logo, which it pretested to ensure its appeal to both Indian and Nepali truck drivers. It uses the logo on posters, leaflets, and counter displays urging the truck drivers to practice safe sex (7).

In Mardan, Pakistan, outreach workers with the Urban Community Development Council, an all-male organization founded 20 years ago, found that there was much higher demand for family planning information and contraception among men than assumed (195). Although most people in Mardan have conservative attitudes, husbands responded positively when male field workers approached them with information about reproductive health services. Demand for contraceptives exceeded expectations. The project now includes five clinics, and over 200 male Community Educators provide family planning information, distribute condoms, resupply oral contraceptives, and refer men to clinics (195).

Lesson 2. Use the mass media to communicate with men.

One proven way to reach and inform men is through the mass media. Mass media can expose male audiences to messages that can influence their reproductive health knowledge, attitudes, and behavior (189, 190, 284). Often, men are more exposed to radio and television than are women, probably because men generally have more free time, more education, more disposable income, and in many cultures more freedom of movement than women (100, 284, 298).

The media can impart different messages depending on the needs of the specific audiences and their stage in the process of behavior change. For instance, men need accurate information about contraceptive methods, women's menstrual and fertility cycles, transmission and prevention of STDs, pregnancy, child health, and their own reproductive health. They also need to know where to go for services, counseling, and answers to their questions.

Radio, television, video, and newspapers all may be used in strategic ways to give men important information about reproductive health. A successful campaign is based on audience analysis and research. It follows a proven model of behavior change to design the campaign, pretest messages and materials, monitor progress, and evaluate results (190).

In Uganda, for example, the Busoga Diocese's Family Life Education Program reached men with information about reproductive health through short radio dramas that addressed questions such as, "What does an STD look like?" (13).

In Bolivia the *Las Manitos* National Reproductive Health Campaign reached about 500,000 potential family planning users through radio and television spots and also through in-clinic videos, audio cassettes played on public buses, and posters. The percentage of men who said they intended to seek reproductive health services increased from 25% in the baseline survey to 60% in the follow-up survey after the campaign (122).

In Swaziland the national Family Planning Association (SFPA) joined forces with *The Times* newspaper to educate citizens about HIV/AIDS. More than 21,000 condoms were inserted into newspapers and distributed by SFPA one Saturday in March 1998 (294).

The mass media also can depict men in positive new roles. Depictions of men in the mass media can influence social norms and expectations of male behavior—for example, by showing men how to become better husbands and fathers. In Egypt a series of television spots encouraging male responsibility featured men in unconventional roles, such as ironing clothes, helping a daughter with school work, and talking with their wives about family planning (136). Also, in Jordan the communication campaign *Together for a Happy Family* depicts positive male roles in television and radio spots and involves religious leaders as advocates for contraceptive use (see box, pp. 26–27).

Lesson 3. Reach out to young and unmarried men.

Men will be more likely to participate responsibly in reproductive health if they begin to do so at a young age, even before they marry. Programs need to address young men's reproductive health issues, including STDs, contraception, unwanted sex, and unintended pregnancies (see **Population Reports**, *Meeting the Needs of Young Adults*, 1995). To do so, programs must learn more about young men's perceptions of their roles and responsibilities as sex partners. They also need to assess what young men know or do not know about sexual health and tailor information appropriately (see p. 17).

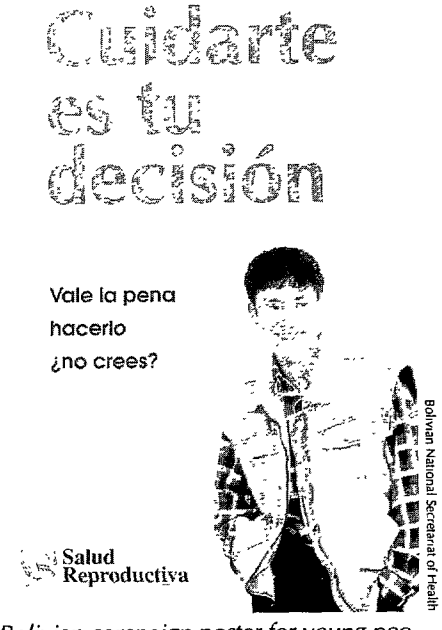
Providing information. To help prepare boys and young men to become more responsible sexual partners and spouses, programs can offer relevant information about sexuality and reproductive health, including the risks of STDs and how to avoid them (159). Young men also need encouragement to delay sexual activity until they are better prepared to cope with their own and their partners' emotional and health needs. Influencing young men to delay sexual initiation requires changing social norms and how young men perceive themselves. It may also mean changing how parents, friends, teachers, and girlfriends define masculinity. Training in interpersonal communication skills can help young men talk honestly with girlfriends about reproductive health issues.

Entertainment formats and the mass media can be powerful ways to reach youth with reproductive health information (123, 159, 198). In Uganda, for example, a national music competition called "Hits for Hope" formed the centerpiece of the government's HIV/AIDS prevention effort (123). Young artists performed original songs with AIDS-prevention messages. The winners recorded their song, *Ray of Hope*, in a professional studio, and it aired on national radio as part of a 6-month mass media campaign in 1995 (123).

Also in Uganda, *Straight Talk*, a monthly insert in a daily newspaper, provides young people with information and advice about sex, sexuality, STDs, and HIV/AIDS (112). Much of the information comes in the form of answers from a sociologist and physician to readers' letters asking for advice. *Straight Talk* also features quizzes, contests, and readers surveys to engage its audience (112).

Young men can be a particularly challenging audience to reach. Because young men and their health needs vary considerably, programs often cannot reach them as a single, homogenous group (80). For example, young men who have dropped out of school are usually much more likely to be involved in risky sexual behavior than are students. They are also harder to reach (297).

Some youth programs have found that peer educators can reach groups of adolescents with reproductive health information (80, 97, 165). In Botswana, for example, as part of the Tsa Banana Reproductive Health Program, peer educators talked to secondary school students about pregnancy, AIDS, HIV transmission, and condoms. They demonstrated correct condom use and taught sexual negotiation skills, including how to refuse sex and how to ask a partner to use a condom (165).



A Bolivian campaign poster for young people says, "Taking care of yourself is your decision. Don't you think it's worth it?"

Applying Lessons in Jordan:

God blesses us with many children but at the same time He says that, if we have a reason for not wanting children,...then it is not prohibited to use contraception. —Urban Jordanian man who uses family planning (78)

In Jordan the communication campaign *Together for a Happy Family* put new perspectives on men into practice to increase men's participation in reproductive health. The campaign was carried out by the Jordanian National Population Commission with assistance from Johns Hopkins Population Communication Services and funding from the United States Agency for International Development.

Men's Roles and Attitudes

In Jordan as in many other countries, men play a principal role in reproductive decision-making. Jordanian men expect to take the initiative in family matters. Women are reluctant to discuss family planning with their husbands unless their husbands introduce the subject (120).

A survey in 1996 found that, among couples who had never used contraception, only 40% had discussed family planning compared with 86% of current contraceptive users (249). Almost 20% of women who had never used contraception reported that the main reason was their husband's opposition. Also, 40% of men said that couples should continue having children until they have a son (78).

Since 1946 Jordan's population has been one of the fastest growing in the world, increasing an average of 4.3% annually. If the current high rate of population growth remains unchanged, the country's population will double in 28 years.

While a large percentage of Jordanian men believe that the spacing of births is sanctioned by Islam, they are uncertain about specific contraceptive methods. Many think that modern methods are unnatural, have undesirable side effects, or have adverse long-term health implications and thus are not compatible with Islam. These findings suggest that efforts to improve men's knowledge, attitudes, and practices would have positive effects on family health and well-being (120).

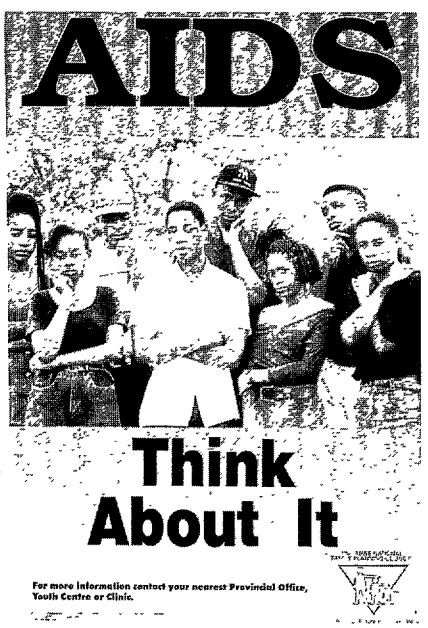
Reaching Men, Improving Health

The campaign *Together for a Happy Family* presented family planning as a regular part of Jordanian life, in harmony with traditional values and religious teachings, and a way to improve the health and well-being of families. The campaign stressed four themes in its messages (120):

- Spousal communication,
- Equal value of the girl child,
- Safety, effectiveness, and reversibility of modern methods, and their concordance with Islam,
- Improved quality of life through family planning.

Together for a Happy Family made use of lessons learned during the past decade about involving men in reproductive health. It built on men's knowledge and approval of family planning by using male community and religious leaders as advocates. The campaign promoted positive male roles and encouraged couple communication about family planning. It addressed gender roles by advocating that men place equal value on daughters and sons. It respected men's concerns by assuring that Islam approves of contraceptive use.

As part of the campaign national television and radio spots featured men in their role as family planning decision-makers. Each spot focused on one of the four themes of the campaign. Also, four short docu-dramas aired on prime-time national television, and 60 press articles, news columns, and reports were released throughout the campaign. The mass-media component of the campaign is estimated to have reached 1.5 million men nationwide (120).



Zimbabwe National Family Planning Council

Lesson 3. (Continued)
Reach out to young and unmarried men.

Serving young men. Many reproductive health programs do not serve young men or women because of opposition from religious, political, and other institutions that condemn sexual activity outside of marriage. Thus unmarried young adults of both sexes often find it much more difficult to obtain contraceptives than do married couples (51). In some places laws prohibit or limit providing contraceptives and other services to young and unmarried people. Some family planning providers have policies against serving unmarried men and women (159). Young men may be the most neglected of all. Even programs for young adults usually pay more attention to women than to men (12, 159).

The attitudes of individual providers also can stand in young men's way. Providers' religious or cultural beliefs may deter them from serving unmarried men and women (12). Rude or judgmental staff can discourage youth from seeking care. For example, in a South African study young field workers posing as clients reported that some clinic personnel resisted their requests for condoms and often provided no instructions about how to use condoms (2).

Young men need access to contraceptives and STD services where they can feel comfortable and accepted (159). Young

Together for a Happy Family

Informing Opinion Leaders

The campaign also aimed to increase men's approval of modern contraceptive methods by informing religious leaders and other opinion leaders about these methods. In mid-1998 some 2,000 male opinion leaders in two major cities attended community meetings where religious leaders, physicians, and social workers made presentations and led discussions of these themes. In preparation for the meetings Jordanian religious leaders visited Cairo on an observational tour, where they met with Islamic leaders who advocate family planning as agreeing with Islam because it improves the quality of family life.

Participants in the community meetings discussed family planning and Islam and how to motivate men to discuss family health issues and to use health services. Participants agreed to return to their communities and use their new knowledge to encourage support for family planning and contraceptive use among their social networks—for a ripple effect that could reach as many as 50,000 people (120).

Although it is too early to evaluate the full campaign, preliminary data suggest reason for optimism. Even though the men at the community meetings were older and more conservative than the general population, their attitudes changed significantly. For example, after the meetings the percentage of participants who believe that family size should be discussed with their wives rose from 61% to 69%. The percentage of participants who thought that having at least one male child is very important decreased from 52% to 44%. Participants' approval of the use of contraceptive methods rose from 74% to 84%, and, among nonusers, the percentage intending to use contraceptive methods rose from 25% to 38% (128).

Such findings suggest that reaching men can make a difference. As more men are exposed to campaigns based on new perspectives on men's participation, men's attitudes can continue to change, and contraceptive use may increase.

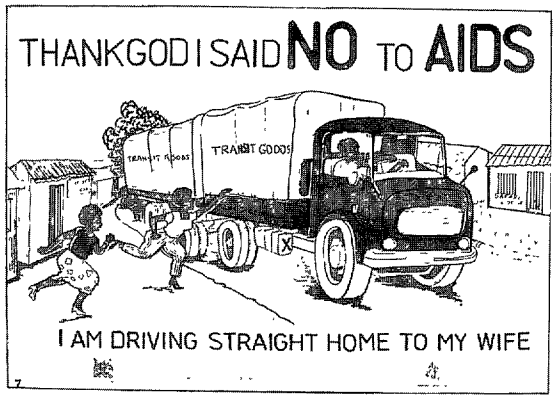
Kivork Tovanian

In Jordan a communication and advocacy campaign applied new perspectives on men to increase men's participation. Community and religious leaders met with physicians and social workers to discuss reproductive health, family planning, and Islam. Participants agreed to encourage support for family planning in their communities.

men often feel embarrassed at clinics and fear that their visits will not be kept confidential. Finding ways to attract young men to reproductive health services is challenging because many are reluctant to seek help.

Providing a comfortable atmosphere and offering a range of services, from general physical exams to STD testing, have proved effective in some places (12, 223, 233). The experience of clinics in the US provides an example (68, 233). In Charlotte, North Carolina, a clinic called The Male Place provides educational classes and counseling on STDs, reproductive health, contraception, and testicular self-exam. It offers its largely African-American clientele general physical exams as well as testing for sickle cell anemia and STDs (68, 230).

Also, in New York City the Young Men's Clinic was created in 1986 when staff realized that very few men were attending the Young Adult Clinic (233). To appeal to young men, the clinic positioned itself as a place where young men could "hang out," receive a physical exam, get advice and counseling, and receive reproductive health care and free condoms (10). The Young Men's Clinic has worked to build a reputation for trustworthiness among the young men in its low-income, mostly immigrant neighborhood. Many clients first go to the clinic because they need to have a general physical exam for school or work. These exams double as "teachable moments," when young men can learn about safe sexual behavior (10, 233).



Uganda Ministry of Health AIDS Control Programme

These posters from Zimbabwe (facing page) and Uganda seek to slow the spread of HIV/AIDS by promoting sexually responsible behavior among men.

■

Use Communication to Promote Behavior Change

An awareness of gender offers a new way to understand the complex relationships between men and women that affect their reproductive health behavior. IEC campaigns can promote new gender roles for men. Also, programs can encourage couple communication and help to foster joint decision-making about reproductive health. In communicating with men, experience teaches the value of reaching out to men in the places where they gather and feel comfortable and thus are more receptive to new information.

Lesson 4. Understand the influence of gender.

Whether reproductive health programs are for men or for women, understanding gender is important (see p. 18). Programs that recognize the widespread influence of gender, particularly how inequality between women and men affects their reproductive health, are better able to avoid reinforcing harmful gender roles. Instead, they can design communication programs and services that take account of gender roles and, over the long term, encourage more equality between the sexes. In recent years, several guides have been developed to help incorporate gender sensitivity into program design, implementation, and evaluation (53, 187).

In 1990 UNICEF launched a multimedia campaign in Asia to promote girls' potential for achievement when they receive equal education and support. Meena, the young heroine of an animated cartoon series, confronts problems that many girls face: son preference, early marriage, lack of educational opportunity, and poverty. The Meena series has been broadcast in 14 languages on both television and radio, reaching about 57 million people. Recently, UNICEF began 13 new episodes in Bangladesh, India, Nepal, and Pakistan.

The series is changing people's attitudes. As one father of four daughters said after watching Meena, "I will make sure my daughters get more opportunities than my wife or mother ever received" (146, 258). Building on the success of the Meena campaign in Asia, a similar character, named Sara, has been developed for Africa. Researchers drew on discussions with over 5,000 people from Eritrea to South Africa to create a realistic girl that Africans will relate to and learn from (163).

Important lessons about gender awareness have also been learned from unintended consequences of programs designed to increase men's participation. For example, during the 1970s and early 1980s, Profamilia in Colombia used the Latino *machisto* image to promote vasectomies. As Executive Director Maria Isabel Plata explains, that was a mistake because it reinforced negative stereotypes, such as sexual promiscuity and male dominance in decision-making. The number of vasectomies remained low. In 1985 Profamilia adopted a new strategy that emphasized male responsibility. "For the first time, men were being told that they could also participate. By (our) being gender sensitive, the number of vasectomies doubled and tripled," says Plata (192).

As another example, in Zimbabwe a multimedia campaign in 1993–94 to promote men's use of family planning relied on prominent sports players to tell men about the importance of practicing family planning (122). The campaign succeeded in reaching men and encouraging their participation. As an unintended consequence, however, some men exposed to the campaign were more likely to believe that they *alone* should make family planning decisions.

One possible explanation is that the campaign unintentionally reinforced stereotypes about male-dominated decision-making (122, 133). Another explanation is that men interpreted the campaign's primary message "Family Planning: It's Your Choice" to mean they should make such decisions by themselves. Subsequent men's participation campaigns in Africa, such as the Challenge CUP Initiative (see p. 29), have pretested messages to ensure that the audience correctly understands the intended reproductive health behavior.

Practical needs, strategic interests. In approaching gender issues, programs often face a difficult decision—how much to accept a society's gender roles and work within their confines to make health gains in the short term, and how much to devote attention to the long-term task of changing gender roles to promote gender equity. These different goals have been described as "practical needs" and "strategic interests" (53). For example, increasing condom use for HIV prevention through social marketing is a practical need. Changing social norms so that men and women feel comfortable discussing sexual relations is a strategic interest.

In Jamaica a new condom called *Slam*, designed to appeal to young men, is prompting a debate about practical needs versus strategic interests (285). The condom is named after the title of a popular song about a sexy dance hall queen, but it also implies violent sex. No Glove, No Love Ltd., the company marketing the condom, argues that condom promotion needs to be realistic in order to appeal to the male audience. By promoting a condom that will enhance sex and make it safer, the company contends, it can help to reduce STD rates, prevent unwanted pregnancies, and save lives.

While supporting these health goals, critics of the campaign worry that the campaign demeans women and encourages men to treat them badly. They argue that the name of the condom sends out a dangerously mixed message that condones or encourages sexual violence against women.

Long-term social change can seem threatening to men who see power distribution as a zero sum game, in which women can gain only if men lose (262). Practical needs and strategic interests need not conflict, however. In fact, addressing the practical needs of women can be an "entry point" to working for longer-term gender equity or fairer power distribution (53). Therefore programs need to address strategic interests with an eye to minimizing opposition and gaining support from male leaders.

Megan Drennan for JHU/CCP

In a Kenyan factory John Karanja educates fellow workers about reproductive health.

Lesson 5. Encourage couple communication.

Increasingly, health care providers and researchers are realizing that the most appropriate client for reproductive health information and services may be the couple rather than the individual (26, 27, 62, 93, 130, 172). For example, men who discuss family planning with their wives are more likely to use contraception and support their wives' use of contraception (see p. 21).

Recently, several projects have increased use of contraception by facilitating communication between husbands and wives. In Bangladesh, for example, the *Jiggasha* project uses existing rural communication networks to make discussion about reproductive health more culturally acceptable and to foster more communication among men and women (190). *Jiggasha* is the Bangla word for "to inquire."

Jiggashas are village discussion groups composed of either men or women; they meet separately. The *jiggashas* create a comfortable place for men and women to ask questions about family planning, contraceptive methods, and reproductive health (122). Specially trained field workers collaborate with male and female opinion leaders in the village to teach about contraceptive methods, answer questions, distribute contraceptives, and make referrals. They also encourage both men and women to talk with their spouses about family planning. Men's participation in the *jiggashas* helps to create an environment of approval for family planning.

Follow-up survey results suggest that the *jiggasha* approach complemented existing family planning efforts by field workers. In villages with family planning field workers as well as *jiggashas*, the contraceptive prevalence rate (CPR) increased from 38% to 56%. In villages with field workers but without *jiggashas*, the CPR rose from 26% to 32% (122).

In rural Honduras an agricultural extension program offers an example of a low-cost way to involve men in reproductive health and to increase couple communication about family planning (194). While meeting with farmers, paid extension workers used an interactive manual to talk about reproductive health. In some areas couples also were given a booklet designed to help husbands and wives plan their long-term family goals. In both areas communication between spouses improved. The percentage of women who reported discussing family planning with their husbands increased from 36% to 50%. The percentage of couples discussing STDs and HIV rose from 42% to 54% (194).

Lesson 6. Bring information to where men gather.

Programs can reach more men when they go where men naturally congregate, such as the workplace, social clubs, or sporting events (61, 122). Men are comfortable in these places, form a ready audience, and may be more receptive to new information. The success of many contraceptive social marketing programs over the years testifies to the validity of this direct approach (see **Population Reports**, *Men: New Focus for Family Planning Programs*, 1986).

There are many different ways to find men. In southern India more than 250,000 barbers have been trained as community health workers. They talk about condoms and distribute them to clients in their shops. Village men say they feel more comfortable talking with their barbers than to clinic workers (11).

In 1995 the Family Planning Association of Kenya (FPAK) began an ambitious 5-year project to involve men in family planning and reproductive health (122). The Male Involvement Project reaches men through a variety of channels, including going to their workplaces. John Karanja is a typical workplace motivator. Employed at the Nakuru blanket factory, he teaches his fellow employees at lunch-time and at after-work seminars about contraception, birth spacing, and HIV/AIDS. He sells contraceptives, such as the Pill and condoms, to men after work. He bicycles to the houses of employees in the factory compound to answer men's questions and to encourage couples to make reproductive decisions together. On these home visits, he also refers clients to the FPAK clinics for vasectomy or tubal ligation, if the couple has decided they want permanent contraception.

To reach other working men in the Nakuru district, male staff members of the FPAK clinic put on puppet shows in the local park during the lunch hour. The puppets are an entertaining, nonthreatening way to educate men and women about contraceptive methods, STD/HIV prevention, and available reproductive health services. At the end of each show the puppeteers invite questions from the audience (93).

All over the world, sports events attract many men. In Africa, as elsewhere, football is a passion among men and boys. Tapping this natural audience, Johns Hopkins Population Communication Services launched the Challenge CUP Initiative in 1997 in Ghana, Kenya, Uganda, and Zambia. CUP stands for "Caring, Understanding Partners." The Challenge CUP Initiative encourages men who attend the football matches to become more sexually responsible, to prevent STDs, to learn more about reproductive health, and to discuss it with their wives or other sex partners. To reach the large crowds attending the games, a variety of materials featuring key reproductive health messages are given away, including trading cards of football stars, T-shirts, sun visors, bumper stickers, and informative pamphlets (207). At the same time, coaches and football players are counseled about positive reproductive health behavior. Several star players serve as spokesmen and role models, speaking about spousal communication and STD prevention at half-time during matches and also on radio and television.

Visual Horizons

In India more than 250,000 barbers are trained to dispense health advice and condoms as well as haircuts.

■

Offer Information and Services That Men Want

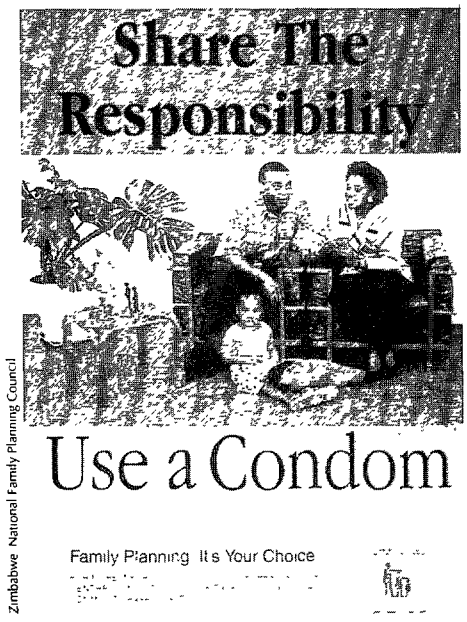
Men need information about contraceptive methods. When they know the facts about male methods, they are more likely to use them. Providers need to offer sensitive counseling to men, whose concerns often differ from those of women. Men are more likely to use reproductive health services that are part of a range of services that interest them.

Lesson 7. Inform men about condoms and vasectomy.

When more men know the basic facts about and benefits of condoms and vasectomy, more will use them (14, 63). In much of the world condoms and vasectomy suffer from misinformation and undeserved poor reputations.

In the developing world, excluding China, the prevalence of condom and vasectomy use among married couples averages just 4% and 3%, respectively. Use is slight partly because men do not know enough about these methods and may believe rumors. Men need clear, factual information from reliable, trusted sources.

Condoms. Condom promotion and sales have increased in response to the HIV/AIDS epidemic, but use of condoms falls far short of the need for them (81, 139, 144). For sexually active people with multiple partners, using condoms is the only way to protect against HIV/AIDS. Many men do not like condoms, however, because they interrupt sex and diminish pleasure. Others do not trust condoms. Many men and women think mistakenly that condoms often break or that tiny, invisible holes allow sperm and HIV to pass through (77).



Encouraging condom use, as in this Zimbabwe poster, can slow STD transmission. Programs can dispel myths and rumors about condoms by presenting the facts.

In many countries social marketing helps to make condoms widely available. Worldwide, social marketing programs sold 937 million condoms in 1997, 20% more than the year before (299). Social marketing programs promote condoms both for family planning and for STD prevention (81, 144, 197). In Vietnam, for example, social marketing has focused on condoms for family planning (94). Cambodia's Condom Social Marketing Program has helped to promote safer sexual behavior as well as to increase demand for condoms for family planning. Before Population Services International (PSI) started a social marketing program in 1993, condom sales in Cambodia averaged about 2 to 3 million annually. In 1997 sales were estimated at 10.5 million (197).

In addition to more promotion and better availability, another approach to increasing condom use is developing new condoms that allow more sexual pleasure and convenience (263). A new, looser condom has been launched in Europe to appeal to men who are skeptical of condoms. The condom is designed to be more comfortable and easier to put on. It is made of polyurethane, not the usual latex, and is about half as thick as a conventional condom (184).

Vasectomy. While many men do not choose vasectomy because they desire more children, others shun vasectomy because they believe incorrectly that it will lower sex drive, cause impotence, and be inconvenient. Several communication campaigns have used the mass media to get facts to men about the safety and ease of vasectomy. For example, a 1994 vasectomy promotion project in Kenya aired spots on a private television station to improve men's attitudes toward vasectomy. Advertisements in newspapers motivated men to request more information about vasectomy and told men about clinics that perform vasectomies (122). As a result, 835 men in the Nairobi area requested information about vasectomy, more than double pre-campaign requests. After six months of the campaign, the number of vasectomies had increased by 125% (134).

An IEC campaign in Dar es Salaam, Tanzania, sought to dispel rumors about vasectomy and to promote its benefits. During 1995 and 1996 the Vasectomy Promotion Project used radio, newspapers, and satisfied client testimonials to give men and women the facts about vasectomy and to provide information about available services. Addressing a common misperception of men, the campaign stressed that vasectomy differs from castration. It sought to allay men's fears of side effects such as loss of sex drive, obesity, and impotence. The campaign, which reached more than 60% of its intended audience, concluded that men are willing to choose vasectomy if providers educate them and inform them of its availability (173).

In Brazil a multimedia campaign promoted vasectomy as "an act of love." The central image of the campaign was a cartoon of two hearts, one male and one female, who playfully depicted the advantages of vasectomy. The animated cartoon aired on television, and the hearts were featured in pamphlets, magazine advertisements, and billboards. During and after the campaign, requests to clinics for information about vasectomies increased substantially (122, 134). Years after the campaign, family planning clients still referred to the two hearts (63).

Potential family planning clients consider information from friends and relatives to be reliable and trustworthy. Thus satisfied vasectomy clients often can recruit new clients (13, 266, 282). The Family Planning Association of Pakistan, for instance, asks its clients in Faisalabad who have had vasectomies to recommend the procedure to friends and relatives interested in permanent contraception. Also in Brazil, Colombia, and Mexico, vasectomized men have been especially influential in helping other men decide to have vasectomies (266).

In Colombia Profamilia opened its first clinics for men in 1985, performing 1,241 vasectomies that year. Its male clientele has increased steadily since then. A decade later Profamilia performed 6,825 vasectomies in a year (14).

Lesson 8. Counsel men with respect and sensitivity.

Service providers who understand and respect men's reproductive health needs are better able to help them. Good counseling can be key to serving men, as it can be to serving women. Experience in Brazil, Colombia, and Uganda suggests that men will accept information and services from either male or female counselors and providers as long as the providers are knowledgeable and respectful (14, 100).

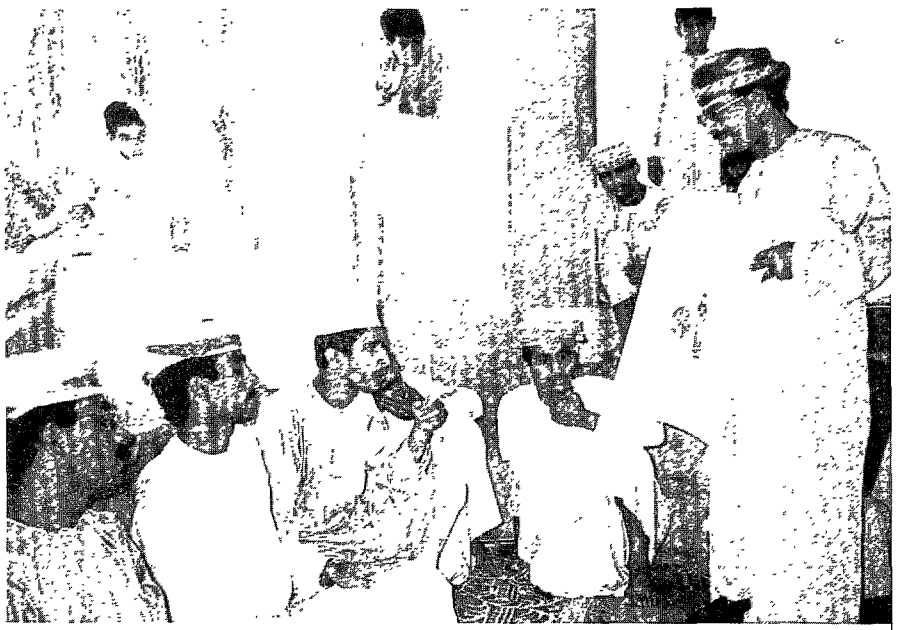
Providers can counsel well by being aware of men's concerns. When men visit clinics, at first they may want to talk about something other than the real reason for the visit (14, 93). Thus sensitive counselors lead the conversation to reproductive health topics and ask questions that draw out men's reproductive health questions and concerns. Men sometimes ask difficult questions about such issues as sexual pleasure, sex drive, and sexual anatomy. Such questions are best answered with accurate information offered in a relaxed, nonjudgmental, and helpful manner. To encourage men's participation, providers can go beyond answering men's questions about contraceptive methods and also help them consider their reproductive goals, those of their partners, and the choices they face together (132).

Some men, especially young men, do not want to reveal their ignorance about sex and reproduction. Thus they may not ask questions, may be quiet in groups, and may act differently if their wife or girlfriend is present. Nevertheless, by being sensitive to men's concerns, educators and counselors can determine what information they need and convey it without causing embarrassment (99).

In Colombia Profamilia has learned the importance of good counseling through more than 10 years of operating men's clinics. In the Bogota men's clinic a counselor meets briefly with each man before his medical visit to give him a chance to ask confidential questions. Before such counseling was provided, male clients often received and paid for medical services they did not need (14).

Since few programs have experience working with men, training clinic staff to assure high-quality care is especially important. Clinic staff may hold prejudices against men and may even discourage them from seeking family planning information and services. In Kenya, for example, a mystery client study found that the quality of counseling for men was inconsistent. Male clients employed by the researchers visited family planning clinics and pretended to want a vasectomy. Some of the men received courteous treatment and knowledgeable counseling. Most of the men, however, reported a mixed experience with the staff. In 4 of 14 visits counselors did not explain the vasectomy procedure correctly. During eight visits female counselors asked the male mystery clients why their wives were not having tubal ligation. A few counselors even tried to persuade the men not to have vasectomies (282).

In 1993 the Jamaica Family Planning Association (FAMPLAN) began comprehensive staff training as part of its efforts to serve men and couples better. The training was part of an effort to integrate STD prevention with family planning services. First, a baseline survey of counselors, nurses, and other staff assessed their knowledge of STDs, including HIV. Then a training curriculum was developed for the entire staff, including the bus drivers and receptionists. Training focused first on STD prevention, including correct condom use, and on counseling. Training later also covered sexual health, sexuality, and advanced counseling skills. Reflecting the program's efforts, condom distribution increased by 350%, from 60,000 condoms in 1992 to 213,000 condoms in 1994 (222).



Carol Underwood for JHU/CCP

In Oman a health worker pretests counseling materials with a group of men. Respectful and sensitive counseling can help men improve their reproductive health.

Lesson 9. Offer men a range of health services.

Reproductive health programs around the world have found that men have similar reproductive health concerns and needs. While working with their male clients, such organizations as Marie Stopes International, Profamilia in Colombia, Promoção da Paternidade Responsavel (PRO-PATER) in Brazil, the Family Planning Association of Kenya, and the Young Men's Clinic in New York City have identified reproductive health services needed by male clients (12, 14, 32, 55, 61, 63, 100, 152, 241, 242, 271):

- Screening and treatment for STDs, including HIV/AIDS,
- Counseling on how to prevent STDs and HIV/AIDS,
- Giving correct information about family planning,
- Providing contraceptive methods,
- Counseling and treatment for infertility,
- Counseling and treatment for sexual dysfunction,
- Screening and treatment for penile, testicular, and prostate cancers.

In reproductive health clinics, offering a constellation of such health services increases the likelihood that men will use the clinic (13, 63, 68, 100, 233). Offering job counseling, skills training, legal counseling, and other nonmedical services also can make health clinics more attractive to men. As an example, AVSC International has developed a comprehensive model for men's reproductive health services for its Men as Partners (MAP) Initiative (12). Similarly, Marie Stopes International has designed the "Well Man Screening" approach (153).

Lesson 9. (Continued)
Offer men a range of health services.

More than 15 years of programmatic experience demonstrates the value of offering a range of services. For example, in Brazil PRO-PATER, which was established in 1980 primarily to meet men's reproductive health needs, offers STD services, treatment for sexual and reproductive health problems, no-scalpel vasectomy, and other contraceptive methods. Counselors inform all clients about contraceptive methods, including vasectomy, and help clients to make informed decisions. PRO-PATER also conducts courses on men's reproductive health for nurses, doctors, social workers, and psychologists (63, 134).

In Colombia Profamilia's three men's clinics provide a range of services to attract clients (14). Health services include general medical exams, urological services, family planning counseling and contraceptive methods, infertility testing and treatment, STD treatment, HIV testing, sex therapy, and plastic surgery. In addition, the organization offers legal services to men for divorce, separation, and child support. Profamilia also educates men about reproductive health, including gender issues, through brochures and posters (14).

Men's rising demand for services and their ability to pay for them has allowed Profamilia to subsidize other family planning services. For example, in 1986 the Bogota's men's clinic covered 70% of its costs from fees charged for services. By 1995 the clinic was self-sufficient and generating a surplus of 21% over costs (14 (14).

Danielle Baron for JHU/CCP

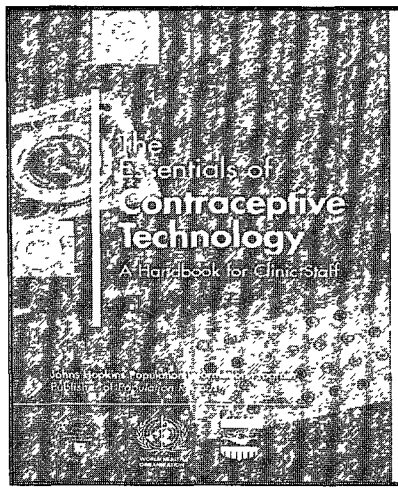
A Senegalese clinic worker discusses contraception with a client. As well as family planning information and methods, men want convenient services, advice on disease prevention, and medical exams.

Operating separate clinics has been an important way to serve men, but it is often an expensive option. Such clinics are not the only way, however. Making family planning programs for women more friendly to men as well can be an affordable approach. Sensitive, knowledgeable staff and a welcoming environment can attract more men to reproductive health services, even when they are offered along with services for women (13).

Many family planning clinics already are encouraging men's participation to a degree (59). One simple way is to treat men more cordially. A number of other low-cost activities can make existing services more friendly to men—for example, encouraging women to bring their male partners for counseling and services, establishing evening and weekend hours for men and offering counseling about STD prevention along with family planning counseling. Indicators of men's participation used with other indicators of program output will help providers recognize the importance of serving men well (100).

■

Men: Full partners and advocates for good reproductive health. In the past decade programs have begun to view men from new perspectives. Policy-makers and service providers increasingly recognize that reaching men is a winning strategy, with benefits for both men and women. Now it is time to apply the lessons learned and to make men full partners and advocates for good reproductive health. Men are ready to change their behavior toward family planning and other reproductive health. To help them do so, programs can cooperate, learn from one another, and develop a variety of approaches that reach and serve men. Programs can find new ways to encourage sexual reponsibility, to foster men's support of their partners' contraceptive choices, and to address the reproductive health care of couples. There is still a long way to go, but with new information, new ideas, and new approaches, programs have already made a strong beginning.



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